PEAK ORTHOPEDICS & SPINE

PATIENT INFORMATION

Patient Name ____
Last First M.I.

Address ____
Street Address

____
City State ZIP Code

Phone # ______________ Work # ______________ Cell # ______________

Date of Birth ____/____/____ Age ________ SSN ______ – ______ – ______

Employer ______________________ Address ______________________

Primary Care Physician ______________________ Phone # ______________________

RESPONSIBLE PARTY *(one who carries insurance)*

Name ______________________ Relationship to Patient ______________

Date of Birth ____/____/____ SSN ______ – ______ – ______

Address ______________ City ______________ State ______ ZIP Code ______

Phone # ______________ Work # ______________ Employer ______________

INSURANCE INFORMATION

Primary Ins. ______________ ID # __________ Group # __________ Copay $ ________

Secondary Ins. ______________ ID # __________ Group # __________ Copay $ ________

EMERGENCY CONTACT *(relative or friend not living with you)*

Name ______________________ Phone # ______________________

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO PHYSICIAN OR SUPPLIER FOR THESE SERVICES AND ALL FUTURE CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE AND IT IS MY RESPONSIBILITY TO KNOW MY COPAYS, DEDUCTIBLES, OUT-OF-POCKET AMOUNTS, ETC. WHICH HAVE BEEN ESTABLISHED THROUGH MY INDIVIDUAL INSURANCE POLICY. I AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND ALL FUTURE CLAIMS.

Signature ______________________________ Date ______________

HEALTH SUMMARY

Patient name (please PRINT):________________________ date: ____________

ALLERGIES NONE: ________

Drug	Reaction	Drug	Reaction

MEDICATIONS NONE: ________

What medications are you taking (including birth control pills, herbals, vitamins, dietary supplements, and over-the counter)?

Name	Dose	Frequency	Name	Dose	Frequency

PRESENT HEALTH CONDITIONS (Check appropriate)

YES	NO	DISEASE	YES	NO	DISEASE
		Heart Attack / Coronary Artery Disease			Prostate Problems
		Congestive Heart Failure			Gout
		Irregular Heart Beat			Arthritis
		Heart Murmur			Skin Disease, Type:
		Rheumatic Fever			Stroke
		High Cholesterol			Epilepsy/Seizures
		High Blood Pressure			Diabetes/High Blood Sugar
		Asthma			Thyroid Problems – too high or too low
		Emphysema/Chronic Bronchitis			Anemia/Low Blood
		Blood Clot in Lung			Bleeding Problems, Type:
		Blood Clot in Leg			Blood Transfusion
		Tuberculosis			Cancer, Type:
		Gallstones			Anxiety
		Liver Disease, Type:			Depression
		Ulcers in Bowel/Stomach			Bipolar disorder
		Bleeding from Bowels			Glaucoma
		Kidney Disease, Type:			Other:
		Kidney Stones			Have you ever tested positive for HIV or
		Osteoporosis			Hepatitis? No Yes (Circle one)

SURGERIES

YES	NO	DISEASE	YES	NO	DISEASE
		Cataract Surgery, Left Right			Joint Replacement of Knee / Hip
		Tonsils Removed			Spine Surgery
		Neck Artery Surgery			Prostate Surgery
		Open Heart Surgery			Hernia Surgery
		Catheterization/ Stents			
		Appendectomy			Vasectomy
		Gallbladder Removal			Hysterectomy
		Abdominal Surgery			Other:
		Broken Bone Repair			
		Joint Scope Surgery			

Height:________ Weight:________ BMI: ______

FAMILY HISTORY

YES	NO	DISEASE	RELATION TO YOU	YES	NO	DISEASE	RELATION TO YOU
		Heart Attack				Bleeding Problems	
		High Blood Pressure				Sickle Cell Anemia	
		High Cholesterol				Diabetes/High Blood Sugar	
		Asthma				Thyroid Problems	
		Tuberculosis				Cancer, Type:	
		Liver Disease				Cancer, Type:	
		Kidney Disease				Alcohol Abuse	
		Gout / Arthritis				Anxiety or Depression	
		Osteoporosis				Glaucoma	
		Stroke				Other:	
		Epilepsy / Seizures					

Review of Systems (Circle those that apply)

General: Fever, fatigue, weight loss / gain ____
Eyes: Blurred, double vision
Ears, Nose, Throat: Difficulty swallowing, hearing loss, chronic sinus infection
Cardiovascular: Chest pain / tightness, pounding of the heart
Respiratory: Shortness of breath, chronic cough, sputum
Gastrointestinal: Nausea, vomiting, diarrhea, constipation, abdominal pain, blood in stool
Genitourinary: Incontinence, frequency, burning
Musculoskeletal: Joint pain, swelling, deformity
Skin: Rash, lumps, bumps
Neurological: Loss of balance, dizziness, headaches, weakness
Endocrine: heat or cold intolerate
Hematologic: Easy bruising, difficulty with stopping bleeding
Immunologic: frequent infections, HIV
Gynecologic: Last menstrual period: ___/___/___

Married:______ Significant other: ____ divorced:____ single:____ Widow / er:____
# of children:_____

OTHER HISTORY

Exercise: ☐ Never ☐ Rarely ☐ Other: ____________________________

Immunizations: Tetanus _______, (Never) ___ / Hepatitis B _______, Pneumovax _______, Flu shot _______,
The following questions are very important: Please answer them accurately.

