Registration and Billing Information
Vermont Interventional Spine Center

LAST NAME _____ FIRST NAME _____ MI _____

MAILING ADDRESS _____

CITY_____STATE_____ZIPCODE _____

PHONE NUMBERS: HOME: _____ CELL: _____ ALTERNATE: _____

EMAIL ADDRESS: _____

DATE OF BIRTH: _____ SEX (M/F) _____MARITAL STATUS: (MARRIED/SINGLE) _____

SOCIAL SECURITY # _____ FORMER NAME(S) _____

EMERGENCY CONTACT & PHONE # _____

REFERRED BY: _____ PRIMARY CARE DOCTOR: _____

ETHNICITY (Please Check one):
__Latino/Hispanic
__Not Hispanic/Latino
__Decline to answer
__Don't Know

Race (Please check one):
__Asian
__African American/Black
__American Indian/Alaskan Native
__Native Hawaiian/Other Pacific Islander
__More than one race
__White
__Decline to answer

PREFERRED LANGUAGE: _____

EMPLOYER INFORMATION:

COMPANY NAME _____ WORK PHONE _____ EXT _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

BILLING ADDRESS (if different than above) OR ALTERNATE SEASONAL ADDRESS:

NAME OF RESPONSIBLE PARTY (if other than self) _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

RELATIONSHIP _____ PHONE NUMBER _____

INSURANCE INFORMATION:

INSURANCE 1 _____ **COPAY AMOUNT $** _____

SUBSCRIBER NAME _____ RELATIONSHIP _____

IDENTIFICATION # _____ GROUP # _____

INSURANCE 2 _____ **COPAY AMOUNT** $ _____

SUBSCRIBER NAME _____ RELATIONSHIP _____

IDENTIFICATION # _____ GROUP # _____

I authorize the release of any medical information necessary to determine my benefits and to process my claims for all services. Signature_____Date _____	I authorize payment of medical benefits for all services provided to Vermont Interventional Spine Center. Signature_____ Date _____

IS CONDITION RELATED TO EMPLOYMENT? _____ AUTO ACCIDENT? _____ OTHER ACCIDENT? _____

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PAYMENT POLICY FOR SERVICES RENDERED

IF YOU HAVE INSURANCE WITH ONE OF THE FOLLOWING INSURANCE COMPANIES, please initial the appropriate line. We are providers for these companies and will bill them directly. You will be responsible for payment of your designated co-pay at each visit to the office BEFORE you see the doctor. You are also responsible for any deductible or out of pocket expense stipulated by your contract with your insurance company. your should always check with your insurance company for

____ BCBS Out of State Plan or Federal
____ Medicare
____ VT Medicaid
____ CBA
____ Aetna Medicare
____ BCBS of Vermont
____ MVP
____ CIGNA/ Great West
____ United Health Care NY
____ Tricare For Life or Prime

IF YOU HAVE WORKERS COMPENSATION COVERAGE, we must have information approving the claim from your employer and accurate billing address information to process the claim. Without this, we will consider payment for this visit to be your responsibility. Vermont Interventional Spine Center requires authorization in writing for all workers compensation visits.

Name of Insurance Company: _____
Address: _____
Claim Number: _____ Date of Injury: _____
Contact Person and their title: _____
Phone: _____ Fax: _____

IF YOU HAVE COVERAGE WITH ANOTHER INSURANCE COMPANY, WE MAY NOT HAVE A CONTRACT WITH THEM. With a copy of your card, we will submit a claim directly to your insurance company for reimbursement. Please review the following procedure and sign.

"I understand that my services are being billed directly to my insurance carrier for me. The insurance company should send payment directly to the office for payment. If the payment is sent to me, I will forward this payment to the office <u>immediately</u>. If payment is not received by the office within 45 days, a statement will be sent to me. I understand that it is my responsibility to follow up with my insurance company. I understand that this entire balance is at all times my responsibility."

Insurance Co Name: _____Signed: _____ Date: _____

IF YOU DO NOT HAVE INSURANCE, you are responsible for payment of your bill, in total, at the time of your visit. We accept personal checks, credit cards or cash. Any Self Pay must be pre-approved before scheduling.

FOR ALL PATIENTS TO READ AND SIGN:

"I understand and agree that regardless of my insurance, I am in the end responsible for the balance of this account for any professional services rendered. I certify that the above information is true and correct to the best of my knowledge. I will notify the office of any changes in my insurance status. I also agree that if I am unable to pay my bill promptly, I will call the billing department to make timely payment arrangements. I understand that if my account becomes delinquent and Vermont Interventional Spine Center incurs any collection charges, they will be my responsibility."

