# PEAK ORTHOPEDICS & SPINE

PATIENT INFORMATION

Patient Name ______________________________________________
Last First M.I.

Address ______________________________________________
Street Address

______________________________________________ Email ____________________
City State ZIP Code

Phone # ____________________ Work # ____________________ Cell # ____________________

Date of Birth ____/____/____ Age ______ Gender M / F 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 RESPONSIBILTIY 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.**

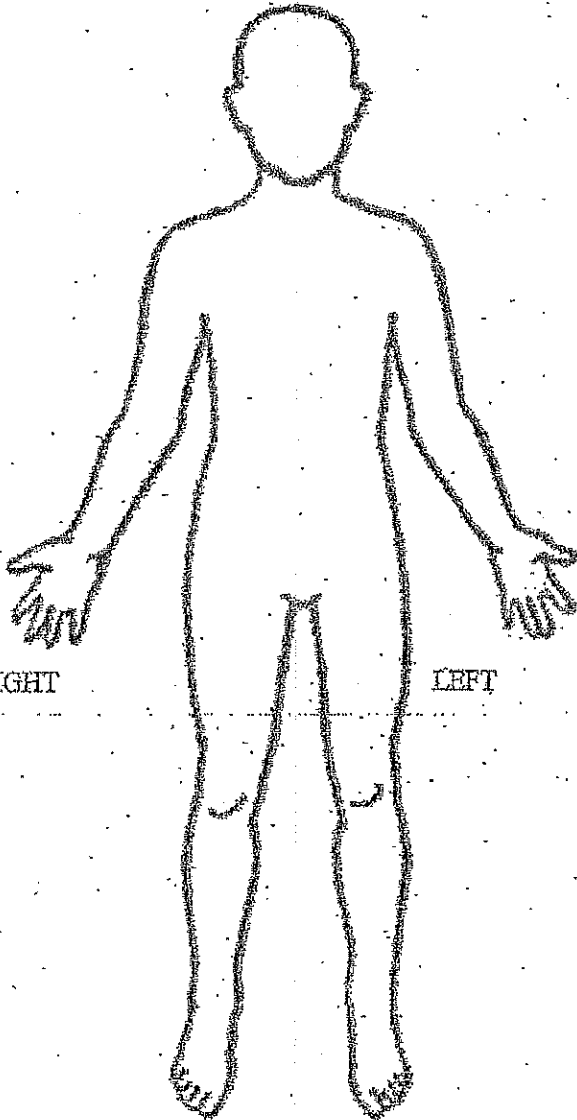
**Patient/Guardian Signature** ____________ **Date** ____________ **Physician's Initial** ____________ **Date** ____________

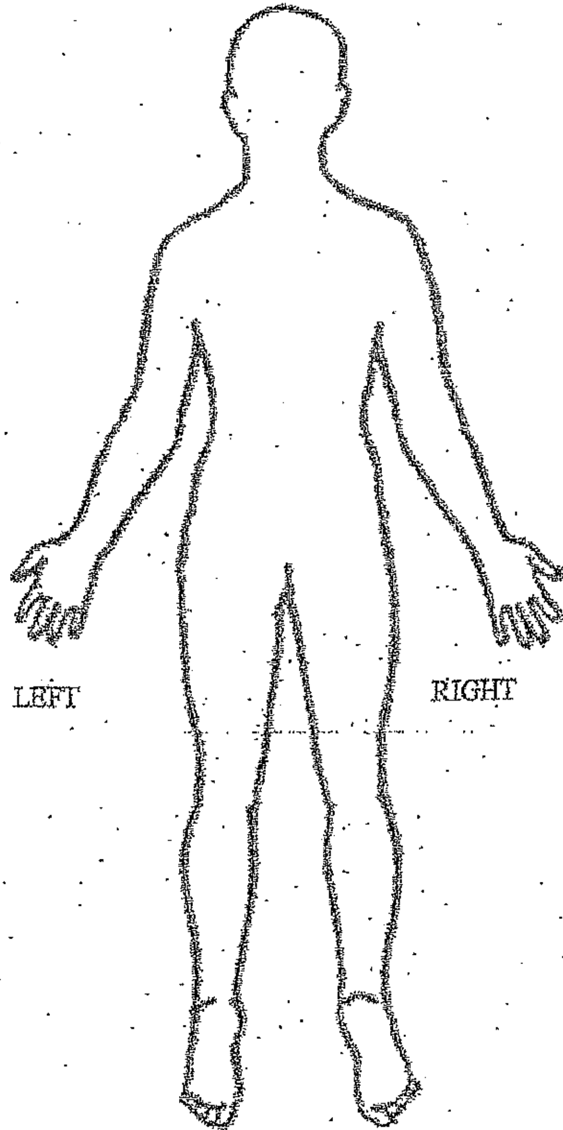
Created on 01/15/2008

## PAIN DIAGRAM

*Please mark the areas where you experience the following sensations:*

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



# 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. To access our new patient paperwork, please visit our website at www.peakorthopedics.com , click on office forms and the physician you are seeing, print out and fill out the forms and bring them with you when you come. If you are unable to do this, you will need to arrive early for your appointment and complete the paperwork.
2. Please make sure you bring a photo ID and proof of insurance with you to your appointment. **If you do not have this information, your appointment will be rescheduled.** Please also bring any tests/studies/films/notes/reports you have had done pertinent to the issue we are treating. We will need this information prior to seeing you.
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

