COLORADO VOICE CLINIC, P.C.

David A. Opperman, M.D. Tracy J. Johnson, PA- C

PLEASE FILL OUT COMPLETELY AND SIGN WHERE INDICATED

Patient Information

First Name _____ Last Name _____ M.I. _____

Preferred Nickname _____ Date of Birth ____ / ____ / _____ Age _____

Gender Identity ☐ M ☐ F ☐ Trans M/F ☐ Decline Preferred Pronouns _____

Social Security No _____ - ____ - _____

Patient Contact Information

Home Address _____ City _____ State ____ Zip _____

Cell _____ - _____ - _____ Other _____ - _____ - _____

Email _____

Employer _____ Occupation _____ Employer Phone _____ - _____ - _____

Emergency Contact

Name _____ Relationship _____

Primary Phone _____ - _____ - _____ Alternate Phone _____ - _____ - _____

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

Name _____ Relationship _____

Address _____ City _____ State ____ Zip _____

Home _____ - _____ - _____ Cell _____ - _____ - _____ Social Security No _____ - ____ - _____

Employer _____ Occupation _____ Employer Phone _____ - _____ - _____

Primary Care Physician

Physician Name _____ Practice Name _____

PCP Phone _____ - _____ - _____ PCP Fax _____ - _____ - _____

Address _____

Referring Physician

Physician Name _____ Practice Name _____

Phone _____ - _____ - _____ Fax _____ - _____ - _____

Address _____

Patient Name: _____

Who We May Speak To Regarding Medical Care

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

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

Name _____ Phone _____ - _____ - _____ Relationship _____

Insurance

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 (REQUIRED – Please fill out)

Pharmacy _____ Phone _____ - _____ - _____ Fax _____ - _____ - _____

Location/Address _____

Medications and Allergies

Are you allergic to any medications ☐ No ☐ Yes

If yes, please list medications:

Name	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

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

Current Medications (REQUIRED – Please fill out)

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

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

Patient Name: _____

Surgeries and Hospitalizations

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:

_____

_____

Do you have a pacemaker or other internal defibrillator? ☐ No ☐ Yes

Please list the last month and year you have had a *breast cancer screening exam*, if applicable.
(Mammogram, Breast MRI, etc) Month & Year _____

Please list the last month and year you have had a *cervical cancer screening*, if applicable.
(PAP Smear) Month & Year _____

Please list the last month and year you have had a *colon cancer screening*, if applicable.
(Colonoscopy or DNA Testing) Month & Year _____

Please list the last month and year you received the *pneumonia vaccine*, if applicable.
(Pneumonia (Flu) Vaccine) Month & Year _____

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)

Patient Name: _____

Colorado Voice Clinic, PC

930 West 7th Avenue Unit B, Denver, CO 80204
Phone: 303-844-3000 Fax: 303-844-3002

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

_____

_____

_____

_____

Patient Name: _____

Colorado Voice Clinic, PC
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Surprise/Balance Billing Disclosure Form

Surprise Billing – Know Your Rights

Beginning January 1, 2020, Colorado state law protects you* from "surprise billing," also known as "balance billing." These protections apply when:

- You receive covered emergency services, other than ambulance services, from an out-of-network provider in Colorado, and/or
- You unintentionally receive covered services from an out-of-network provider at an in-network facility in Colorado.

What is surprise/balance billing, and when does it happen?

If you are seen by a health care provider or use services in a facility or agency that is not in your health insurance plan's provider network, sometimes referred to as "out-of-network," you may receive a bill for additional costs associated with that care. Out-of-network health care providers often bill you for the difference between what your insurer decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

When you CANNOT be balance-billed:

Emergency Services

If you are receiving emergency services, the most you can be billed for is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility where you receive emergency services and any providers that see you for emergency care.

Non-emergency Services at an In-Network or Out-of-Network Health Care Provider

The health care provider must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. They must also tell you what types of services that you will be using may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. In this case, the most you can be billed for **covered** services is your in-network cost-sharing amount, which are copayments, deductibles, and/or coinsurance. These providers cannot balance bill you for additional costs.

Additional Protections

- Your insurer will pay out-of-network providers and facilities directly.
- Your insurer must count any amount you pay for emergency services or certain out-of-network services (described above) toward your in-network deductible and out-of-pocket limit.
- Your provider, facility, hospital, or agency must refund any amount you overpay within sixty days of being notified.
- No one, including a provider, hospital, or insurer can ask you to limit or give up these rights.

If you receive services from an out-of-network provider or facility or agency OTHER situation, you may still be balance billed, or you may be responsible for the entire bill. If you intentionally receive nonemergency services from an out-of-network provider or facility, you may also be balance billed.

If you want to file a complaint against your health care provider, you can submit an online complaint by visiting this website:
https://www.colorado.gov/pacific/dora/DPO File Complaint

If you think you have received a bill for amounts other than your copayments, deductible, and/or coinsurance, please contact the billing department, or the Colorado Division of Insurance at 303-894-7490 or 1-800-930-3745.

*This law does NOT apply to ALL Colorado health plans. It only applies if you have a "CO-DOI" on your health insurance ID card.

Please contact your health insurance plan at the number on your health insurance ID card or the Colorado Division of Insurance with questions.

Patient Name: _____

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Colorado Voice Clinic P.C. has a policy that requires patients to cancel their appointments with Dr. David Opperman or Jill Brogdon, FNP-BC at least 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.

I acknowledge that I have received and had an opportunity to review the Surprise/Balance Billing Disclosure Form. I also acknowledge that I am voluntarily and intentionally seeking services from Colorado Voice Clinic, P.C. I further acknowledge that I have been told if Colorado Voice Clinic, P.C. is out-of-network, the types of services an out-of-network health care provider may provide, and my right to request an in-network health care provider to provide the services.

_____ _____

Patient Signature Date

Patient Name: _____

Colorado Voice Clinic, PC

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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 still 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 (i.e., it is out-of-network). (**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**).

Notwithstanding anything herein to the contrary, you are entitled to the protections set forth in the Surprise/Balance Billing Disclosure Form if you receive covered emergency services, other than ambulance services, from an out-of-network provider and/or you unintentionally receive covered services from an out-of-network provider at an in-network facility in Colorado.

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 telemedicine consultations and will be billed accordingly. You are also responsible and will be billed for 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.

9. You are aware that anything done at Colorado Voice Clinic requires the use of standard Medicare codes that may appear as "Surgical Procedures" or "Surgical Interventions" on your insurance Explanation of Benefits (EOB). This is normal and customary operating procedure for medical services and you are responsible for these bills.

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 it is my responsibility to contact my insurance company to verify that it will pay for the charges incurred.

_____ _____

Signature of Patient or Guardian Date

_____

Print Name

_____

Patient Name (if different)