

**Eric A. Kelts, M.D.**  
7400 East Arapahoe Road, Suite 100  
Centennial Colorado 80112  
Phone (303) 284-7950 Fax (720) 542-9930

Please find enclosed the paper work for your appointment with us on:

\_\_\_\_\_ at \_\_\_\_\_.

Please make sure to bring the following (some may not apply to your visit):

Completed Paper Work

Insurance Card(s)

Co-Pay if needed for your insurance( we prefer Checks, Cash, or credit/debit--we can accept Visa, Disc, Amex or MC)

MRI or CT Films or Disc

MRI, CT, &/or EEG Report(s); Visual Field, Gdx, HRT, OCT, fundus photos, flourescein angiograms

Lab Work

Any additional information that you may have regarding your diagnosis or symptoms.

Please call your doctor that referred you to us and make sure that they have faxed us over the last two chart notes, lab work, and MRI, CT, &/or EEG reports. Our fax number is (303) 751-3364.

If you have any questions or concerns please feel free to call us at (303) 284-7950

Sincerely,

**The Neurovision Team**



Eric A. Kelts, M.D.  
NeuroVision, PC and A Good Night's Sleep Center  
7400 East Arapahoe Road Suite 100  
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**New Patient Information Questionnaire**

Today's Date: \_\_\_\_\_

To help make your consultation as helpful as possible, we ask that you complete this patient information form and bring it to your appointment. Your responses will remain confidential.

Full Name: _____	Sex/Gender _____
Address: _____	Date of birth: _____
City, State, Zip: _____	Age: _____ SS#: _____
Telephone: (H) _____	Occupation: _____
(W) _____	Handedness: R _____ L _____
(C) _____	Marital Status: M _____ S _____ D _____ W _____
e-mail: _____	

**Primary Insurance**

Insurance Name \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Ins. Phone \_\_\_\_\_ Name of Insured \_\_\_\_\_ Relationship \_\_\_\_\_

SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employers Name \_\_\_\_\_ Phone \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Secondary Insurance**

Insurance Name \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Ins. Phone \_\_\_\_\_ Name of Insured \_\_\_\_\_ Relationship \_\_\_\_\_

SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employers Name \_\_\_\_\_ Phone \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Does the purpose of your evaluation relate to pending legal action? Yes No**

**Primary Care Physician:**

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

**Referring Physician:**

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

I request that all reports and evaluation results be sent to each of the physicians indicated above.

\_\_\_\_\_  
(Patient or patient representative signature)

\_\_\_\_\_  
(Date)



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**Emergency Contact**

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_

**Primary Caregiver (if applicable)**

Name \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_

I give permission for the results of my evaluation to be discussed with the following individuals:

Name	Phone	Relationship
_____	_____	_____
_____	_____	_____

Patient Initials: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby authorize Drs. Kelts and/or Trinko 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. I 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 \_\_\_\_\_



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**MEDICAL / HEALTH HISTORY**

**HISTORY OF PRESENT ILLNESS** (Describe your main problem)


**PHYSICIAN'S NOTES**

**MEDICATIONS** (List medications your are currently taking)

Current Medications

Dosage/Time

Current Medications	Dosage/Time

Please list other medications previously tried for your neurologic or ophthalmologic problem.

Medicine

Dosage/Time

Medicine	Dosage/Time

**ARE YOU ALLERGIC TO ANY MEDICATIONS?**

Please list: \_\_\_\_\_

Please list any other allergies \_\_\_\_\_

**PAST MEDICAL HISTORY**

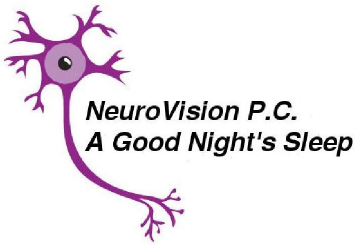
List any serious illnesses, injuries, operations, and hospitalizations

Date

Event

Date	Event

Pregnancies/Miscarriages/Abortions \_\_\_\_\_



**FAMILY HISTORY**

Please use the space below to list all of your immediate family (parents, siblings and children). Please list serious illnesses or diseases. Please comment on the general health of the person when applicable.

Relationship	Age	Deceased (Y/N)?	Health Status

Is there a family history of Glaucoma or Macular Degeneration? Y/N \_\_\_\_\_

**SOCIAL HISTORY**

Years of education: \_\_\_\_\_ Degree(s): \_\_\_\_\_  
 Living arrangements: \_\_\_\_\_  
 Employment: \_\_\_\_\_  
 Smoking: packs per day \_\_\_\_\_ Prior smoking: \_\_\_\_\_  
 Alcohol: approximate drinks per week \_\_\_\_\_  
 Drug use: \_\_\_\_\_  
 Spouse's occupation: \_\_\_\_\_  
 Spouse's health: \_\_\_\_\_

