

HIPAA AUTHORIZATION FORM B

(This brings in your medical records from other doctors, therapists, hospitals, etc.)

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|---------------|--|
| Printed Name: | |
|---------------|--|

I, hereby authorize (insert name of practice / person)

| | | | |
|--------|--|------|--|
| | | | |
| Phone# | | Fax# | |

to release the following information: (Please be specific and check those that apply)

| | | | |
|--|--------------------------|--|--|
| | History & Physical | | Activity / Occupational Assessment |
| | Psychiatric Assessment | | Clinical & Laboratory Results |
| | Psychological Evaluation | | Pregnancy Status |
| | Treatment Plan / Report | | Discharge summary from @ facility/practice |
| | Vocational Assessment | | Transfer Forms |
| | Physician Progress Notes | | Radiology Films or Disk and Reports |

To: Jonathan Woodcock, MD, Neurological Rehabilitation Resources, PC
 C/O: Sara Burns, 8515 Pearl Street, #203, Thornton, CO 8022, Fax: 303-288-7874 / Email: info@nrrmd.com

Neurological Rehabilitation Resources does not pay for copying or mailing fees. These fees are the responsibility of the patient or the authorized personal representative. **(Please do not fax over 25 pages)**

This Private Health Information (PHI) is being used or disclosed for carrying out treatment, evaluation, disability evaluation, payment and/or: _____
(HIPAA requires you to provide a specific reason(s))

This authorization shall be in force and effect until (specify date) _____ or (specify an event that relates to the patient or the purpose of the use or disclosure) _____ at which time this authorization is to be used and the disclosures expiration. I understand that I have the right to revoke this authorization, in writing, at any time by sending a revocation.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to inspect or copy the PHI to be used or disclosed as permitted under federal or state law. I understand that I have the right to refuse to sign this authorization.

| | | | |
|-----------------------------|--|-------------------------|--|
| Patient's Social Security # | | Patient's Date of Birth | |
|-----------------------------|--|-------------------------|--|

| | |
|--|-------|
| Signature of Patient or Personal Representative: | Date: |
| Name of Patient or Personal Representative: | |
| Description of Personal Representatives Authority: | |

This form may be photocopied.
Each entity/person releasing your medical records needs a separate form.

HIPAA CONSENT FORM

PATIENT CONSENT FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use/disclosure of my private health information (PHI) by Neurological Rehabilitation Resources, P.C. for the purposes of diagnosing, providing care and treatment to me, obtaining payment for my health care bills or conducting the health care operations of Jonathan H. Woodcock, MD. I understand that diagnosis or treatment of me by Neurological Rehabilitation Resources, P.C. may be conditional upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or the healthcare operations of this practice. Neurological Rehabilitation Resources, P.C. is not required to agree to the restrictions that I may request. However, if Neurological Rehabilitation Resources, P.C. agrees to a restriction that I request, the restriction is binding on Neurological Rehabilitation Resources, P.C., Jonathan H. Woodcock, M.D. I have the right to revoke this consent, in writing, at any time, except to the extent that Neurological Rehabilitation Resources, P.C. has taken action in reliance on this consent.

My PHI means health information, including demographics, collected from me and created or received by my physician, another health provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Neurological Rehabilitation Resources, P.C.'s Notice of Privacy Practices prior to signing this document. The Neurological Rehabilitation Resources, P.C.'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of health care operations of the Neurological Rehabilitation Resources, P.C. The Notice of Privacy Practices for Neurological Rehabilitation Resources, P.C. is provided at 8515 Pearl Street, #203, Thornton, CO 80229. This Notice of Privacy Practices also describes my rights and the Neurological Rehabilitation Resources, P.C.'s duties with respect to my PHI.

Neurological Rehabilitation Resources, P.C. will retain your patient file for a minimum of seven (7) years after the termination of treatment described herein, at which time the file may be disposed of in a confidential manner at the discretion of this firm.

Neurological Rehabilitation Resources, P.C. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent to me in the mail or by asking for one at the time of my next appointment.

| | |
|--|-------|
| Signature of Patient or Personal Representative: | Date: |
| Name of Patient or Personal Representative: | |
| Description of Personal Representatives Authority: | |

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

(This notice is effective as of January 1, 2005)

TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Neurological Rehabilitation Resources, P.C. uses and discloses your protected health information for treatment, payment and health care operations. Some examples of when our office may use or disclose your health care information for these purposes include:

- Sharing test results with other health care providers for confirmation of a diagnosis;
- Providing your diagnosis or other information about your health to your insurance provider or our billing service to obtain payment for the health care services we provide;
- Reviewing information as part of our quality improvement program.

OTHER USES AND DISCLOSURES

Neurological Rehabilitation Resources, P.C. may also use or disclose your protected health information, in compliance with guidelines outlined by law, for the following purposes:

- Providing you with information related to your health;
- Contacting you regarding appointments, information about treatment alternatives, or other health related services;
- Incidental uses or disclosures (e.g., listing your name on a sign-in sheet, etc.);
- Compliance with all laws (including reports of suspected abuse, neglect or violence);
- Providing certain specified information to law enforcement or correctional institutions;
- Providing information to a coroner, medical examiner, funeral director, or organ procurement organization;
- Public health activities when requested by a public health authority or the FDA.
- Responding to health oversight agencies;
- Responding to court or administrative tribunal orders, subpoenas, discovery requests or other lawful process;
- Research activities;
- When necessary to avert a serious threat to health or safety;
- Military affairs, veterans affairs, national security, intelligence, Department of State, or presidential protective service activities;
- Providing information regarding your location, general condition or death to public or private disaster relief agencies; or
- Informing a family member, other relative, or close personal friend when:
 - Information is relevant to the individual's involvement with your care;
 - Notification of your location, general condition or death;
 - To assist in your health care (e.g., pick-up prescriptions or other documents, note follow-up care instructions, etc.).

