Electronic Communication (E-mail) Agreement

Electronic (online) communications include e-mail, webmail, secure messaging, electronic file transfer, text messaging and internet "portals" to exchange information between computers, tablets, smartphones. These can be useful ways for patients and healthcare providers to communicate, in addition to more usual visits and phone calls.

Advantages

- E-mail is a simple, convenient and popular way of connecting; many people use it regularly
- Messages can be sent and received without needing both parties online at the same time
- Messages can be saved, copied and forwarded; they keep a record of what was said
- Some messaging systems are encrypted to help keep information private
- Some questions and issues can be handled by online messaging without a phone call or visit

Disadvantages

- E-mail devices and connections can fail, messages can be lost or sent to the wrong person
- There is no way to know if a message was ever received
- Messages can contain typing mistakes
- If the other party is away or their device is turned off, messages might not be seen promptly
- It is possible for a dishonest person to send a false message or impersonate a patient or a doctor
- If both parties are not online at the same time, there is no opportunity to clarify misunderstandings
- Saved copies or messages sent in error can't be erased or retracted
- Messages can contain viruses that can damage systems or steal information
- Some medical questions and issues cannot be handled through online messaging

Our E-mail Policies

1. **No emergencies or urgent messages.** E-mail is not to be used for emergencies or urgent messages. We do not monitor our In-Box constantly. You can send a message any time, but we may not read it until the next business day. We check messages during regular work hours, and answer them in the order received. We try to deal with messages within 1 work day, but circumstances could cause us to fall behind. Use the telephone if you need a response right away. Of course, in a life-threatening emergency call 911.

2. **Uses.** Our practice accepts E-mail messages for these purposes:

   General messages like making or changing appointments, billing issues, or other questions that can be answered by any appropriate staff person.

The email you can use to reach us is nss@neurosurgicalandspine.org

3277 S. Lincoln St
Englewood, CO 80113

3. **Part of the record.** E-mail messages are considered part of your medical record. Our policies for record privacy and appropriate uses of medical information apply to messages we send to each other.

4. **Security.** You need to protect the E-mail address you give us, to make sure our communications remain private. This is the only way we can trust that messages from your E-mail are really from you, and messages we send are not going to someone else. If we aren't sure about a message, we will try to contact you in some other way.

5. **Availability.** If you ask us to use E-mail to communicate with you, we will assume that you check your In-Box at reasonable intervals. We don't guarantee that we will respond to your messages and we understand you can't guarantee that you will respond to ours. In cases of uncertainty, we will try other ways of communicating.

6. **Sensitive medical information.** We can't always know what information you consider especially private. We take care with all medical records, but we know that some facts are more sensitive than others. Because E-mail can't be guaranteed 100% secure, please don't put extremely sensitive matters in messages without considering this.

7. **Voluntary.** Using E-mail is voluntary for both of us. If we feel you are using E-mail inappropriately (or, if we think your address has been hacked by an imposter), we may block your messages. If you decide you don't want to receive E-mail from us any longer, just let us know.

8. **Changes of address.** If your E-mail address changes, you need to let us know.

9. **Non-essential uses.** We will only use your E-mail address for important communications related to our practice. We will not give your E-mail address to anyone who is not part of our practice. Please don't send non-essential messages to us, because they slow down our ability to respond to the important ones.

10. **Mistakes.** Mistakes happen. If you believe you have received or sent a message by mistake, or one that contains errors, please let us know. You should delete messages that are not intended for you.

11. **Other risks.** In addition to those above, electronic communication can have other risks and disadvantages that might cause inconvenience or harm. Everyone using E-mail needs to use good judgment about these valuable technologies, and must remember that there are alternatives that would be better for some situations.

Acknowledgement and Agreement

I acknowledge that I have read this form. I understand that electronic (online) communication has risks, including possible risks not mentioned above. I agree to abide by the policies described above. I agree to use reasonable judgment with regard to any messages I send or receive. I do not have any unanswered questions about what this Agreement requires.

Patient (or legal representative) name: _____

Signature: _____ **Date:** _____

E-mail address to be used: _____

3277 S. Lincoln St
Englewood, CO 80113

Today's Date:_____

Name:_____ Nickname:_____ DOB:___/___/_____ AGE:_____

Are you: ☐ Left handed ☐ Right handed

Referring Physician:_____

PCP:_____

Reason(s) for your visit today – Please list ALL your symptoms in order of severity:

_____

_____

_____

_____

_____

How long have your symptoms been bothering you?_____ It is trending: ☐ Better ☐ Worse ☐ Not changed (Circle one)

What makes it better?_____ What makes it worse?_____

On a scale of 1-10, how would you grade your pain? Worst days:_____ Best Days:_____ Today:_____

What treatments (and when) have you already had for this (i.e., NSAIDS, physical therapy, surgery, etc.)?

_____

Have you had similar symptoms in the past? ☐ No ☐ Yes When?_____

If they improved or resolved in the past, what type of treatment helped?

