

**COLORADO VOICE CLINIC, P.C.**  
David A. Opperman, M.D. William Y. Reifman, N.P.P.A.

PLEASE FILL OUT COMPLETELY AND SIGN WHERE INDICATED

**Patient Information**

(OFFICE: PI-1 \_\_\_\_\_)

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ M.I. \_\_\_\_\_

Preferred Nickname \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Age \_\_\_\_\_ Sex  M  F Social Security No \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Race  American Indian/Alaska Native  Asian Black/African American

Native Hawaiian/Pacific  White  Other  Decline

Ethnicity  Hispanic or Latino  Not Hispanic or Latino  Unspecified  Decline

**Primary Care Physician**

(OFFICE: PI-2 \_\_\_\_\_)

Physician Name \_\_\_\_\_ Practice Name \_\_\_\_\_

PCP Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ PCP Fax \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_

**Referring Physician**

(OFFICE: PI-3 \_\_\_\_\_)

Physician Name \_\_\_\_\_ Practice Name \_\_\_\_\_

Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Fax \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_

**Patient Contact Information**

(OFFICE: CI-1 \_\_\_\_\_)

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Other \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Email \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Employer Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Emergency Contact**

(OFFICE: CI-EC \_\_\_\_\_)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Primary Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Alternate Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Responsible Party** *(Person responsible for balance not covered by insurance)*

(OFFICE: CI-PG2 \_\_\_\_\_)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Social Security No \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Employer Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Who We May Speak To Regarding Medical Care**

(OFFICE: CI-PG1 \_\_\_\_\_)

*Please put the names of any friends, relatives or family members that we may speak with regarding your medical care. If this section is left blank, we will not be allowed to give information to anyone other than the patient.*

Name \_\_\_\_\_ Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Relationship \_\_\_\_\_

**Referral Information**

(OFFICE: CI-PR \_\_\_\_\_)

*If you were not referred by a physician, please list the person who referred you here.*

Name \_\_\_\_\_ Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Relationship \_\_\_\_\_

**Insurance**

(OFFICE: CI-PR \_\_\_\_\_)

*Please list all insurance. We will make copies of all insurance cards and a valid photo ID.*

Primary: \_\_\_\_\_ Secondary: \_\_\_\_\_

**Patient Health Information**

*In order for us to obtain a complete medical history, it is important for you to fill out every item below as completely as possible. This information will be entered into our computer and you are welcome to a copy of this report if you wish.*

**Preferred Pharmacy**

(OFFICE: Rx-Ph \_\_\_\_\_)

Pharmacy \_\_\_\_\_ Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Fax \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Location/Address \_\_\_\_\_

**Medications and Allergies**

Are you allergic to any medications  No  Yes

(OFFICE: Red-P \_\_\_\_\_)

If yes, please list medications:

Name \_\_\_\_\_ Reaction \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*(Use the back of this page if you need more space)*

*Current Medications*

(OFFICE: Yel-P \_\_\_\_\_)

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

*(Use the back of this page if you need more space)*

*Surgeries and Hospitalizations*

(OFFICE: HX \_\_\_\_\_)

Have you ever had any problems with anesthesia (being numbed or put to sleep)?  No  Yes

If yes, please describe the problem or reaction:

\_\_\_\_\_

List any surgeries you have had (including dates). Please be as specific as possible:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever been hospitalized for non-surgical reasons?  No  Yes

If yes, please describe the hospitalization:

\_\_\_\_\_

\_\_\_\_\_

I hereby acknowledge that I have received a copy of the Colorado Voice Clinic, P.C. Notice of Privacy Practices. I authorize you to use or disclose my personal health information to collect payment for the services and treatment I require or request. I authorize the release of any medical information and payment of medical benefits to the undersigned physician or supplier for services necessary to process a claim. I agree to be responsible for any deductible, co-insurance, co-pay, or any other balance not paid by my insurance.