AUTHORIZATION FOR OTHER USES

Neurological Rehabilitation Resources, P.C. will make other uses and disclosure of your protected health information only after obtaining your written authorization. If you authorize a use not contained in this notice, you may revoke your authorization at any time by notifying us in writing that you wish to revoke your authorization.

YOUR RIGHTS REGARDING THE PRIVACY OF YOUR HEALTH INFORMATION

Subject to limitations outlined by law, you have certain rights related to use and disclosure of your protected health information, including the right to:

- Request restrictions on certain uses and disclosures. However, Neurological Rehabilitation Resources, P.C. is not obligated to agree to requested restrictions.
- Receive confidential communications of protected health information.
- Inspect and copy your protected health information with some limited exceptions;
- Amend your health information;
- Receive an accounting of disclosures of your health information;
- Obtain a copy of this notice.

DUTIES REGARDING THE PRIVACY OF YOUR HEALTH INFORMATION

Subject to limitations outlined by law, Neurological Rehabilitation Resources, P.C. has certain duties related to your protected health information, including:

- Neurological Rehabilitation Resources, P.C. is required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.
- Neurological Rehabilitation Resources, P.C. is required to abide by the terms of the privacy notice that is currently in effect.
- Neurological Rehabilitation Resources, P.C. will retain your patient file for a minimum of seven (7) years after the termination of treatment described herein, at which time the file may be disposed of in a confidential manner at the discretion of this firm.
- Neurological Rehabilitation Resources, P.C. reserves the right to change a privacy practice described in this notice and to make such change effective for all protected health information. Revised notice will be posted in our office and available upon request.

CONCERNS

If you believe your privacy rights have been violated, you may make a complaint by contacting Sara Burns, the Privacy Officer of Neurological Rehabilitation Resources, P.C. (303-288-7882) or the Secretary for the Department of Health and Human Services. No individual will be retaliated against for filing a complaint.

ACKNOWLEDGMENT

I acknowledge that I may obtain a copy of this signed notice regarding the use and disclosure of my health information at any time.

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|--|-------|
| Signature of Patient or Personal Representative: | Date: |
| Name of Patient or Personal Representative: | |
| Description of Personal Representatives Authority: | |

HIPAA AUTHORIZATION FORM A

(This release allows Neurological Rehabilitation Resources, P.C. to send out our records on the patient.)

| | |
|---------------|--|
| Printed Name: | |
|---------------|--|

I, hereby authorize **Dr. Jonathan Woodcock, Neurological Rehabilitation Resources, PC, 8515 Pearl Street, #203, Thornton, CO 80229** to release the following information: (Please be specific and check those that apply)

| | | | |
|--|---------------------------------|--|--|
| | History & Physical | | Activity / Occupational Assessment |
| | Psychiatric Assessment | | Clinical & Laboratory Results |
| | Psychological Evaluation | | Pregnancy Status |
| | Treatment Plan / Report | | Discharge Summary |
| | Physician Progress Notes | | X-rays, Scans, MRI films or disk and Reports |
| | Vocational Assessment | | Transfer Forms |

and/or: _____

My records are being used or disclosed for: _____

(HIPAA requires you to provide a specific reason(s))

To:

| | | | |
|------------------|--|------|--|
| Name: | | | |
| Mailing Address: | | | |
| Phone# | | Fax# | |

I understand that I have the right to revoke this authorization, in writing, at any time by sending such a revocation is not effective to the extent that Neurological Rehabilitation Resources, P.C. has relied on the use or disclosure of the protected health information. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I have signed the consent form of Neurological Rehabilitation Resources, P.C. and have been made aware of the Practices "Notice of Privacy Practices." The statements included in this authorization are binding with Neurological Rehabilitation Resources, P.C. Per HIPAA compliance, please allow 4 weeks for completion of your request. Physician to physician medical records requests are not charged as a professional courtesy

I understand that I have the right to inspect or copy the PHI to be used or disclosed as permitted under federal or state law. I understand that I have the right to refuse to sign this authorization.

| | |
|--|-------|
| Signature of Patient or Personal Representative: | Date: |
| Name of Patient or Personal Representative: | |
| Description of Personal Representatives Authority: | |

**This form may be photocopied.
Each entity/person releasing your medical records needs a separate form.**

Rights of Patients

Getting Care: Patients have a right to expect medical care no matter what race, creed, sex, religion, country of origin or how he/she will pay for care.

Respect and Honor: The patient has the right to be treated with respect and honor at all times.

Privacy: This right is recognized by statute or common law in almost every state, and it entitles an individual to be free of harassment, unwanted publicity, commercial exploitation and intrusion into his/her personal life. The patient has the right within the law to privacy as listed in these rights:

1. To refuse to talk with or see anyone, including the office staff, as part of his/her care.
2. To be asked questions and have his/her body checked in a place where others cannot see or hear what is said. This means a person of the same sex can be there during parts of a physical check or treatment done by a doctor or office staff member. To not to be undressed any longer than needed.
3. To have any talks about his/her case in private. To have no one present who is not part of his/her care without saying "yes" or "no."
4. To have his/her chart read only by someone who is doing part of the care or looking at the quality of care. Anyone else can read it only with him/her saying "yes" or "no."
5. To keep secret all records or talking about his/her care or how he/she will pay for care.
6. To be told of any experiments or projects that might be part of his/her care.

