Springs Rehabilitation, PC

6005 Delmonico Dr., Suite 130
Colorado Springs, CO 80919
(719) 634-7246

PATIENT REGISTRATION FORM

(Print clearly & press firmly in BLACK or BLUE ink)

Today's Date_____

Patient Name_____
Last First MI Preferred name

Date of Birth _____ SSN _____ Gender (circle) F M

Address _____
Street Apt/Ste City State Zip

E-Mail _____ Providing email address will give access to the patient web portal

Marital Status: Single Married Divorced Widowed

Primary Phone (circle) Home or Cell ( )_____ May we leave a message? (circle) YES / NO

Secondary Phone (circle) Home or Cell ( )_____ May we leave a message? (circle) YES / NO

Work Phone ( )_____ OK to call work? (circle) YES / NO Ok to leave message? YES/NO

Patient's Employer_____

Primary reason for today's visit_____

Pharmacy:_____

Primary Care Physician_____ Referring Physician_____
Last First Last First

Is this work-related? (circle) YES NO Related to an auto accident? (circle) YES NO *If YES on EITHER, please complete Auto/WC Form*

Current insurance card(s) and photo identification are required for scanning. Please complete the following:

Primary Insurance _____ Policy #/ID _____ Group # _____

Name of Policy Holder _____ SSN _____ Date of Birth _____ Gender (circle) F M

Relationship to Patient_____ Employer _____ Employer Phone ( )_____

Secondary Insurance _____ Policy #/ID _____ Group # _____

Name of Policy Holder _____ SSN _____ Date of Birth _____ Gender (circle) F M

Relationship to Patient_____ Employer _____ Employer Phone ( )_____

If you are a Medicare beneficiary, please circle any of the following that apply to you: (circle) Working-Aged Veterans Disability

If patient is a minor, name of Custodial Parent _____

Custodial Parent's Primary Phone( )_____ Secondary Phone( )_____

Custodial Parent's SSN_____ Date of Birth_____

If 65 or older, do you have an Advanced Directive (circle) YES NO

If so, Please list name of designated representative _____

Emergency Contact – Close friend or relative not living with you that we can contact in an emergency:

Name _____ Relationship _____ Phone( )_____
Last First

Name of person we may speak with other than yourself regarding your medical care?_____

Primary Phone( )_____ Secondary Phone( )_____ Relationship_____

Additional name of person we may speak with _____

Primary Phone( )_____ Secondary Phone( )_____ Relationship_____

Springs Rehabilitation, PC
6005 Delmonico Dr. Suite 130
Colorado Springs, CO 80909
(719)634-7246

FINANCIAL POLICY

(print clearly & press firmly in BLACK or BLUE ink)

TODAYS DATE: _____ **PATIENT NAME(PRINT):** _____ **DOB:** _____

We are committed to providing you with the best possible medical care. If you have medical insurance, we would like to help you receive the maximum allowable benefits. To achieve this, we will need your assistance and understanding of our financial policies. Please carefully review this information and sign/initial where indicated. A copy will be provided to you upon request.

INSURANCE: We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until you can provide a current copy of your card. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you have regarding your coverage.

ASSIGNMENT: I request that payment of authorized insurance, Medicare and Health First Colorado-Medicaid benefits be made payable to Springs Rehabilitation, PC on my behalf for services furnished to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. If my account is turned over to a collection agency, I agree to pay all reasonable cost of collections and understand that I may no longer be a patient at this office.

_____**(Initial) I have read and agree to the above statement.**

CO-PAYS/COINSURANCE/DEDUCTIBLES: All co-payments and a portion of annual deductibles must be paid at time of service. This arrangement is part of your contract with your insurance company and we are obligated to collect these fees. Springs Rehabilitation will be implementing a deductible-payment policy effective 1-1-2018. All patients with annual deductibles will be required to pay $75 at time of service until annual deductible is met. The exception to this is for EMG/NCV studies; a $300 payment will be required at time of service. If at any time you have any questions or concerns regarding our fees, policies or responsibilities please feel free to contact Rachael (Practice Manager) at 719.634.7246.

