

IVY PAIN AND REHABILITATION

80 Garden Center South C, Broomfield, CO 80020 Phone: 303.317.4421 Fax: 303.317.4619

PATIENT INFORMATION

LAST NAME		FIRST NAME & MIDDLE INITIAL		DATE
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE		SOC SEC #		
DATE OF BIRTH	AGE	MARRIED ___	SINGLE ___	DIVORCED ___ WIDOWED ___
PATIENT'S EMPLOYER			OCCUPATION	
EMPLOYER'S ADDRESS				
CITY		STATE	ZIP	
EMPLOYER'S PHONE				

GUARANTOR INFORMATION

RESPONSIBLE PARTY'S LAST NAME		FIRST NAME & MIDDLE INITIAL		
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE		SOC SEC #		
PATIENT'S EMPLOYER			OCCUPATION	
EMPLOYER'S ADDRESS				
CITY		STATE	ZIP	
EMPLOYER'S PHONE				

PLEASE SHOW YOUR INSURANCE CARD TO THE RECEPTIONIST

INSURANCE INFORMATION

INSURANCE NAME				
ADDRESS				
CITY		STATE	ZIP	
POLICY HOLDER'S LAST NAME		FIRST NAME	RELATIONSHIP	
ID OR CLAIM NUMBER		GROUP NUMBER	MEMBER NUMBER	

PRIMARY CARE PHYSICIAN

PHYSICIAN NAME		PHONE NUMBER
CITY		

REFERRAL SOURCE

REFERRED BY

HOW MAY WE CONTACT YOU

PLEASE CHECK ALL METHODS OF COMMUNICATION YOU ARE COMFORTABLE WITH

HOME <input type="checkbox"/>	VOICEMAIL <input type="checkbox"/>	LEAVE A MESSAGE WITH 3 RD PARTY <input type="checkbox"/>	CELL PHONE <input type="checkbox"/>	WORK <input type="checkbox"/>	WORK VOICE MAIL <input type="checkbox"/>
EMAIL (AS ALLOWED BY HIPAA) <input type="checkbox"/> PLEASE PROVIDE EMAIL ADDRESS:					

THE FOLLOWING FAMILY/FRIENDS MAY BE CONTACTED REGARDING MY CARE :

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PHARMACY

NAME OF PHARMACY PRIMARILY USED:
LOCATION:

EMERGENCY CONTACT

GIVE THE NAME OF NEAREST RELATIVE OR CLOSE FRIEND TO CONTACT IN CASE OF AN EMERGENCY

NAME	HOME PHONE	WORK PHONE
RELATIONSHIP	CITY	STATE

<p>I authorize the release of any medical information necessary to process this and all future claims. I agree to pay reasonable attorney and/or collection agency fees if my account is turned over to an attorney and/or collection agency for collection.</p> <p>X _____ Signed (Insured or authorized person)</p>	<p>I authorize the release of any medical information necessary to process this claim and all future claims.</p> <p>X _____ Signed (Insured or authorized person)</p>
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Notice of HIPAA Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can gain access to the information. Please review carefully.

Ivy Pain and Rehabilitation takes seriously the trust you place in us in providing health care for you and your family. We have always honored your trust to our utmost to keep personal and medical information private and secure. The Federal Government now mandates that we make this notice available to you and to abide by the notice currently in effect. We reserve the right to change this notice and will post the updated notice in our waiting room and make it available upon your request.

Use and Disclosure of Information

- We will use your “protected health information” for the reasons such as recommending medical treatment, sending a billing statement or insurance claim form (securing payment), or calling you for an appointment reminder (operations).
- We will limit the amount of information we share to the minimum required for the intended purpose. We will share appropriate information with other physicians when referred or transfer of care occurs in the event that you request and consent to sending information to a third party, as required by law, or to comply with peer review. This information may include medical claims, medical reports, social security number, address, date of birth, and telephone number. While this list is not all-inclusive, it should give you an idea of the type of information we are referring to in this Notice.

Individual Rights

You have the right to:

- Inspect and obtain a copy of your Protected Health Information.
- Request an amendment to your Protected Health Information (medical record) or
- Request an accounting of, or restriction to certain uses and disclosures, and we reserve the right to agree to such requests.
- Receive confidential communications.
- Receive an accounting of disclosures.
- Complain about our privacy practices:
 - By contacting our Privacy Officer at (303)317.4421 or in writing at 80 Garden Center, Broomfield, CO 80020
 - Or by contacting the Secretary of US Dept of Health and Human Services.

As indicated in this notice, we will use and disclose information expressly authorized by you, and you have the right to revoke such authorization.