Personal Safety: The patient has the right to expect to be safe in our office. Please do not bring your pet into the office for your appointment or for any other reason. **A service animal is not a pet.** Please ask the staff if you require further information regarding this policy.

Right To Know: The patient has the right to know the name and title of anyone who is giving care. The patient has the right to know about others who work with his/her doctor.

Knowing The Facts: Patients have the right to hear about the doctor's diagnosis, treatment, and what the results may be.

Communication: The facts must be in words the patient can understand or be given to his/her family. When the patient does not speak English, we advise bringing with you a family member or friend who can interpret for the patient.

Questions: The patient has the right to ask any question about their care/treatment and to ask for a second opinion or a special doctor when needed.

Refuse Care: The patient has the right to refuse care as written in the law. Refusing care may mean that the doctor can stop care when the patient has been told, and anything that happens will be the fault of the patient.

Payment: The patient has the right to have a copy of the total bill for their care. The patient has the right to be told by any insurance that payment may be stopped.

Patient's Part in Care

1. The patient is obliged to tell the physician the truth about the nature and duration of his/her symptoms/illness/injury and to provide medical history. Failure to do so could adversely affect the physician's ability to diagnose and treat the patient's illness.
2. The patient should tell the doctor all about his/her past and current medications, past and current treatments, and providers seen related to their symptoms/illness/injury.
3. The patient is expected to follow the physician's instructions concerning diet, medication, exercise, habits, treatment plan, and follow-up appointments, etc.
4. The patient must see that his/her doctors are paid for the care that was given.
5. The patient should follow the rules that are part of his/her care and treatment plan.
6. The patient should pay attention to the rights of other patients waiting to be seen by the doctors. The patient should not smoke in the building. The patient must be careful with things in the office that do not belong to him/her.

Doctor's Rights

Physicians in private practice have certain rights.

1. Physicians have the right to accept patients into their practice of their own choosing and to refuse service to new patients, existing patients (with notification), and former patients even in if another physician is not available.
2. Physicians also have the right to stipulate the types of service they will give and how these service will be provided.
3. Physicians have the right to take time off. They must make arrangements for qualified substitutes to care for their patients during times of unavailability.
4. Physicians may set their own office hours. They must, however, give patients reasonable notice of any such changes.
5. Physicians reserve the right to not accept all insurances. Physicians can expect to be compensated from the patient for services rendered.

I have read and understand my rights as a patient while under the care of Neurological Rehabilitation Resources.

| | |
|--|-------|
| Signature of Patient or Personal Representative: | Date: |
| Name of Patient or Personal Representative: | |
| Description of Personal Representatives Authority: | |

Medication Warnings

Dr. Woodcock may prescribe medication for your condition. All medications may produce side effects. These may be somewhat common for the medication, and expected, or be unusual and unexpected, but still related to the medication.

Medications may also have additional or unexpected side effects when taken in combination with other prescription medications, over the counter medications, alcohol (in any form), or "street drugs" of any kind (marijuana, cocaine, methamphetamine, etc.).

Therefore, you are responsible to monitor your reaction to all of the medication you take, whether prescribed by Dr. Woodcock, another physician, or purchased over the counter.

You should always familiarize yourself with your response to your medications before engaging in driving, the operation of dangerous machinery, or other risk related behaviors. You should pay attention to any sedating effects, drowsiness, effects on coordination or speed of response, or blanking out at all times while taking medications, even after having been on them for a long time.

Should you experience any such effects, you should not drive, operate dangerous machinery, or engage in other risk related behaviors.

Almost all medications can also have potential adverse effects on the developing fetus, so any possibility of pregnancy should be discussed with your physician(s) if you are of child bearing potential.

Dr. Woodcock will be happy to discuss any of these issues about possible medication effects with you.

I have read and acknowledge these warnings.

| | |
|--|-------|
| Signature of Patient or Personal Representative: | Date: |
| Name of Patient or Personal Representative: | |
| Description of Personal Representatives Authority: | |

Request For Authorization of Protected Health Information

| | |
|-----------------------------|--|
| Patient Name (Please Print) | |
| Date of Birth | |

This Authorization gives Dr. Woodcock and his staff the right to receive and provide limited information on your behalf with family, friends, and caregivers that you specify. Without your written consent, this office can not release your office visit note or any personal information given during your doctor/patient visit. This Authorization **does not** allow persons on this list to change any medications and treatment.

Type of PHI to be authorized:

1. Clarification of treatment plan.
2. Prescription renewals, pharmacy information, and medications dispensing directions.
3. Conversations/correspondence related to the patient's current condition or problem.
4. Receipt of information to allow Neurological Rehabilitation Resources to aid in the continuity of care for the above patient.
5. To make, change or cancel patient appointments with this office.

| Print Name | Relationship to the Patient |
|------------|-----------------------------|
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| | |

Signature of Patient or Legal Guardian

Date

Acknowledged by the patient's physician:

Jonathan Woodcock, MD

I rescind my above restrictions.