**REVIEW OF SYMPTOMS**

Have you had any of the following? Give dates and details when possible

Do you have headache?	Y/N
Where is your headache located?	
What does the headache feel like?	
How long does the headache last?	
Frequency	
Sensitivity to Light/Sound w/Headaches?	
Forgetfulness/Memory Loss/Confusion?	Y/N
Difficulty reading or writing?	Y/N
Loss of vision/blind spots?	Y/N
Double vision Blurred vision Trouble seeing distance or near?	
Eye pain Eye drainage Eyelid problems Cataract Glaucoma Macular Degeneration	
Facial numbness?	Y/N
Facial weakness?	Y/N
Loss of hearing?	Y/N
Difficulty chewing or swallowing?	Y/N
Tingling or numbness in limbs?	Y/N

**PHYSICIAN'S NOTES**

Heaviness or weakness in limbs?	Y/N
Fever, weight loss	Y/N
Ear, nose, or mouth problems	Y/N
Heart problems (chest pain, palpitations)	Y/N
Circulation Problems	Y/N
Respiratory problems (shortness of breath, wheezing, cough, sputum, etc)	Y/N
Gastrointestinal problems (bleeding, diarrhea, constipation, incontinence, etc.)	Y/N
Sexual problems	Y/N
Menstrual problems (date of last period)	Y/N
Back or neck pain	Y/N
Joint pain or swelling	Y/N
Hormone problems	Y/N
Anemia, easy bruising, rash	Y/N
Frequent infections	Y/N
Loss of consciousness/fainting	Y/N
Seizures	Y/N
Lack of coordination or clumsiness	Y/N
Involuntary shaking of limbs or head	Y/N
Difficulty walking	Y/N
Pain in arms or legs	Y/N
Depression/thoughts of suicide	Y/N
Difficulty maintaining home	Y/N
Need assistance with eating	Y/N
Need assistance with dressing	Y/N
Need assistance with bathing	Y/N
Need assistance with toileting	Y/N
Lack of energy	Y/N
Loss of appetite	Y/N
Loss of pleasure in life	Y/N
Difficulty concentrating	Y/N
Difficulty speaking	Y/N
Difficulty finding your way	Y/N
Difficulty managing finances	Y/N
Difficulty remembering information	Y/N
Insomnia/Severe Snoring/ Excessive Daytime Sleepiness	Y/N
History of obstructive sleep apnea	Y/N

Other symptoms you may want to mention or expand upon:

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**Office Use Only:**

Reviewed by: \_\_\_\_\_ Date \_\_\_\_\_



Welcome to **Neurovision PC/A Good Night's Sleep Center**. We are pleased and thank you for selecting our practice to provide your specialty care. To ensure a pleasant and efficient patient/physician and patient/staff relationship, our practice has implemented the following policies and procedures:

## **EFFECTIVE IMMEDIATELEY**

### **NO SHOW / CANCELLATION POLICY**

All cancellations should be made *no later than 24 hours prior to your appointment*. Please inform us of cancellations during our normal business hours, Monday through Friday, 8:30 AM to 4:30 PM. For emergencies we do have an after hours answering service which you can reach by calling our main office number.

A no show or failure to cancel your appointment may result in a \$50.00 no show charge. If you are more than 10 minutes late to your appointment you may be asked to reschedule.

### **PATIENT FORM POLICY**

In general, we require up to 14 days completing forms for patients, although we will try to expedite this as much as possible.

### **PRESCRIPTION REFILL POLICY**

Telephone request for prescriptions and refills are authorized only during office hours Tuesday through Friday 10 AM to 4:30 PM. Please have your pharmacist call during these times for any refills.

**Prescriptions will not be filled after hours or on the weekends.** We require up to 48 hours for prescription refill authorizations; please notify us before you are out of your medication.

### **NEW PATIENT AND FOLLOW-UP APPOINTMENTS**

Please bring all MRI scans, CT scans, X-Rays, other specific test results and **ALL** physician reports that pertain to your specific condition. If you choose to have your scans mailed/couriered or reports faxed to us, please call their offices at least 48 hours in advance to request them, and please call our office at least 24 hours before your appointment to confirm that we have received them.

If we do not have the information needed to accurately diagnose your condition, you may be asked to reschedule your appointment.

I have acknowledged that I have read the above and agree to it.

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Signature

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Date

**Notice of Privacy Practices Summary**

This notice is a summary of how your protected health information is used and disclosed and how you can obtain access to this information. Please see the front desk to review a full copy of our Privacy Practices.

**Uses and Disclosures of Health Information**

We use health information about your treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive.

We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at anytime. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each examination room. You can also request a copy of our notice at anytime. For more information about our privacy practices, contact the person listed below.

**Your Rights**

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- Obtain a paper copy of the notice of privacy practices upon request
- Inspect and obtain a copy of your record as provided for in 45 CFR 164.524
- Amend your health record as provided in 45 CFR 164.528
- Obtain an accounting of disclosure of your health information as provided in 45 CFR 164.528
- Request communication of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Following a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

**Complaints**

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

**Our Legal Duty**

We are required by law to protect the privacy of your information, provide this notice about our information practices and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact **Dr. Eric Kelts at 7400 E. Arapahoe Rd, Suite 100, Centennial, CO 80112** or call **(303) 284-7950**.

**Written Acknowledgement**

I acknowledge that I have reviewed the **Notice of Privacy Practice** which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed.

Signature of Patient/Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_