If you have any questions, would like further information, or have a dispute regarding your rights or our Privacy Practices, please contact our Privacy Officer.

I have read this Notice of Privacy Statement, been provided an opportunity to ask questions, and understand that I may request and review the detailed Privacy Policy for Ivy Pain and Rehabilitation PLLC.

Signed: _____ Date: _____



Financial Responsibility and Consent for Treatment

Patient Name: _____ **Date:** _____

Social Security #: _____ **Date of Birth:** _____

Insurance Billing: Ivy Pain and Rehabilitation does not participate with Medicare, Medicaid. If you are covered with one of the insurances we are contracted with we will bill them accordingly. All co-pays are due at the time of service. Dr. Worwag may recommend treatment that could be considered by your insurance as “Alternative” or “Experimental” and may not be a covered benefit. Any amount not covered by your insurance due to co-insurance, deductible or non-covered services will be the responsibility of the patient. Patients are responsible to know their plans coverage and limitations.

Self Pay Patients: If you do not have insurance coverage or are covered by an insurance company not contracted with Ivy Pain and Rehabilitation, payment in full is expected at the time of service. Ivy Pain and Rehabilitation charges \$200.00 an hour billed by the quarter hour. Procedures, injections and supplements are additional. Missed appointments without a prior cancellation will be charged \$100.00. We will, as a courtesy to our patients, bill your insurance company on your behalf. However, we cannot guarantee payment and will not conduct any follow-up with your insurance as to non-payment. Please be aware that some/all of the procedure/treatment received by you may not be covered by your insurance.

Financial Policy: Payment is due in full at the time of service. We accept cash, check, Visa and MasterCard. In the event your check is returned by your bank, per Colorado law, you will be charged \$20.00 or 20% of the amount of the check, whichever is greater. In the event your account is referred to an outside collection agency, you will be held liable for attorney’s fees and court costs associated with collecting the debt.

Financial Responsibility: I understand that I am financially responsible for payment of medical charges incurred on my behalf at Ivy Pain and Rehabilitation, regardless of insurance coverage.

Assignment of Insurance Benefits: I hereby authorize payment of insurance benefits directly to Ivy Pain and Rehabilitation.

Release of Information: Ivy Pain and Rehabilitation may disclose all or any part of the patient’s record to any party or organization responsible for payment of all or part of the patient’s medical charges. Dr. Worwag believes it is critical to her patients care to coordinate with their PCP (primary care physician). Dr. Worwag routinely forwards visit notes to her patients PCP. The physician may also disclose all or any part of the patient’s record to other health care providers or regulatory agencies as deemed by law.

Consent for Treatment: The undersigned authorizes the physician to undertake such treatment and procedures as deemed appropriate to remedy or improve the condition of the patient in the professional judgment of the physician. It is recognized, however, that the practice of medicine is not an exact science, and as such no guarantees are made by the physician as to the result of treatment or examination performed. The patient is advised that he/she has the right to a full explanation of any examinations, treatment or procedures utilized. The patient understands that he/she has the right to refuse treatment at any time, but in doing so should also understand that the desired outcome of the program may be affected.

I confirm that I have read (or had read to me) the above information and understand its content. I give my consent to treatment under these conditions willingly and knowingly.

Signed: _____ Date: _____



Jutta Worwag, MD, MPH

Name: _____

Date: _____

Please provide a list of your current medical problems

On a scale from 0-10 how much pain are you normally in daily, 0 being none and 10 being you are dead.

0	1	2	3	4	5	6	7	8	9	10

On a scale from 1-10 how much pain are you currently in, 0 being none and 10 being you are dead.

0	1	2	3	4	5	6	7	8	9	10



Jutta Worwag, MD, MPH

Name: _____

Date: _____

Medication List

Please provide a list of current medication:

Medication	Dosage	Frequency	Date Started Taking	Side Effects
	mg	x a day	/ /	
	mg	x a day	/ /	
	mg	x a day	/ /	
	mg	x a day	/ /	
	mg	x a day	/ /	
	mg	x a day	/ /	

Please provide a list of medications that you have taken and found not be helpful.

Medication	Dosage	Frequency	Date Started Taking	Side Effects
	mg	x a day	/ /	
	mg	x a day	/ /	
	mg	x a day	/ /	
	mg	x a day	/ /	

Complete the following diagram drawing the symbols below to show where you have your typical pain

Ache >>>>
>>>>
>>>>

Numbness ----

Pins & 0000
Needles 0000
0000

Burning XXXX
XXXX
XXXX

Stabbing ////
////
////

Please draw in the face.

