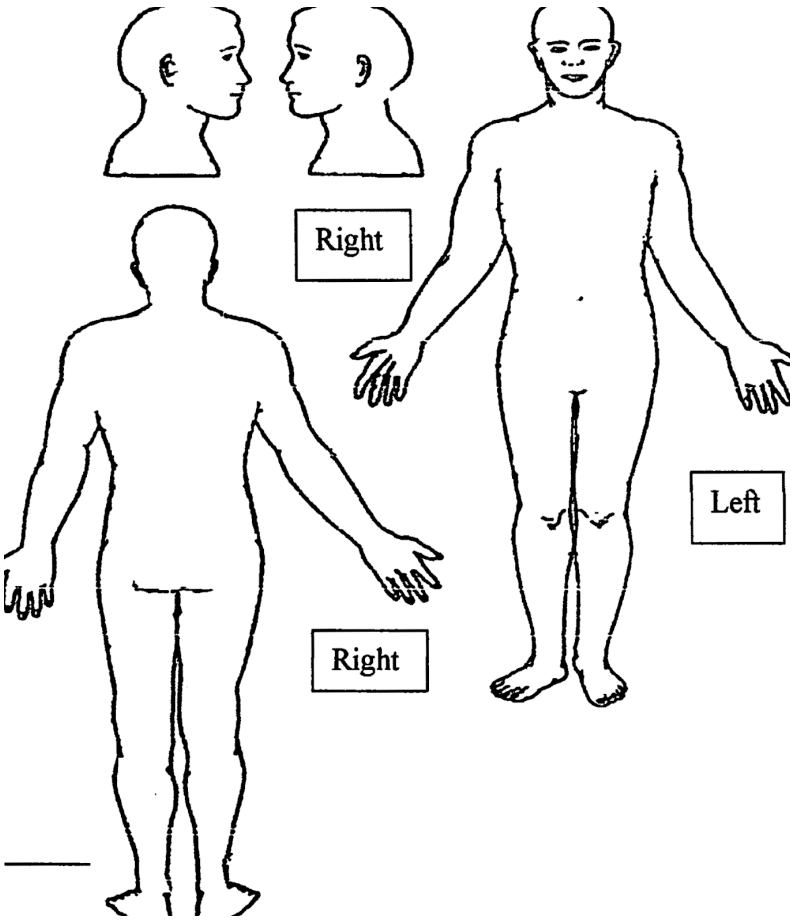
North Colorado Spine & Orthopaedics
Dr. Scott Dhupar
6200 W. 9th Street Unit 1B, Greeley CO 80634
Phone: 970-353-5959 Fax: 970-353-5967

Name (Last, First)_____ Date of Birth____/____/____ Age_____

Address_____ City_____ State_____ Zip_____

Ethnicity (hispanic, latino, white etc.) _____

Using the diagram below, Where does it hurt?



Height_____ Weight_____

If Injury occurred, what is the Date of Injury?
_____

How long have you had this pain?
_____ Years _____ Months

What were you doing when it started?
_____

On a scale from 1-10 what is your pain level?
(10 being the Highest level of pain)
1 2 3 4 5 6 7 8 9 10

If you're getting X-rays as part of your exam is there possibility of pregnancy? (circle one)
Yes No

Preferred Pharmacy:
_____

Primary Care Physician:
_____

Referring Physician: (if different from Primary Care):
_____

What kind of **treatment** have you had for your **current** episode of pain:

	Yes	No		Yes	No
Bed rest / activity modification			Acupuncture (if yes, please list location)		
Medications (if yes, please list below)			Brace		
Physical Therapy (if yes, please list location)			Massage Therapy (if yes, please list location)		
Heat or Cold therapy			Injections (cortisone) (if yes, please provide dates.)		
Chiropractor (if yes, please list location)			Other Treatments. (please describe below)		

Additional Information: _____
_____

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Have you missed work because of this issue? Y N
Is this the result of a work related injury? Y N
Is this the result of a motor vehicle accident? Y N
Is there a lawyer involved? Y N