Signature of Patient or Legal Guardian

Date

FINANCIAL POLICY

Welcome to Neurological Rehabilitation Resources, P.C. In order for us to be able to deliver the best quality of care, we have established financial polices practice. **PLEASE READ ALL INFORMATION AND ACKNOWLEDGE BY SIGNING BELOW.**

1. We reserve the right to not accept all insurances, therefore we ask that you present current proof of your insurance at each visit. It is your responsibility to provide us with the correct information to bill your insurance(s). This includes workers compensation, auto accidents, commercial and any supplemental insurances. If your attorney is paying for your visit(s) his/her complete name, company name, address, phone and fax numbers are required.
2. At every visit you will be asked to verify that patient's address, telephone numbers, employer, insurance, and date of injury. Please notify the receptionist of any changes. You will also be asked to sign a financial responsibility statement for each date of service.
3. We will collect your deductible, co-payment or charge for non-covered services at the time of your visit. If you have a balance after an insurance payment from a previous service, we will also ask for that payment. We accept cash, checks, Visa, Mastercard, and Discovercard. We do not accept American Express.
4. We reserve the right to not accept all insurances. If we do not participate with your insurance, we will file your claims as a courtesy. You will be expected to follow-up to make sure payments are made to us in a timely manner. If we do not receive payment from your insurance within *45 days*, you will be billed for any unpaid balance.
5. In the case of your insurance carrier denying our charges for any given reason or there is an ongoing dispute between you and the insurance carrier for payment responsibility which is over 6 months from the date of service, you will be financially responsible for payment of our total charges. Prompt payment to N.R.R. is require.
6. We do not assess monthly interest charges on unpaid balances. We will send the account to our collection company if not paid.
7. **Should your account be sent to collections, you are considered dismissed from our practice. You will need to find another doctor.**
8. **MEDICARE PATIENTS:** We are participating providers with Medicare. Each year you will be expected to pay the allowed amount of your charges until your Medicare deductible is met. Patients, it is your responsibility to make sure Medicare has your current insurance information, including any secondary insurances, or any outstanding balances will be your responsibility.
9. **MEDICAID PATIENTS:** We are participating providers with Medicaid and will bill Medicaid for all your covered charges. Your copay is required at each visit.

- 10. Your co-payment will be collected at the time of service - no exceptions. If your plan requires you to choose a PCP, it is your responsibility to make sure your insurance has the name of your PCP on file. We are specialists and therefore *cannot be your primary care physician*. If your plan requires you to have an authorization to see a specialist, before your next visit you will need to notify your PCP's office that an authorization is required.
- 11. HMO-PPO PATIENTS: If we participate with your plan, we will bill your insurance for you. Your co-payment will be collected at the time of service - no exceptions. If your plan requires you to choose a PCP, it is your responsibility to make sure your insurance company has the name of your PCP on file. We are specialists and therefore we *cannot be your primary care physician*. If your plan requires you to have an authorization to see a specialist, before your next visit, you will need to notify your PCP's office that an authorization is required. Please bring proof of the authorization with you to the appointment. If we do not participate with your plan, we will file your charges and expect prompt payment of your portion of the out-of-network benefit charges.
- 12. SUPPLEMENTAL INSURANCE: If you have supplemental insurance we will bill that for you. If payment is not received from your supplemental insurance within *45 days* of being submitted, we will bill you for the balance due. If you do not have a supplemental insurance, your portion will be invoiced to you for prompt payment.
- 13. SELF-PAY PATIENTS: Patients with no insurance will be expected to pay at the time of service. If you will not be able to pay in full; please contact Sara Burns, Office Manager, prior to seeing the doctor and/or physician assistant to make payment arrangements.
- 14. You will be charged \$25.00 "Same Day Cancellation-No Call/No Show" fee for missed appointments. When an appointment is not canceled in advance, and the patient "no shows," another patient that needed to be seen may have been unable to because the time slot was already taken. We understand there may be times when you are unable to keep an appointment, but we ask the courtesy of a phone call from you to cancel your appointment. This fee is not covered by insurance companies. Your chart will be reviewed by the physician for possible dismissal from our practice.

Remember, whether you do or do not have insurance, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our financial policy, please contact Sara Burns at 303-288-7882.

I have read and have a full understanding of the financial policy of Neurological Rehabilitation Resources, P.C.

| | |
|--|-------|
| Signature of Patient or Personal Representative: | Date: |
| Name of Patient or Personal Representative: | |
| Description of Personal Representatives Authority: | |

PATIENT FEES NOT COVERED BY INSURANCE

This office charges administrative fees for the following services not covered by your insurance company. These services can be paid for with cash, personal check, money order, cashier's check or appropriate accepted credit cards. Your prompt payment is appreciated.

- Mailing of any written prescriptions to your home (including monthly recurring) . \$10.00
(These will be sent certified mail, return receipt requested for tracking purposes)
- Prescription replacement \$10.00
(for any lost, misplaced or stolen prescriptions - AND - after hours prescriptions)
- The patient is solely financially responsible for phone consults regarding treatment.
This service can not be billed to your insurance company. The charges are as follows:
1- 5 mins. = no charge 5-10 mins.=\$25 10-20 mins.=\$45 20+ mins.=\$75
- Letters of medical necessity: To Be Determined
The price will be based on the subject matter requested or needed, the amount of time spent on preparing the document, and time frame needed for the information.
- Forms and general correspondence requests (including year insurance forms and exemption from jury duty):
- Not requiring a physician dictation \$30.00
- Requiring physician completion / dictation \$75.00
- Parking certificates authentication \$15.00
- Returned check fee \$35.00/check
- Overnight services (we use Airborne Express) \$25.00
(This administrative fee is in addition to the actual overnight carrier charges.)
- In-office record copying fees *: Pages 1-10 / \$14.00
..... Pages 11 - 40 / .50/page
..... Pages 41 to the end / .33/page
Diskette WC: \$14.00 / Non WC: \$25