_____

Are these symptoms the result of an: ☐ Auto accident ☐ Work related

Current Height:_____ Current Weight:_____ Weight 2 years ago:_____ Weight 4 years ago:_____

Past Medical History *Include all medical problems for which you see a doctor or other medical provider.*
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Surgeries of Prior Injuries
1.
2.
3.
4.
Did you have an adverse reaction to anesthesia with any of these surgeries: ☐ Yes ☐ No If yes, please explain: _____

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Current Medication

Include prescribed, over the counter, and supplements(asp. herbs, and vitamins).

Medicine	Reason Taken	Dosage	How long?

Allergies

Antibiotics:			Reaction:
Pain medicine/Sedatives:			Reaction:
Seizure medicines			Reaction:
X-Ray dye ☐	Tape ☐	Latex ☐	Reaction:
Food allergies:			Reaction:

Are you pregnant?	YES ☐ NO ☐ N/A ☐
Are you claustrophobic?	YES ☐ NO ☐
Have you ever worked with metal?	YES ☐ NO ☐

Do you have any metal in your body? ☐ YES ☐ NO

☐Pacemaker ☐Replaced heart valve ☐Vena cava umbrella ☐Defibrillator ☐Implanted pump
☐Aneurysm clip ☐Neurostimulator ☐Metal plate ☐Other

Social History

Occupation: | Hobbies/Activities:

Education: ☐High School ☐Vocational ☐College ☐Post Graduate

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated

Do you have Children? ☐YES ☐NO

Do you have anyone to help you at home if you have surgery? ☐ YES Who?_____ ☐ NO

Do you smoke cigarettes? ☐Never ☐Yes_____packs per day for_____years. Quit date:_____
☐Cigars ☐A tobacco pipe

Do you drink alcohol? ☐Never
☐ YES, _____drinks/_____day_____week_____month

What quantity do you drink: ☐Coffee/tea _____/day ☐Cola/pop_____/day ☐Other caffeine product_____/day

Have you ever used recreational/street drugs? ☐Never ☐YES If yes, list type and frequency:_____

Are you at risk for AIDS or Hepatitis? ☐NO ☐YES If yes, please explain:_____

NEUROSURGICAL & SPINE SPECIALISTS, INC.

Review of Body System *Check all that apply*		
General	**Lung**	**Urinary**
☐ Weight loss	☐ Asthma	☐ Recent bladder infection
☐ Unexplained fever	☐ Emphysema	☐ Blood in urine
☐ Night sweats	☐ Chronic bronchitis	☐ Incontinence
☐ Head, Ears, Nose, and Throat	☐ Shortness of breath (while resting)	☐ Prostate disease
☐ Glaucoma	☐ Bloody sputum	☐ Kidney stones
☐ Cataracts	☐ Recent pneumonia	☐ Kidney disease
☐ Balance problems/dizziness	☐ Ongoing cough	☐ Other:
☐ Sinus problems	☐ Sleep apnea	**Nervous or Muscular Systems**
☐ Frequent sore throat	☐ Oxygen use	☐ Low back pain
☐ Other:	☐ Other:	☐ Leg pain/numbness/weakness
Heart	**Stomach and Digestion**	☐ Neck pain
☐ Heart attack	☐ Frequent nausea/vomiting	☐ Arm pain/numbness/weakness
☐ Chest pain or angina	☐ Blood in vomit or stools	☐ Frequent headaches/migraines
☐ High blood pressure	☐ Liver disease	☐ Seizures
☐ High cholesterol	☐ Jaundice	☐ Problems remembering
☐ Heart murmur	☐ Ulcer or gastritis	☐ Difficulty speaking
☐ Irregular heart beat	☐ Esophageal reflux (GERD)	☐ Confusion
☐ Swelling of feet/ankles	☐ Disease of the colon	☐ Double or blurred vision
☐ Date of last EKG/stress test:	☐ Constipation/diarrhea	☐ Multiple sclerosis
	☐ Frequent stomach pain	☐ ALS
☐ Other:	☐ Other:	☐ Parkinson's disease
Glands	**Blood/Immune System**	☐ Stroke/TIA
☐ Diabetes	☐ Anemia	☐ Other:
☐ Thyroid disease	☐ Bleeding/clotting problems	**Psychological**
☐ Hormone problems	☐ Lupus	☐ Depression/Bipolar
☐ Other:	☐ Rheumatoid arthritis	☐ Anxiety
	☐ HIV/AIDS	☐ Other:
	☐ Other:	

Other medical conditions:

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Family History

Family members with medical problems

	Mother	Father	Brother	Sister	Child	Grandparent
High Blood Pressure						
Heart Attack						
Diabetes						
Cancer (Where?)						
Stroke						
Migraine						
Neuropathy						
Seizures						
Tremors						
Parkinson's Disease						
Epilepsy						
Alzheimer's/Dementia						
Multiple Sclerosis						
Age at Death						
Cause of Death						

Please list other significant medical family history:

_____

_____

The information provided on this form is accurate to the best of my knowledge.