If this injury is work or Auto related, Please answer the following:
Work Comp / Auto Insurance Company: _____
Claim Number _____
Work Comp / Auto adjuster Name:_____ Phone: _____

Illnesses/ Injuries / Surgeries / Hardware:

Date of:	Illness / injury / Surgery / Hardware	If surgery was done, who was the physician

Past Medical History (circle Y or N)

Anxiety / Depression	Y	N
Nervous Breakdown	Y	N
Any psychiatric disorder	Y	N
Heart attack	Y	N
Angina (chest pain)	Y	N
Congestive heart failure	Y	N
High Blood Pressure	Y	N
Bleeding Disorders	Y	N
Kidney failure	Y	N
Pneumonia	Y	N
Emphysema	Y	N
Chronic Bronchitis	Y	N
Pulmonary Embolism	Y	N
Hepatitis	Y	N
HIV or AIDS	Y	N
Diabetes Mellitus	Y	N
Cancer	Y	N
Recurrent infections	Y	N

Social History:

Alcohol use?	Y	N
Tobacco use?	Y	N
Electronic/ Vape	Y	N
Marijuana	Y	N

Biological Family Members with Medical Problems?

Relation_____ Disorder_____
Relation_____ Disorder _____
Relation_____ Disorder_____
Relation_____ Disorder_____

Allergies to Medications __ Yes __No
If you answered “no” Please leave this Blank
Medication_____ Reaction_____
Medication_____ Reaction_____
Medication_____Reaction_____
Medication_____Reaction_____

Do you have a Latex allergy? (Circle One) YES NO Do you have a metal allergy? YES NO

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Medications:

Name of Medication	Dose	Name of Medication	Dose

ROS: (place an"X" if you NOW have or RECENTLY have had)

General		**Hematologic / Lymph**		**Musculoskeletal**	
Fever		**Gastrointestinal**		Leg cramps in the Calf	
Chills		Heartburn		Joint pain	
Difficulty Sleeping		Abdominal pain		Fibromyalgia	
Feeling tired		diarrhea/ constipation		**Skin**	
Heart		**Genitourinary**		Skin Lesions	
Mitral valve prolapse		Incontinence		**Psychiatric**	
Chest pain		Urinary Frequency		Depression	
Palpitations		Uncontrollable Bowels		Anxiety	
Swollen ankles/ feet		**Nose / Mouth / Throat**		**Other**	
Skipped beats		Recent weight loss		Decrease in appetite	
		Head / Eyes		Motor Disturbances	
		Eyesight problems		Sensory Disturbances	
		Headaches			

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Demographic Information:

Today's Date:_____
Full Name _____
Mailing Address _____
City, State, Zip: _____
Social Security # _____-_____-_____
Cell Phone: (____)_____-_____
Home Phone (____)____-_____
Email address:_____

Do you consent to receive:

Email Appointment Reminders	YES	NO
Text appointment reminders	YES	NO
Voice appointment reminders	YES	NO

Employer _____
Employer Address _____
Employer City, State, Zip _____

Date of Birth _____/_____/_____
Gender Identity
Circle one: Male Female NonBinary

If you are under the age of 18 years old

Guardian's Name_____
Guardian's Address_____
SSN _____-_____-_____
D.O.B. ____/_____/____

Who may we contact if we cannot reach you?
Name_____
Relationship_____
Phone_____

HIPAA Privacy Authorization:

Print Name:_____ DOB_____

I _____, hereby authorize and request North Colorado Spine Center LLC to release my Health Information (PHI) to the following people. I furthermore acknowledge that I have the right to authorize access and disclosure of my Protected health information (PHI) to anyone of my choosing for billing, condition, treatment and prognosis to the following individual(s):

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

I request the following restriction(s) to release my PHI: _____

_____

I understand that I am entitled to a copy of the North Colorado Spine Center LLC Notice of Privacy practices. I can access a copy of the Notice of Privacy Practices from asking the office directly.
I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Unless otherwise revoked this authorization shall be in force and effect for two years from Today's date at which time this authorization expires.

