Douglas E. Hemler, M.D. *Board Certified PM&R, Pain Medicine, Electrodiagnostic Medicine*

SPINE AND SPORT

Kyle C. Morgan, D.O. *Board Eligible PM&R, Pain Medicine, Electrodiagnostic Medicine*

Kirk Prochnio, P.A.-C.

NAME:______________________________ DOB:______________________

**Please read and sign all of the following:**

*Assignment of Benefits*

I understand that I am responsible for all charges regardless of insurance coverage. I agree to pay my account with this office in accordance with the regular rates and payment terms of this office. If my account is referred to collection, I agree to pay reasonable collection expenses including attorney's fees. In the event that I am entitled to health insurance or other benefits relating to my medical condition and available to cover the costs of treatment provided by this office, I hereby assign those benefits to this office to be applied to my bill. I understand that there will be a $25 charge for cancelling an appointment with less than 24 hours notice or failing to attend an appointment with no notice. Further, I understand that there will be a charge for telephone consultations. I agree that this office may release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan. I further permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing.

_______________________________________________ _______________

Signature Date

*HIPAA - Notice of Privacy Notices*

I acknowledge that I will be given a copy of the Notice of Privacy Practices for Douglas Hemler M.D. and KyleMorgan, D.O., if I request a copy.

_______________________________________________ _______________

Signature Date

*FMLA/Disability Form Completion*

I am aware that an appointment is required for all forms to be completed. This includes but is not limited to FMLA and Disability Paperwork. There is also a two week turn-around time for all forms so please plan ahead.

_______________________________ _______________

Patient Signature Date

*Check in time / arrival time policy*

Our office requires that all new patients arrive thirty minutes early and all established patients arrive fifteen minutes early. We ask our patients to arrive prior to their scheduled appointment time because we do have multiple patients scheduled with multiple providers. This early arrival time allows our staff adequate time to process all the necessary paperwork in a timely fashion in order to help keep all of our providers on schedule, and to honor your scheduled appointment. In the event that our providers are running late, we will make every attempt to notify you prior to your arrival. If you are not able to arrive early as our policy states, you may be asked to reschedule.

_______________________________ _______________

Patient Signature Date



2801 Youngfield Street
Suite 150
Golden, CO 80401

303-238-4277
Fax: 303-238-4977
www.starcolorado.com

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*Prescription Refill Policy*

**Please initial each section**

_____ Prescription refills are handled Monday thru Thursday from 9am to 4pm. Prescriptions will not be refilled after hours or on the weekends.

_____ Requests for prescription refills require an appointment with a provider. Please be aware of when you are coming to the end of the supply of your medications, emergent appointments cannot always be accommodated.

_____ No walk-in appointments for prescription refills will be accommodated.

_____ Prescription refills will only be approved for 3 months or 1 month for controlled substances, after which an appointment with a provider is required.

_____ If you need to change the type of medication, an appointment with a provider is required. In emergent situations you may go to an Urgent Care or ER, after contacting our office.

_____ If you lose or misuse a prescription, we will not authorize a refill without an appointment.

_____No refills authorizations will be called in or faxed to the pharmacy.

_____ We are not responsible for getting your mail in prescriptions to your mail in pharmacy. This is the patient's responsibility.

___________________________________ ________________
Patient Signature Date



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