_____**(Initial) I have read and agree to the above statement.**

REQUESTS FOR INFORMATION: Should I receive any requests from my insurance company regarding my services at this office, I must respond to that correspondence immediately, to have the claim processed and paid. If your insurance company does not pay the claim within 30 days, the balance will be automatically billed to you.

_____**(Initial) I have read and agree to the above statement.**

PATIENT BALANCE/NONPAYMENT: Self pay and previous balance amounts are due and payable at the time of service. If your account is over 60 days past due, you will receive a statement requesting payment in full within 20 days. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we will refer your account to a collection agency and you may be discharged from this practice.

WORKERS' COMPENSATION: I will provide approval/authorization by the Workers' Compensation carrier at the initial visit. If the claim is deferred, the private medical insurance will be billed. I understand if the claim is denied, I will be responsible for payment in full. If the claim is in litigation, a verification of this from an attorney and/or the Workers' Compensation carrier will be provided to this office.

_____**(Initial) I have read and agree to the above statement.**

RETURNED CHECKS/NO SHOW POLICY: I understand and agree to pay a returned check charge of $50 for each check that is returned to any reason. I agree to pay the amount of the check plus the service charge within 30 days of receipt of notification. I understand and agree to pay a $50 charge for appointments that I do not honor or do not call to cancel within 48 hours prior to the scheduled appointment.

_____**(Initial) I have read and agree to the above statement.**

APPOINTMENT POLICY: You are expected to arrive 15 minutes prior to your appointment time. Late arrival may result in cancellation of your appointment. Failure to attend 3 scheduled appointments will result in the termination of your care at Springs Rehabilitation.

PRIVACY POLICY: I have been made aware of the privacy policy of Springs Rehabilitation PC and have received (or been given the option to receive) a copy of the Notice of Privacy Practices.

_____**(Initial) I have read and agree to the above statement.**

I have read and agree to the above information and I, the undersigned patient am ultimately responsible for the fees. By signing below, I consent to be contacted by regular mail, email or by telephone regarding any matter related to the above referenced account by the creditor, its successors or assigns. This consent includes any updated or additional contact information that I may provide and includes contact that employs auto-dialer technology and/or prerecorded messages.

SIGNATURE: _____

SPRINGS
REHABILITATION, P.C.

6005 Delmonico Drive
Suite 130
Colorado Springs, CO 80919
719 634.PAIN (7246) • fax 719 634.4042
www.springsrehab.net

Kenneth P. Finn, M.D.

Sonja R. Griffith, FNP-C

Authorization for Disclosure of Health Information To Springs Rehabilitation, PC

_____ _____
Name of Patient Date of Birth

_____ _____
Street Address City, State, Zip Code

I hereby authorize the disclosure of my protected health information to Springs Rehabilitation, PC as described below:

Information to be released:

_____Medical History, Examination Reports
_____Treatment or Tests
_____X-ray Reports/Films
_____Laboratory Reports
_____HIV Test Results*
_____Mental Health
_____Sexually Transmitted Disease
_____Alcoholism
_____Surgical Reports
_____Hospital Records including reports
_____Developmental Disabilities
_____Prescriptions
_____Consultations
_____Allergy Records
_____Drug Abuse
_____Other (Please Specify)_____ *A listing of the statutory exceptions to release of HIV test results without consent is available.

Purpose for Need of Disclosure

_____At the request of the individual
_____Other (Please Specify)_____

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be redisclosed without obtaining my authorization.

I understand that I have the right to:

- **Receive a Copy of this Authorization.**
- **Revoke This Authorization,** except to the extent that the person(s) and or organization(s) listed above have already made in reference to this authorization.

This authorization will remain in effect until the following date(s):_____

_____ _____
Signature of Patient (or legal representative) **Date**