Signature of Patient _____ Date _____/_____/_____

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Insurance Information:

	Primary Insurance	Secondary Insurance
Insurance Company		
Effective Date		
Policy #		
Group #		
Policy Holder's Name		
Relationship		
Policy Holder's DOB		
Policy Holder's SSN		
Insured Policy Holder's Address (if different)		

***Account balances over 30 days old will be charged $10 per month or accrue interest at the rate of 18% annually, whichever is greater.**CONSENT FOR CARE: I give my consent to all health care services performed by North Colorado
Spine and Orthopaedics' medical staff and/or employees, including diagnostic procedures, medications, injections and other procedures or services given as ordered by our physicians. I understand that NCSO participates in training programs for healthcare personnel. Some patient services may be provided by persons in training under the supervision and instructions of our physicians or employees.
I understand and acknowledge that my insurance coverage is a contract between my insurance company and me and that I am personally responsible for all medical expenses incurred during evaluation and treatment at North Colorado Spine and Orthopaedics. I understand that as a courtesy my primary insurance will be billed; however, it is my responsibility to follow up on delinquent claims.

If I am a member of a PPO or HMO I am required to make my copay and coinsurance payments at the time of service, and I am responsible for keeping my primary care referrals current. I understand that I am responsible for paying any charges which insurance does not pay as a result of my not obtaining a referral from my primary care physician.

I understand that I am responsible for paying any charges which insurance does not pay as a result of me providing any incorrect insurance information.

I understand that I am responsible for paying any charges which insurance does not pay as a result of me not providing information about past durable medical equipment that I have received.

I hereby authorize North Colorado Spine Center, LLC (EIN 26-244525 and NPI 1487096061) to unconditionally file and submit claims and appeals on my behalf to my insurance company for any and all dates of service.

Account balances older than 60 days will be sent to collections. If your account is sent to collections, It is your responsibility to have your medical care transferred to another medical practice.

I assign all benefits from said claim to North Colorado Spine & Orthopaedics. I further agree that a photocopy of this agreement shall be valid as the original.

I authorize North Colorado Spine & Orthopaedics to release all necessary medical information to the PCP and referring physician listed on the front of this form and to my insurance carrier for processing my claims. _____ (Initial)

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Patient or Responsible Part's Signature _____ Date_____/_____/_____

Financial Policy
Patient-Doctor Commitment

We are committed to providing you with the highest quality care using the best materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum orthopedic health. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as one of your health providers, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract. If payment from your insurance company is not received within 90 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our office by signing the authorization on the Assignment of Benefits Agreement. In order for our office to file your insurance claim, you must bring a completed medical insurance form or proof of insurance at each appointment.

Your **copay** is due at the time service is provided. Our office accepts cash, personal checks, Visa & Mastercard. If proof of insurance or copay is unavailable, your appointment will be rescheduled.

Returned checks and balances older than 30 days may be subject to collection fees and finance charges of $10 per month or at the rate of 1.5% per month (18% annually), whichever is greater.

Account balances older than 60 days will be sent to collections. If your account is sent to collections, it is your responsibility to have your medical care transferred to another medical practice.
If you have questions regarding our financial policy, please ask. We are committed to providing you with the most positive experience in orthopedic care.
I have read the above internal policies and understand my financial options and obligations as described.

_____
Patient or Responsible Party Signature

_____
Date

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_____ _____

Name of Patient (Please Print) ***Date of Birth***

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have received North Colorado Spine & Orthopaedics' Notice of Privacy Practices.

_____ _____

Signature of patient or Patient representative Date

Documentation of Good Faith Efforts

to obtain patient's acknowledgement that they received provider's Notice of Privacy Practices

The patient presents to the office on _____ and was provided with a copy of North Colorado Spine & Orthopaedics' Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/ her receipt of the Notice. However, such an acknowledgement was not obtained because:

- ❑ Patient refused to sign
- ❑ Patient was unable to sign or initial because:

  _____
- ❑ The patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity
- ❑ Other reason (describe below)

  _____

_____ _____

Signature of Employee Completing Form Date