# Physician Financial Disclosures

Colo. Rev. Stat. 25.5-4-414(2)(a) of Colorado State Health Care Policy and Financing Act

Dear Patient

Thank you for choosing Peak Orthopedics and Spine (A division of Orthopedic Centers of Colorado) as your providers for surgical evaluation and care. As part of your treatment plan, you may be referred to other provider services. Our mission is to offer ancillary services that offer state of the art technology and a dedicated team to maximize your safety. Some of these entities are specific to the subspecialty of your provider. The purpose of this disclosure is to notify you, the patient that your attending physician(s) may receive remuneration for referring you to any of the following healthcare providers for certain healthcare services:

## Marvosa, LLC

Marvosa is Provider Network of skilled neurologist that we have chosen to read and evaluate the neuromonitoring data provided by National Neuromonitoring during surgery. Your physician does not have any financial interest in National Neuromonitoring. Neuromonitoring is a method of monitoring the electrical impulses in your nerves while you are asleep during anesthesia. It helps guide our work around the nerves and spinal cord.

## Cherry Creek Surgery Center (CCSC)

CCSC is a multi-specialty outpatient surgical center committed to providing high quality surgical services for orthopedic, spine and pain management services. As a physician owned entity, we bring our service oriented commitment to the structure and function of the facility. As an in network facility CCSC can provide cost effective and low complication rates.

## Orthopedic Centers of Colorado Imaging

OCC Imaging is unique in offering state of the art equipment and a dedicated team of fellowship trained neuro and musculoskeletal radiologists to achieve the most accurate interpretation of each image.

## Medacta Implant Royalty

Your physician may receive a royalty for implants and procedures they have developed to help advance medical care. As a rule the physician does not receive a royalty for implants that they place in you the patient, but rather those placed by other physicians elsewhere in the world. Your physician may receive remuneration of evaluation and feedback regarding FDA approved devices and implants as a consultant for a medical device company. This also applies to educating visiting surgeons on innovative techniques.

Recognizing that you, the patient, have a choice in where you receive care or imaging, we are happy to provide alternate sites where your physician has priviledges or wher imaging can be obtained. In furnishing this list we are not endorsing any alternate facilities. Please verify your financial responsibilty and expected payment with these providers.

**EXHIBIT A**

**FORM OF PHYSICIAN DISCLOSURE**

As required by Colo. Rev. Stat. § 25.5-4-414(2)(a) of the Colorado State Health Care Policy and Financing Act.

Colorado law requires a physician to disclose to a patient those arrangements permitted under applicable Colorado law whereby such physician accepts remuneration to secure or solicit a patient or patronage for a person licensed, certified or registered by a Colorado health care regulatory agency. The purpose of this Disclosure is to notify you, the patient, that your attending physician(s) may receive remuneration for referring you to any of the following healthcare providers for certain healthcare services:

# MARVOSA, LLC

Accordingly, I hereby acknowledge that my attending physician(s) have disclosed to me, at the time of initial contact and at the time of referral (i) his or her affiliation with the foregoing healthcare provider(s) for whom, I, the patient am being referred, and (ii) that he/she will receive, directly or indirectly, remuneration for the referral to such healthcare provider. I understand that I, the patient, have the right to choose the providers of my healthcare services and/or products and, as such, I have the option of receiving healthcare services from any healthcare provider and/or facility that I choose.

By: ______________________________

Patient Name: ______________________

Date: _____________________________

# Acknowledgement of Privacy Notice and Disclosures

I acknowledge receipt of the Notice of Privacy Practices for Peak Orthopedics and Spine.

Patient signature ___________________________

Patient Printed name ____________________________

Date ______________

**Disclosures**

I acknowledge that my attending physician(s) have disclosed to me at the time of initial contact and at the time of referral:

1). His or her affiliation with the foregoing healthcare provider(s) for whom, I, the patient am being referred

2). That he or she will receive directly or indirectly, remuneration for the referral to such health care providers

I understand as a patient that I have a right to choose the providers of my healthcare services and/or products and implants.

Patient signature____________________________

Date____________________

# 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 ____________________________

Peak Orthopedics & Spine, PLLC
9777 S. Yosemite Street, Suite 220
Lone Tree, CO 80124
Ph. 303.699.7325
Fax. 303.699.5486

Mark Fitzgerald, MD
Robert Greenhow, MD
Craig Loucks, MD
Hugh McPherson, MD
In Sok Yi, MD

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

*Please fill out this form completely. Incomplete forms are invalid and will not be processed.*

Patient's Name________________________________________ Date of Birth ______________
Last First MI

This will authorize: ______________________________
______________________________
______________________________

To release to: Peak Orthopedics & Spine, PLLC
9777 S. Yosemite Street #220
Lone Tree, CO 80124

The following information (choose one):

_____ Copy of Entire Patient Chart

_____ Other (list)

______________________________

______________________________

For the purpose of:

_____ Transfer of Care

_____ Insurance/Benefits

_____ Other (list)

______________________

AUTHORIZATION: I certify that this request was made voluntarily and that the information given is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time by notifying Peak Orthopedics & Spine, PLLC in writing. I understand that any request for revocation will have no effect on any actions taken prior to its submission.

______________________________ ______________ ______________________________
Signature of patient (or legal representative) Date If legal representative, relationship to patient