Smoking:
Have you ever smoked: ☐ Yes ☐ No How many packs per day do you smoke now? _______ How many years did you smoke? _______
When did you quit? _______ Do you use smokeless tobacco: ☐ Yes ☐ No
Alcohol/Drugs:
☐ Yes ☐ No Do you drink? How much? _______ How often? _______
☐ Yes ☐ No Do you use drugs? How much? _______ How often? _______ What kind? ________________
What drugs have you used in the past?____

The above information is current and correct to the best of my knowledge. **I have reviewed the above history.**

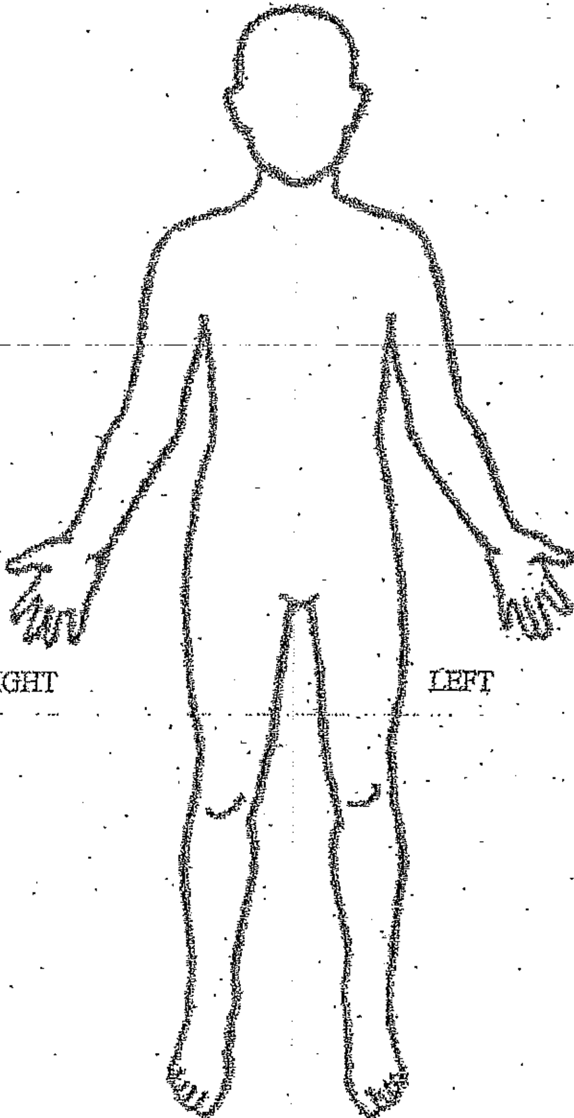
Patient/Guardian Signature **Date** **Physician's Initial** **Date**