Signature \_\_\_\_\_ Today's Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

*(Insured or Authorized Person)*

OFFICE: PI-Photo \_\_\_\_\_

HIPAA \_\_\_\_\_

Chart # \_\_\_\_\_



## **Colorado Voice Clinic, PC**

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930 West 7<sup>th</sup> Avenue, Suite B Denver, CO 80204  
Phone: 303-844-3000 Fax: 303-844-3002

**Please State in your own words why you are here today.**

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## Colorado Voice Clinic, PC

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930 West 7<sup>th</sup> Avenue, Suite B Denver, CO 80204  
Phone: 303-844-3000 Fax: 303-844-3002

Colorado Voice Clinic P.C. has a policy that requires patients to cancel their appointments with Dr. David Opperman or William (Buzz) Reifman N.P, P.A. 24 hours prior to the scheduled appointment time.

I am consenting to a \$50.00 office charge for not cancelling my appointment with Colorado Voice Clinic within 24 hours prior to my appointment. I understand that I will be charged for any appointment that was cancelled or changed after the 24-hour period.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



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930 West 7<sup>th</sup> Avenue, Suite B Denver, CO 80204  
Phone: 303-844-3000 Fax: 303-844-3002

### COLORADO VOICE CLINIC, P.C.

*Thank you for choosing Colorado Voice Clinic as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality of healthcare. We ask that you read and sign this form to acknowledge your agreement and understanding of our financial responsibility policy.*

### FINANCIAL RESPONSIBILITY POLICY

1. **You are financially responsible for payment in full of all charges incurred regardless of insurance coverage. If your insurance company denies payment or makes partial payment, you are responsible for the balance due. Further, you acknowledge you are aware that if any of the following circumstances apply, they may cause your insurance company to deny payment or make partial payment. This list is not exhaustive – your insurance company may deny payment or make partial payment for other reasons – it is your responsibility to verify that your insurance company will pay the charges incurred.**
  - a. If you fail to accurately and fully complete any forms or provide any information requested by your insurance company.
  - b. If you fail to pay your insurance premiums when due.
  - c. If there is any miscommunication between you and your insurance company or between your insurance company and Colorado Voice Clinic, P.C.
  - d. If your insurance plan does not cover the services provided or the equipment used.
  - e. If you have not obtained a referral or authorization required by your insurance plan.
  - f. If you fail to comply with any of the terms of your insurance plan.
  - g. If Colorado Voice Clinic, P.C. is not a contracted provider with your insurance plan **(NOTE: COLORADO VOICE CLINIC, P.C. IS NOT A CONTRACTED PROVIDER WITH MOST INSURANCE PLANS OFFERED THROUGH AFFORDABLE CARE ACT EXCHANGES AND AS A RESULT YOU WILL BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES).**
  - h. If Colorado Voice Clinic, P.C. is outside the network for your insurance plan.
2. You (or your guardian, if a minor) are ultimately responsible for payment of the costs incurred for treatment and care. We are pleased to provide billing for our contracted insurers. However, you are required to provide us with correct and updated information about your insurance.
3. You are responsible for payment of deductibles, co-insurance, co-payments, and costs of services not covered by insurance. For your convenience, we accept cash, check and most major credit cards at our office.

4. Costs for services that are unknown at the time of consultation will be billed to you. You are responsible for payment of these costs in a prompt fashion.
5. You are responsible to verify insurance benefits and to ensure proper referrals and authorizations are in place prior to our providing services to you. Failure to do so could result in denial of insurance coverage resulting in your financial responsibility for these non-covered services.
6. If you do not call to cancel your appointment at least 24 hours prior to your appointment or you do not show up for your scheduled appointment, you will be billed \$50 and are responsible for payment.
7. You are responsible for payment of charges for extensive phone consultations and after-hours care or treatment, for extensive form completions and charges for copying and distribution of medical records.
8. You are responsible for all costs and expenses associated with or incurred in connection with our enforcement of this Financial Responsibility Policy form, including, but not limited to, charges for returned checks, collection agency fees, court filing fees and attorney's fees.

**I have read, understand and agree to the provisions of this Financial Responsibility Policy form and agree to pay Colorado Voice Clinic promptly all amounts for which I am responsible under this form.**

**I agree that I am financially responsible for payment in full of all charges incurred regardless of insurance coverage. I am aware that my insurance company may deny payment or make partial payment and I agree that I will be responsible for the balance due. I am aware that it is my responsibility to contact my insurance company to verify that it will pay for charges incurred.**

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Patient Name (if different)