* You will be required to pick up the completed copying and pay the balance at that time. Credit card payments will ensure delivery by postage. Per HIPAA compliance, please allow 4 weeks for completion of your request. Physician to physician medical records requests are not charged as a professional courtesy.

| | |
|--|-------|
| Signature of Patient or Personal Representative: | Date: |
| Name of Patient or Personal Representative: | |
| Description of Personal Representatives Authority: | |

Insurance Information

Please fill out this insurance page completely and accurately. If you have an auto or workers compensation claim please provide written proof of your claim information from your insurance carrier. **AT EVERY VISIT we will require proof of insurance by taking a photocopy of your insurance card.**

**** NOTE ** We reserve the right to not accept all insurances. It is NOT the policy of Neurological Rehabilitation Resources to understand every patient's individual insurance policy or coverage. We may reschedule your appointment if your current insurance information is in question or not provided at this and/or future visits.**

| | |
|--|---|
| <input type="checkbox"/> Private Ins. <input type="checkbox"/> Work Comp. <input type="checkbox"/> Auto <input type="checkbox"/> Other Injury Date of Injury: | |
| ** PRIMARY INSURANCE ** | |
| Insurance Co. | |
| Claims Address | |
| Customer Sve / Adjustor | |
| Phone: | Fax: |
| | |
| Insured/Policy Holder: | |
| Insured Holder's SSN: | DOB: |
| Relationship to Patient: | |
| Policy/Group Name: | |
| Policy/Group Number: | |
| Patient's ID / Claim # | |
| Employer: | |
| Insured's Address if different from the pt. | |
| | |
| Patient Information: | |
| Do you work? | <input type="checkbox"/> No - <input type="checkbox"/> Full-time Student <input type="checkbox"/> Pt-time Student <input type="checkbox"/> Yes - <input type="checkbox"/> Full-time <input type="checkbox"/> Pt-time |
| Employer/School Name: | |
| Employer at time of Injury, if applicable: | |
| | |

| ** SECONDARY INSURANCE INFORMATION ** | |
|--|-------------|
| Insurance Co. | |
| Claims Address | |
| Customer Sve / Adjustor | |
| Phone: | Fax: |
| | |
| Insured/Policy Holder: | |
| Insured Holder's SSN: | DOB: |
| Relationship to Patient: | |
| Policy/Group Name: | |
| Policy/Group Number: | |
| Patient's ID / Claim # | |
| Employer: | |
| Insured's Address if different from the pt. | |
| | |

New Patient Checklist

To assist you in preparing for your initial visit with your doctor please review and check-off those items you have completed.

| | |
|--|--|
| | Your appointment may last several hours. Please make suitable childcare arrangements before your appointment. |
| | You have prepared a signed release HIPAA "B" and have requested your medical records to arrive at our office prior to your appointment by contacting all the doctors, specialists, and therapists directly related with your injury or illness. - or - You have made arrangements with your attorney's office to provide to us your medical records. |
| | You have prepared a signed release HIPAA "A" for each person or entity you wish to receive a copy of your office visit report or you have a list of the names and addresses of those individuals you want to receive a copy of your office visit report. (IE: doctors, layers, therapists, etc.) |
| | The New Patient Packet is completed, including all forms, questionnaires, and signatures. |
| | Bring a list of questions you would like the doctor to specifically answer regarding your illness or injury. |
| | Bring a notepad, tape recorder or someone to help you remember the doctor's instructions. |
| | Bring in <u>ALL</u> the current over-the counter drugs, vitamins, and medication bottles you are taking for your illness or injuries. You may also provide us with a complete list. |
| | Bring your current insurance card or written proof of claim information related to your illness or injury. NOTE: We reserve the right to reschedule your appointment if your insurance information is not provided at this and future visits. |
| | Verify if a referral/authorization is required from your primary care physician to see a specialist. (Referrals are needed for all HMO plans.) Bring the referral/authorization information with you. This information should include a referral/authorization number, number of approved visits, a start and stop date. |
| | You are responsible to provide payment upon check-in of all applicable deductibles, co-payments, and payment for services not covered by your policy. We accept cash, checks, and most major credit cards. |
| | Verify that this packet is complete for signatures in all areas and brought with you to the appointment. |

Lien Patients

| | |
|--|---|
| | I have checked that my attorney is sending my medical records to Dr. Woodcock before my appointment. |
| | My attorney has sent the retainer check to Dr. Woodcock. |
| | My attorney has explained to me Dr. Woodcock's lien agreement. Lien patients, make sure the lien agreement has been signed by both you and your attorney. This agreement will be sent with you to the appointment or mailed separately with the retainer. |

Directions

**Jonathan H. Woodcock, MD
Neurological Rehabilitation Resources, P.C.**

**8515 Pearl Street, #203
Thornton, Colorado 80229**

Phone: (303) 288-7882 Fax: (303) 288-7874

Contact Us: info@nrrmd.com

Visit us on the web: www.nrrmd.com

Directions to Thornton, Colorado (north of the city of Denver):

Take I-25 to 84th Avenue (Exit 219). Turn east (away from the mountains).

The first street to cross is Grant (Arbys will be on your left).

The next street is Pearl. At Pearl there is a left turn lane.

(If you hit Washington Street you have gone too far).

