

Registration and Billing Information
Vermont Interventional Spine Center

LAST NAME _____ FIRST NAME _____ MI _____
 MAILING ADDRESS _____
 CITY _____ STATE _____ ZIP CODE _____
 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 Race (Please check one): Asian
 Not Hispanic/Latino African American/Black
 Decline to answer American Indian/Alaskan Native
 Don't Know Native Hawaiian/Other Pacific Islander
 More than one race
 White
 PREFERRED LANGUAGE: _____ Decline to answer

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

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. you should always check with your insurance company for

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|--|--|
| <input type="checkbox"/> BCBS Out of State Plan or Federal | <input type="checkbox"/> BCBS of Vermont |
| <input type="checkbox"/> Medicare | <input type="checkbox"/> MVP |
| <input type="checkbox"/> VT Medicaid | <input type="checkbox"/> CIGNA/ Great West |
| <input type="checkbox"/> CBA | <input type="checkbox"/> United Health Care NY |
| <input type="checkbox"/> Aetna Medicare | <input type="checkbox"/> 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 immediately. 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."

If the patient is a minor: **“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)	Arthritis	

VISC 2015

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