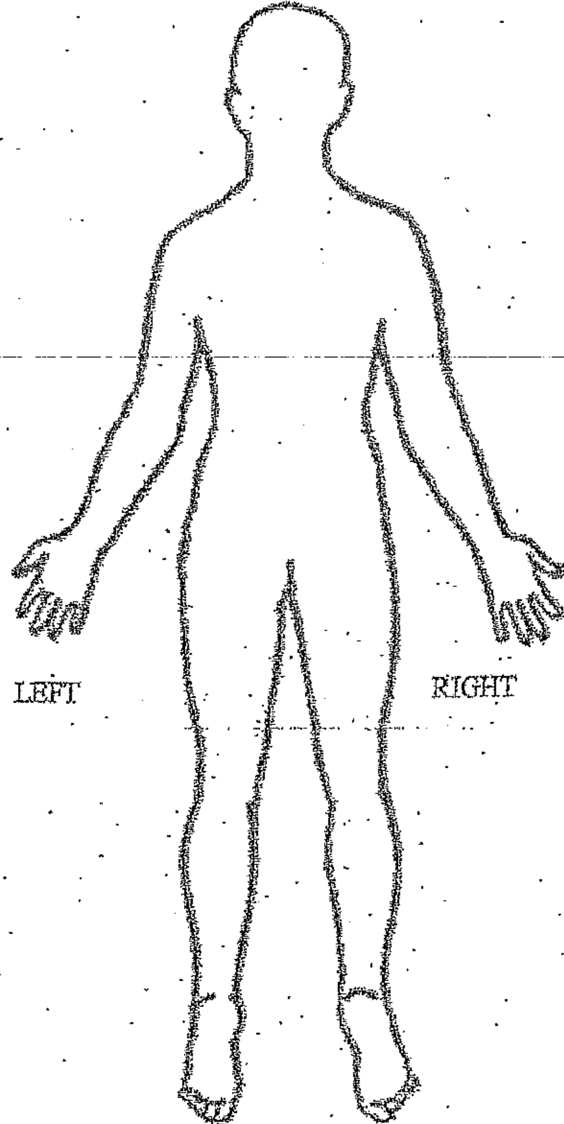
Created on 01/15/2008

PAIN DIAGRAM

Please mark the areas where you experience the following sensations:

Ache	^^^	Numbness	ooo	Pins & Needles	===	Burning	XXX	Stabbing	///
	^^^		ooo		===		XXX		///
	^^^		ooo		===		XXX		///





Medication Contract

The purpose of this agreement is to prevent a misunderstanding about how narcotic and any and all other related prescriptions are distributed by the physician to the patient in this office.

Our Policy

- We are not required to provide medication prescriptions. We do not provide Pain Management, but rather use medication in conjunction with planning and performing of surgery. We reserve the right to deny requests for medication.
- Your Physician may decide to treat you prior to surgery planning, and/or in conjunction with ongoing non-operative therapy for a period not to exceed 45 days.
- Medication prescriptions shall be provided **Post Surgery** for a period of 45 days.
- After 45 days, alternative sources shall be recommended by the physician that may include: return to primary care physician, a pain management program, or other treating physician.
- We will not write new prescriptions if you are enrolled in a Pain Management program.
- You must allow **48hours** for processing of refills.

As a patient, I agree to comply the following conditions

- I understand that if I break this agreement, my doctor will stop prescribing any medication.
- I will not use any illegal substance, including marijuana, cocaine, methamphetamine, etc. while under this agreement and in the care of Peak Orthopedics and Spine.
- I will not trade, borrow, give or sell my medications with anyone.
- I will not attempt to obtain any controlled medications, specifically narcotics, stimulants, or anti-anxiety medication from any other health care provider without written consent from my prescribing physician.
- I will safeguard my medicine from loss or theft. **Lost or stolen medication WILL NOT be replaced.**
- I will turn in any unused medication if a prescription is changed.
- I agree that requests for prescriptions refills shall only be made during regular business hours. **NO REFILLS will be filled after hours, Fridays, or on weekends.**

I authorize the doctor, doctor's representative, and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including, but not limited to, the State Board of Pharmacy, the Board of Medical Examiners, and the Drug Enforcement agency (DEA) in the investigation of any possible misuse, sale, or other diversion of my medication. I agree to waive any applicable right to privacy or confidentiality with respect to these authorizations.

I agree to comply with this policy. All my questions and concerns regarding this agreement have been answered. I can request a copy of this agreement but the original shall remain in my chart.

(Signature) ______________________________ Date ____/ ____/ ____

Print Name:______________________________Witness:______________________________

PEAK ORTHOPEDICS & SPINE POLICIES AND PROCEDURES

Welcome to Peak Orthopedics & Spine! Our Physicians and staff are looking forward to providing you with exceptional care. It is important to us that you understand our policies so that we may operate efficiently and effectively.

1. Please arrive for your appointment 10 minutes prior to your scheduled time. If you are a New Patient and need to fill out New Patient paperwork, please visit our website at www.peakorthopedics.com , click on office forms and the Doctors name you are seeing, print out the forms and fill them out and bring them with you when you come. If you are unable to do this, you will need to fill them out in the office and arrive 15 minute prior to your scheduled time.
2. Please make sure you bring a photo ID and proof of insurance with you to your appointment. We will need this information prior to seeing you. **If you do not have this information, your appointment will be rescheduled.**
3. If your physician orders any special test (i.e. MRI, CT scan etc.), you will need to make a follow up visit to go over the results of your test. You can either make that follow up appointment when you leave the office or call and schedule an appointment when your test is complete. The Doctor usually will not go over results on the phone, so please make sure you schedule your follow up.
4. You may be under a global follow up period (generally 90 days) after surgery or a fracture. Depending on the agreement between you and your insurance, you may not be charged an office visit co-pay. You may be responsible for any x-rays, casting, equipment fittings etc. that may occur during this period.
5. If you are unable to make your scheduled appointment, please notify us as soon as possible. If we are not notified prior to your scheduled appointment time, you will be charged $50 for a missed appointment.