Turn left (north) onto Pearl.

The first building on the left is the Waffle House.

The second is a one-story hospital.

The third is the Colorado Occupational Medicine building.

We are located in the Colorado Occupational Medicine 3-story office building.

We are on the 2nd floor, north side of the building, suite 203.

Medical/Social History Form

| | | | |
|---|----------------|--|--|
| Name: | | Date: | |
| Age: | Date of Birth: | Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female | Dominant Hand: <input type="checkbox"/> Right <input type="checkbox"/> Left |
| Reason for today's visit: | | | |
| Approximate date of onset of problem/injury: | | Onset of problems: <input type="checkbox"/> instant <input type="checkbox"/> sudden <input type="checkbox"/> gradual | |
| Illnesses: (Do you have diabetes, organ problems, HIV, etc?) If yes please describe in detail or attach a separate page) | | | |
| | | | |
| | | | |
| What illnesses run in your immediate family? (parents, siblings, children) | | | |
| | | | |
| | | | |
| ** Females Only ** | | | |
| Total Number of Pregnancies: | | <input type="checkbox"/> None | <input type="checkbox"/> Premature # <input type="checkbox"/> Full Term # <input type="checkbox"/> Miscarriages # |
| Delivery: <input type="checkbox"/> Caesarian Section <input type="checkbox"/> Vaginal | | Did you have a multiple birth? <input type="checkbox"/> No <input type="checkbox"/> Yes Describe: (twins, triplets, etc): | |
| Complications? <input type="checkbox"/> No <input type="checkbox"/> Yes | | Describe complications: | |
| | | | |
| ** All Patients ** (Attach separate paper if necessary for any section below) | | | |
| Current Doctor's Name / Therapist: | | Why are you seeing this person? | |
| | | | |
| | | | |
| | | | |

PAST SURGERIES

| | |
|-------|------------------|
| Date: | Type of surgery: |
| | |
| | |
| | |
| | |

**HAVE YOU EVER HAD AN ACCIDENT WITH INJURIES/FRACTURES? YES NO.
IF YES, PLEASE DESCRIBE.**

| | |
|-------|--------------------------|
| Date: | Type of injury/fracture: |
| | |
| | |
| | |
| | |

YOUR BIRTH / DEVELOPMENTAL HISTORY

| | |
|---|--|
| Birth: <input type="checkbox"/> Premature <input type="checkbox"/> Full Term | Delivery: <input type="checkbox"/> Caesarian Section <input type="checkbox"/> Vaginal |
| Was yours a multiple birth? <input type="checkbox"/> No <input type="checkbox"/> Yes # | Birth/Post-natal complications: ? <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Describe complications: | |
| | |
| Developmental milestone delays (walking, talking, etc.): <input type="checkbox"/> No <input type="checkbox"/> Yes | |
| Describe delays: | |
| Learning disabilities: <input type="checkbox"/> No <input type="checkbox"/> Yes | Attention Deficit / Hyperactivity Disorder: <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Describe any disabilities: | |

CHILDHOOD

| | |
|--|-----------------------------|
| Where were you raised (City & State): | |
| Describe your childhood: | |
| | |
| Who was in your home as you were growing up? | |
| | |
| What were your relationships with them like? | |
| | |
| History of school problems? | |
| History of behavioral problems? | |
| High School: <input type="checkbox"/> Did Not Graduate <input type="checkbox"/> Graduated <input type="checkbox"/> GED obtained | Year Graduated/Left School: |
| Name of School: | |
| College: <input type="checkbox"/> Did Not Attend <input type="checkbox"/> Did Not Graduate <input type="checkbox"/> Graduated | Year Graduated & Degree: |
| Name of College: | |
| Legal Problems (arrests): <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe: | |
| | |

ADULTHOOD

| | | |
|---|---|-----------------------------|
| Current Marital Status: (Please be specific: married-separated, single-divorced, widow/er): | | |
| Spouse Name: | Spouse occupation: | |
| Length currently married/divorced/widowed: | Any prior marriages? <input type="checkbox"/> No <input type="checkbox"/> Yes # | |
| Do you exercise regularly? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe: | | |
| Military Service: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Retired from military | Branch: | Years Served: |
| Rank upon discharge: | What was your job? | |
| What is your usual occupation? | <input type="checkbox"/> FT | <input type="checkbox"/> PT |
| After your injury? | <input type="checkbox"/> FT | <input type="checkbox"/> PT |
| Number of hours per week working: _____ Working with restrictions _____ Working without restrictions _____ | | |
| Describe your past jobs: | | |
| | | |
| | | |
| Legal Problems (arrests): <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please describe: | | |
| | | |
| | | |
| Litigation History (lawsuits): <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please describe: | | |
| | | |
| | | |

CURRENT MEANS OF SUPPORT

| | |
|---|---------------------------------------|
| <i>(Please check which best describes your situation)</i> | |
| <input type="checkbox"/> | Working |
| <input type="checkbox"/> | Disability |
| <input type="checkbox"/> | Workers Compensation (temporary) |
| <input type="checkbox"/> | Workers Compensation (permanent) |
| <input type="checkbox"/> | Social Security Disability Ins (SSDI) |
| <input type="checkbox"/> | Social Security Ins. (SSI) |
| <input type="checkbox"/> | Other: |