Patient Signature:_____ Date:_____

Phone: (303) 996-7555 • Fax: (303) 996-7556

Acknowledgement of Receipt of Notice of Privacy Practices

Neurosurgical and Spine Specialists, PC
3277 S Lincoln St
Englewood, CO 80113
303.996.7555

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient

Name of Patient: _____

Address of Patient: _____

_____

_____

Neurosurgical and Spine Specialists, PC
Financial Policies and Information

Our commitment is to provide the very best care to our patients while recognizing the need to limit services to only those that are necessary for each patient. To meet this commitment, we recognize the need for a definite understanding and agreement concerning our patient's health care and financial arrangements for that medical care. Your clear understanding of our financial policies is important to our professional relationship. Please contact our billing office regarding any questions about our fees, financial policies, or your insurance coverage and your responsibilities.

Professional fees: Our fees for medical services are comparable to other similarly trained physicians in the community and reflect the complexity of your specific needs, the physician time dedicated to your care, the specialized nature of the doctor's training and education, supplies, and support costs associated with providing and coordinating your care.

Patient Payments/Balances: Co-payment, deductibles, services not covered by your insurance plan or outstanding balances are due at the time of your appointment (per your contract with the insurance). **All account balances must be paid within six (6) months of receiving your first statement. We are happy to set up a payment plan.** Payment may be made by: cash, check, or credit card. Nonpayment may result in your account being turned over to a collection agency.

Insurance Payments: We participate in assignment of payment with **specific** insurance plans in the area. It is your responsibility to ensure our providers are participating/contracted with your insurance plan. When the correct insurance information is provided, we will submit your claims as a courtesy to you, our patient. Your insurance coverage is a contract between you and your insurance plan. You are responsible for unpaid balances left on your account regardless of the amount your insurance coverage.

Referrals/Authorization: It is your responsibility to obtain any referral/authorization required by your insurance carrier prior to services being rendered. Failure to obtain required referral/authorization will result in you being responsible for the full balance.

Self-Pay
Patients who are not billing a third party or health insurance are required to pay at the time of service for all office services at the time of service and will receive a 25% discount off our fee schedule. All procedures requiring services at a facility (hospital or surgery center) are pre-paid to the office at least two (2) days prior to the procedure and will receive a 25% discount. If payment is not received within the specified time period, your procedure will need to be rescheduled.

Additional Fees:

Missed appointments: Please understand your appointment is time that has been reserved for your needs and that your lack of attendance at that visit prevents others from receiving care at that particular time. To assist patients with access to our physicians, we will charge a fee of $50.00 for any office appointment not canceled 24 hours in advance.

Medical Forms: The completion of disability forms, attending physician statements and other supplemental insurance forms require additional physician and staff time. The first form will be no charge to you. A recurring fee of $30.00 will be charged for additional forms.

Collection Agencies: If it becomes necessary to place your account with a third party collection agency due to your non-payment, the account of the person responsible will be turned over to collections, and the patient will be dismissed from our practice. The responsible party will be required to pay all late fees, collection fees, in addition to the balance on the account.

Bounced Checks: A $30.00 charge will be applied for each check returned by the bank or your account will be placed immediately with a third party collection agency for collection.

Your signature on this page constitutes an agreement to this policy.

I have read and agree to the above policies and authorize payment directly to Neurosurgical and Spine Specialists, PC for medical benefits.

Signature of Person Responsible for Account/Patient _____ **Date** _____

Printed Name _____

PATIENT REGISTRATION

Patient Last Name:_____ First Name:_____ Middle Initial:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

SS#:_____ Date of Birth:_____ Sex:_____ Marital Status:_____

Employer's Name:_____ Phone:_____

Employer Address:_____ City:_____ State:_____ Zip:_____

INSURANCE INFORMATION

Insurance Name:_____ Policy #:_____ Phone:_____

Name on Insurance Card:_____ Relationship to Insured:_____

SS#:_____ Date of Birth:_____

Employer's Name:_____ Phone:_____

Employer Address:_____ City:_____ State:_____ Zip:_____

Secondary Insurance

Insurance Name:_____ Policy #:_____ Phone:_____

Name on Insurance Card:_____ Relationship to Insured:_____

SS#:_____ Date of Birth:_____

Employer's Name:_____ Phone:_____

Employer Address:_____ City:_____ State:_____ Zip:_____

Referring Physician Name:_____ Phone:_____

PCP Name:_____ Phone:_____

Emergency Contact:_____ Phone:_____

I hereby authorize Dr. Sean Markey and providers of Neurosurgical and Spine Specialist, P.C. to treat the patient identified above. I acknowledge that I am responsible to pay all charges for all treatments administered by the physician to the patient. I understand that insurance may not pay for all charges and I understand that I am obligated to pay for all charges not paid by insurance. I also agree to pay reasonable attorney fees if my account is turned over to an attorney or collection agency.

Signature of Patient / Authorized Person:_____ Date:_____

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for non covered services. Ii also authorize the physician to release any information required in the processing of this claim and all future claims.

Signature of Patient / Authorized Person:_____ Date:_____