FINANCIAL POLICY

1. It is the responsibility of the patient to know your coverage benefits and co-pay amounts. Peak Orthopedics & Spine is a specialist and you will pay a specialist co-pay. Please call your insurance company to obtain this information prior to your visit if you are unsure of your co-pay amount.
2. All co-pays and outstanding balances are to be paid at the time of your office visit.
3. If you are uninsured, the cost for an office visit is $250.00 and must be paid at the time of visit. After the first visit, any follow up visits are $50 and up depending on x-rays, casting, braces etc... and payment is due at the time of service.
4. Peak Orthopedics & Spine does not do third party billing. We will bill your health insurance only. If you are seeing us because of an auto accident, we will not bill auto insurance. We will bill your health insurance and you submit a claim to your auto insurance. If you are an uninsured patient and seeing us as a result of an accident, you will be charged accordingly and you may obtain all copies of your bills to submit to auto insurance for possible reimbursement.
5. We do not see patients on a lien basis. You will be considered self-pay and may obtain copies of your bills to submit for possible reimbursement to the party in which the claim is against.
6. If you are seeing us on a Workmen's Compensation claim, you will need to provide the following information at your visit: The Workmen's Comp carrier, the billing address, adjusters name and phone number and a claim number. This information can be obtained from your employer and you will need to have this information with you at the time of your visit. If you do not have this information, you will need to reschedule your appointment.
7. All amounts due for surgical services must be paid prior to surgery.
8. A surgical assistant may be medically necessary as decided by your physician. Please understand this assistant is necessary to provide efficiency in the operating room and is not always covered by your insurance company.

I, ______________________________, have read and agreed to the above policies and procedures.

______________________________ ______________

Patient Signature Date

Peak Orthopedics and Spine
Notice of Privacy Practices for Protected Health Information
Effective Date : 01/17/2008

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully!

The office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Your Health Information Rights

The health and billing records we maintain are the physical property of the office. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering (In writing) a request to our office. We are not required to grant the request, but we will comply with any request granted;
- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information.
- Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering the request to our office (With appropriate notice and fees);
- Appeal a denial of access to your protected health information, except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a request (In writing) to our office. We may deny your request if you ask us to amend information that:
  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the health information kept by or for the office.
  - Is not part of the information that you would be permitted to inspect and copy; or,
  - Is not accurate and/or complete.
  - If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office/hospital. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition, or your death.
- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office, except to the extent information or action has already been taken.

Our Responsibilities

The office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office. We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Disclosures and Uses

We may disclose information, as authorized by law, related to the following:
Communication with family health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency; notification of a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death; to researchers when their research has been approved by an Institutional Review Board; for Specialized Governmental Functions, Coroners, Medical Examiners, and Funeral Directors; Organ Procurement Organizations (if you are an organ donor); Food and Drug Administration (FDA); Employers when related to Workers Compensation, Public Health Board; Board of Medical Examiners; Law Enforcement; Health Oversight; Judicial/Administrative Proceedings; to report Abuse & Neglect, avert a Serious Threat, or to assist in disaster relief efforts

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem, or want to exercise any of the above rights or file a complaint in writing or in person during regular business hours:

Jillian Abramson MBA, Administrator
Peak Orthopedics & Spine
9777 S. Yosemite Street, Suite 220
Lone Tree, CO 80124
Fax (303) 991-4319

You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services, whose street address and e-mail address is: Office for Civil Rights - U.S. Department of Health and Human Services - 200 Independence Avenue S.W. - Room 509F, HHH Building - Washington, D.C. 20201.

Acknowledgement of Privacy Notice

I acknowledge the receipt of the notice of Privacy Practices for Peak Orthopedics & Spine, PLLC.

Patient Signature ____

Patient Printed Name ____

Date ___________________________

Mark Fitzgerald, MD
Robert Greenhow, MD
Craig Loucks, MD
Hugh McPherson, MD
Lloyd Mobley, MD

Authorization for Release of Information

Physician or Facility to Provide Records:

____

____

____

I authorize the health Care Provider above to release the information specified below to Peak Orthopedics and Spine. I specifically authorize the release of the following information:

_____ **Office Chart Notes**

_____ **Films/Radiology Reports (MRI, CT, X-Rays)**

_____ **Operative Report(s)**

To Release to:

Peak Orthopedics & Spine, PLLC
9777 S. Yosemite Street #220
Lone Tree, CO 80124
Phone: (303) 699-7325
Fax: (303) 699-5486

Please list any individuals who you grant access to your medical records and/or patient information:

____________________________________ ____________________________________
Name (Relationship to Patient) (Name) (Relationship to Patient)

I understand that I may revoke this authorization at any time by notifying Peak Orthopedics & Spine, PLLC in writing. Copies of fax representations of this authorization may be utilized with the same effectiveness as the original.

____________________________ ____________ ____________________________
Signature of patient (or legal representative) Date If legal representative, relationship to patient