Family History

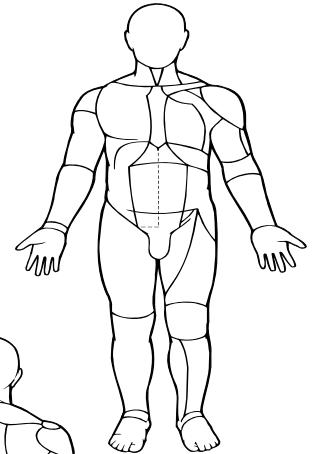
| Family Member | Living/Deceased | Age | Sex | State of Health (Excellent, Fair, Poor) | If poor, why? |
|---------------|-----------------|-----|-----|--|---------------|
| Spouse: | | | | | |
| | | | | | |
| Child: | | | | | |
| Child: | | | | | |
| Child: | | | | | |
| Child: | | | | | |
| | | | | | |
| Father: | | | | | |
| Mother: | | | | | |
| | | | | | |
| Sibling: | | | | | |
| Sibling: | | | | | |
| Sibling: | | | | | |
| Sibling: | | | | | |
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PAIN ASSESSMENT QUESTIONNAIRE

Patient Name: _____
(Front)

Date: _____

Where does your pain begin? _____



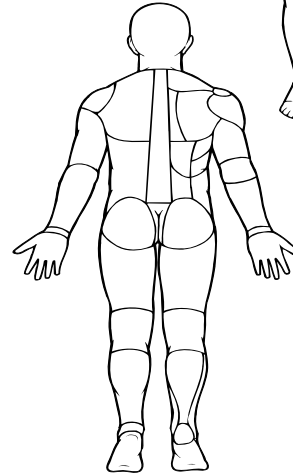
1. Indicate on the drawings the location(s) of pain and radiation if present.

2. Date of pain onset: _____ (Back)

3. How often does it occur? _____
 Chronic Intermittent

4. How long does it last? _____

5. Describe how the pain feels:
 Sharp Aching Throbbing Stabbing Burning
 Tingling Pressure Wringing
 Other _____



6. Severity: "On a scale of 0 to 10, with 0 being no pain and 10 being the worst possible pain, (see scale below)

6a. What number would you give your pain now? _____ Most severe in past 24 hours? _____
 At your best (least pain)? _____

| | | | | | | | | | | |
|---------|---|-----------|---|--------------------|---|----------------|---|------------------------|---|---------------------------|
| None | | Annoying | | Uncom- fortable | | Dreadful | | Horrible | | Agony |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| No Pain | | Mild Pain | | Mod. Pain | | Severe Pain | | Very Severe Pain | | Worst Possible Pain |

7. Aggravating factors: "What makes your pain worse?"

8. Alleviating factors: "What makes your pain better?"

Heat Cold Massage Music Distraction Medication Prayer Meditation

Other: _____

9. Side effects currently experiencing with pain:

| | | | | |
|-----------|-------------------------------------|-------------------------------------|---|---|
| GI | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Constipation | <input type="checkbox"/> Loss of appetite |
| Nervous | <input type="checkbox"/> Drowsiness | <input type="checkbox"/> Confusion | <input type="checkbox"/> Hallucinations | |
| Emotional | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Mood Changes | |
| Other | | | | |

| | | |
|---------------------------------------|--------------------------------------|---|
| Who is completing this form? | | |
| <input type="checkbox"/> Patient | <input type="checkbox"/> Interpreter | <input type="checkbox"/> Family Member: |
| <input type="checkbox"/> Office Staff | | <input type="checkbox"/> Friend/Other: |

Patient: _____

Date: _____

What problems or issues do you want to talk to Dr. Woodcock about at your visit? If you are a returning patient, please include any important details or changes since your last visit.
(Circle, highlight or check all that apply)

| | | | |
|---|------------------|------------|-------------------------------|
| Do you need a prescription? | - Medication | - Therapy | - Referral |
| Do you have: | | | |
| <ul style="list-style-type: none"> - treatment questions? - medication side effects? - behavior changes? | | | |
| Do you have medication questions? | | | |
| <ul style="list-style-type: none"> - have you changed your medications? - has another healthcare provider changed your medications? - do you need your medical records sent to another provider? | | | |
| Insurance: | - authorizations | - problems | - prior auth. for medications |
| Do you need any healthcare forms completed or letters of medical necessity? | | | |
| <ul style="list-style-type: none"> - insurance - government (State or Federal) - disability | | | |

| | |
|---|--|
| 1 | |
| 2 | |
| 3 | |
| 4 | |

Symptoms Check List

| | |
|---|-------|
| Patient's Name: | Date: |
| Who is filling out this form? <input type="checkbox"/> Patient <input type="checkbox"/> Interpreter <input type="checkbox"/> Office Staff | |
| <input type="checkbox"/> Family Member _____ <input type="checkbox"/> Friend/Other _____ | |
| Please mark only those symptoms you are currently experiencing. | |

| | |
|-----------|---|
| 1. | General |
| | Fatigue |
| | Night Sweats |
| | Fever |
| | Unexplained weight gain |
| | Unexplained weight loss |
| | Swollen feet or ankles |
| | Trouble getting to sleep |
| | Trouble staying asleep |
| | Waking up too early and can't get back to sleep |
| 2. | Nervous System |
| | Seizures Frequency: |
| | Headaches Frequency: |
| | Memory Loss |
| | Balance problems |
| | Light headedness |
| | Sense of spinning |
| | Weakness |
| | Areas: |
| | <input type="checkbox"/> Numbness |
| | Areas: |
| 3. | Vision |
| | Blurred vision at near objects |
| | Blurred vision at far objects |
| | Double vision |
| | Spots in front of eyes |
| | Caracts |
| 4. | Hearing |
| | Hard of hearing |
| | Ringing in the ears |

