COLORADO VOICE CLINIC, P.C.

David A. Opperman, M.D. William Y. Reifman, N.P.P.A.

PLEASE FILL OUT COMPLETELY AND SIGN WHERE INDICATED

Patient Information **(OFFICE: PI-1 _____)**

First Name _____ Last Name _____ M.I. _____

Preferred Nickname _____ Date of Birth ____ / ____ / _____

Age _____ Sex ☐ M ☐ F Social Security No _____ - ____ - _____

Race ☐ American Indian/Alaska Native ☐ Asian Black/African American
☐ Native Hawaiian/Pacific ☐ White ☐ Other ☐ Decline

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unspecified ☐ Decline

Primary Care Physician **(OFFICE: PI-2 _____)**

Physician Name _____ Practice Name _____

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

Address _____

Referring Physician **(OFFICE: PI-3 _____)**

Physician Name _____ Practice Name _____

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

Address _____

Patient Contact Information **(OFFICE: CI-1 _____)**

Home Address _____ City _____ State ____ Zip _____

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

Email _____

Employer _____ Occupation _____ Employer Phone _____ - _____ - _____

Emergency Contact **(OFFICE: CI-EC _____)**

Name _____ Relationship _____

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

Responsible Party *(Person responsible for balance not covered by insurance)* **(OFFICE: CI-PG2 _____)**

Name _____ Relationship _____

Address _____ City _____ State ____ Zip _____

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

Employer _____ Occupation _____ Employer Phone _____ - _____ - _____

Who We May Speak To Regarding Medical Care **(OFFICE: CI-PG1 _____)**

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 **(OFFICE: CI-PR _____)**

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

Name _____ Phone _____ - _____ - _____ Relationship _____

Insurance **(OFFICE: CI-PR _____)**

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 **(OFFICE: Rx-Ph _____)**

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

Location/Address _____

Medications and Allergies

Are you allergic to any medications ☐ No ☐ Yes **(OFFICE: Red-P _____)**

If yes, please list medications:

Name	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

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

Current Medications **(OFFICE: Yel-P _____)**

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

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

Surgeries and Hospitalizations **(OFFICE: HX _____)**

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 what year you received the pneumonia vaccine, if applicable. Year _____

Please list what month and year you received the flu vaccine, if applicable. 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)

OFFICE: PI-Photo _____ HIPAA _____ Chart # _____

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.

_____

_____

_____

_____

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

Colorado Voice Clinic P.C. has a policy that requires patients to cancel their appointments with Dr. David Opperman or William (Buzz) Reifman N.P, P.A. 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.

_____ _____

Patient Signature Date

Colorado Voice Clinic, PC
930 West 7th Avenue Unit B, Denver, CO 80204
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 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 (**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**).
    h. If Colorado Voice Clinic, P.C. is outside the network for your insurance plan.

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 payment of charges for extensive phone consultations and 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 I am financially responsible for payment in full of all charges incurred regardless of insurance coverage. I am aware that my insurance company may deny payment or make partial payment and I agree that I will be responsible for the balance due. I am aware that it is my responsibility to contact my insurance company to verify that it will pay for charges incurred.

_____ _____

Signature of Patient or Guardian Date

_____

Print Name

_____

Patient Name (if different)