<u>If the patient is a minor</u>: **"By consenting to care at Vermont Interventional Spine Center, I am agreeing that I will take responsibility for the payment of the medical bills. I will provide the office with all information necessary and will communicate with the office regarding any changes in responsibility.**

_____ _____
Patient or Guardian Signature Date

Vermont Interventional Spine Center
356 Mountain View Drive, Suite 200
Colchester, VT 05446

Consent to Use or Disclose Protected Health Information for Treatment, Payment and Healthcare Operations

I consent to allow *Vermont Interventional Spine Center* to use or disclose my protected health information for treatment, payment and healthcare operations.

-Treatment means the provisions, coordination, or management of healthcare and related services by one or more healthcare providers.

-Payment means the activities undertaken by a healthcare provider or health plan to obtain or provide reimbursement for the provisions of healthcare.

-Healthcare operations means conducting quality assessment and improvement activities; reviewing the competence or qualifications of healthcare professionals; underwriting, premium rating, and other activities related to health insurance contracts; medical reviews; legal services; auditing functions; business management and general administrative activities of *Vermont Interventional Spine Center*.

I consent to allow *Vermont Interventional Spine Center* to disclose my protected health information for treatment activities of another healthcare provider.

I consent to allow *Vermont Interventional Spine Center* to disclose my protected health information to another covered entity or to another healthcare provider for the payment activities of the entity that receives the information.

I consent to allow *Vermont Interventional Spine Center* to disclose my protected health information to another covered entity for healthcare operations activities, provided that *Vermont Interventional Spine Center* and the other entity has or had a relationship with the below named patient. The disclosure must be for treatment, payment, or healthcare operations or for the purpose of healthcare fraud and abuse, detection, or compliance.

I acknowledge that I have received a copy of *Vermont Interventional Spine Center's* Notice of Privacy.

Name of patient_____

(PLEASE PRINT)

_____

Signature of Person Authorizing Consent Date

_____

Patient Medical Questionnaire

Name:_____ **Date:**_____/_____/_____
Referring Doctor:_____ **Primary Care Doctor**:_____
Sex: M/F **Birthdate**:____/____/____ **Marital Status:** S/M/D/W **Occupation:** _____
Primary Area Of Pain? _____**X-Rays/MRI/CT** **Height**_____ **Weight**_____
Tobacco Use? ____Current Smoker, every day ____Heavy Tobacco Smoker ____Former Smoker
____Current Smoker, some days ____Light Tobacco Smoker ____Never Smoked

Alcohol Use? _____ **Illegal Substance Use?** _____ Past/Present
Allergies?_____**/None**
Medications: include **all** prescription, over-the-counter, vitamins, supplements, and anything you may take even if not on a daily basis. Use the back of the sheet if needed.

Medication	Dose	Frequency	Medication	Dose	Frequency

Family History, if yes please list which relative (mother, father, sister, brother):
Heart Disease Yes/No _____ **Diabetes** Yes/No_____ **Cancer** Yes/No_____

History of Falling Please check one of the following:
___ Any fall with an injury in the past year ___No falls in the past year
___One fall without injury in the past year ___Two or more falls in the past year

Medical History: Check all that apply

	Heart Attack		Depression		Swelling in Hands
	COPD		Bipolar Disorder		Swelling in Feet
	Asthma		History of HIV		History of Stroke
	Arthritis		History of Pneumonia		Lightheadedness
	High Blood Pressure		History of Bronchitis		Dizziness
	High Cholesterol		Hepatitis		Headache
	Urinary Infections		Cancer		Limb Weakness
	Fatigue (feeling tired)		Nausea		Limb Numbness
	Fever /Chills		Vomiting		Skin Rash
	Weight loss (unexplained		Stomach Ulcer		Anxiety
	Eye problems (besides glasses)		Constipation		Use Walker or Cane
	Loss of Hearing		Frequent Bowel Movements		Central Serous Retinopathy (CSR)
	History of sinusitis		Change in Urinary Habits		Other condition:
	Chest Pain		Diabetes		Other condition:
	Heart Problems		Thyroid Disorder		**Prior Surgeries:**
	Difficulty Breathing		Kidney Disease		
	Cough		Easy Bleeding		
	Heartburn		Easy Bruising		
	GERD (reflux)		.		

Directions

Coming from the North: Travel south on I-89, take exit 16, go left off the exit, take your first left onto Mountain View Drive, building 356 is on your right, within the building we are on the second floor in suite 200

Coming from the South: Travel north on I-89, take exit 16, go right off the exit, take your first left onto Mountain View Drive, building 356 is on your right, within the building we are on the second floor in suite 200

From the Winooski Circle: Head north on RT 7 (Main Street), you will pass under I-89, take a left onto Mountain View Drive, building 356 is on your right, within the building we are on the second floor in suite 200