| | |
|-----------|--|
| 5. | Musculoskeletal |
| | Pain in joints |
| | Areas: |
| | <input type="checkbox"/> Pain in muscles |
| | Areas: |
| | <input type="checkbox"/> Pain in jaw |
| 6. | Cardiovascular |
| | Chest pain |
| | Pressure in chest |
| | High blood pressure |
| | Low blood pressure |
| 7. | Respiratory |
| | Shortness of breath |
| | <input type="checkbox"/> on exertion <input type="checkbox"/> at rest <input type="checkbox"/> night |
| | Cough |
| | Sputum production |
| | Dry mouth |
| 8. | Gastrointestinal |
| | Trouble chewing |
| | Trouble swallowing |
| | Stomach pain |
| | Nausea |
| | Vomiting |
| | Diarrhea |
| | Constipation |
| | Trouble controlling bowel movements |
| 9. | ** Females Only ** |
| | Change in menstrual cycle |
| | When/How long? |
| | Explain: |

| | |
|-------------------------|--|
| 10. | Genitourinary |
| | Pelvic pain |
| | Loss of sexual interest |
| | Problems in sexual function |
| | Urinating too frequently |
| | Pain or burning when urinating |
| | Losing urine involuntarily |
| Birth Control Method: | |
| 11. | Endocrine |
| | Diabetes |
| | Thyroid <input type="checkbox"/> hyperglycemic <input type="checkbox"/> hypoglycemic <input type="checkbox"/> emotional |
| 12. | Emotional |
| | Nervousness |
| | Anxiety |
| | Depression |
| | Irritable |
| | Panic Spells |
| | Moodiness |
| 13. | Alcohol |
| | Does NOT drink alcohol |
| | Year quit: |
| | Does drink alcohol |
| Specify type: | |
| Frequency: | # of years: |
| 14. | Caffeine |
| Amount per day or week: | |
| | Caffeinated Coffee / Total servings per day: |
| | Caffeinated Tea / Total servings per day: |
| | Caffeinated Soft drinks / Total servings per day: |
| Other/Name: | |
| | |
| | |
| | |

| | |
|---|---|
| 15. | Tobacco |
| | Chewing Tobacco |
| Frequency: | # of years: |
| | Smoker <input type="checkbox"/> Cigarette <input type="checkbox"/> Cigars |
| Frequency: | # of years: |
| | Non-Smoker # of years: |
| 16. | Other Personal Habits |
| | Marijuana |
| Frequency: | # of years: |
| | Other Street Drug: |
| Frequency: | # of years: |
| | Other Street Drug: |
| Frequency: | # of years: |
| 17. | Travel |
| Have you traveled outside of the State of Colorado in the last 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Where? | |
| Have you traveled outside of the United States in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Where? | |

| <h1>Headache Questionnaire</h1> | | | | |
|---------------------------------|--|-----|----|----------|
| Patient Name: | | | | Date: |
| | | Yes | No | Response |
| 1. | Do you have an idea of what may be causing your headache? | | | |
| 2. | Did this same type of headache ever occur before? | | | |
| 3. | Do you have more than one type of headache? | | | |
| 4. | Is the headache pain so intense that sometimes it becomes unbearable? | | | |
| 5. | When do your headaches occur? (stress, tension, nervous, home, work, social) | | | |
| 6. | Do your neck, shoulder muscles or head junction feel tight and painful during the headache? | | | |
| 7. | Is your headache pain dull and steady, like an intense constant pressure? | | | |
| 8. | Does your headache feel like a tight band around the head? | | | |
| 9. | Do you usually have one (1) or more headaches per week? | | | |
| 10. | Do your headaches occur during the day? | | | |
| 11. | Does mother, father, or any blood relative have similar headaches? | | | |
| 12. | Does exertion (lifting, running, straining, sex) affect your headache? | | | |
| 13. | Does nausea and/or vomiting occur before or during your headache? | | | |
| 14. | Do you have any changes in vision (flashing lights, sensitivity to light, spots, blurred vision, etc.) Before or during your headache? | | | |
| 15. | Does your headache usually start on one side of the head? | | | |
| 16. | Does your headache throb and pulsate or feel like it is pounding? | | | |
| 17. | Do your headaches usually occur during the night or upon awakening? | | | |
| 18. | Do your headaches usually occur during weekends and holidays ? | | | |
| 19. | (Females Only) Is your headache associated with your menstrual period? | | | |
| 20. | Do you have watering of the eye on the affected side of the headache? | | | |
| 21. | Do alcoholic drinks cause or aggravate your headaches? | | | |
| 22. | Does chocolate, cheese, milk, nuts, Chinese food, or any other food cause or worsen your headaches? | | | |
| 23. | Do you have any hearing problems - noise, drainage or stuffiness in either ear? | | | |
| 24. | Have you noticed any paralysis, muscle weakness, numbness, swallowing problems or speech changes during your headaches? | | | |
| 25. | Do you have facial pain, aching jaws, stuffiness or congested sinuses with your headache? | | | |
| 26. | Has it been over eighteen (18) months since you last visited a dentist? | | | |
| 27. | Have you had tests for headaches? (X-ray, brain scan, injections, etc.) | | | |

You Are Done!!

**Thank you for taking the time to
complete our packet.**

**Remember to sign all pages,
complete all patient forms, and
bring this packet with you to
your appointment.**