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 ______________

Patient History

Name ______________________________

Date of Birth __________ Age____ Height______ Weight______ Marital Status: ☐ Married ☐Single ☐Divorced ☐Widow(er)
☐Right or ☐Left handed?

Status: ☐Employed ☐Unemployed ☐Retired ☐self-employed What is/was your occupation? ________________

Social Security #: ______-_____-_______

Primary Care (Family) Physician______________________ Phone Number ______________________________

Address______________________________ City______________ State______ Zip Code ___________

Referring Physician______________________________ Phone Number ______________________________

Address______________________________ City ______________ State ______ Zip Code___________

Present Complaint or Problem: ____

Duration of Present Complaint or Problem: ____

Have you seen any other Physician in THIS practice: No Yes If yes, whom: __________________ When: ________

PLEASE LIST ALL MEDICATIONS CURRENTLY BEING USED (*PLEASE PRINT NEATLY*)

Name, Dose and How Often	Problem being treated	Date of Prescription	Prescribing Doctor

Are you allergic to ANY medication, food, or non-medications like pollen? ☐No ☐Yes If yes, please list below.

Name of Medication	Type of Reaction

SOCIAL HISTORY

Have you ever used tobacco in any form? ☐ No ☐Yes If yes, please state when you quit ________________

Have you ever used alcohol in any form? ☐No ☐ Yes If yes, please list type and how much a week:________

Have you ever used any other recreational substances: ☐No ☐ Yes

PAST HEALTH Have you ever been DIAGNOSED with any major health problems? Including but not limited to:

Cancer (type) ________ ☐No ☐Yes If yes, when ____

Nose and Sinus:

Nasal Allergies ☐No ☐Yes If yes, when ____

Heart and Blood Vessels:

High/elevated cholesterol ☐No ☐Yes If yes, when ____

Heart Attack ☐No ☐Yes If yes, when ____

High Blood pressure ☐No ☐Yes If yes, when ____

Lungs and Respiratory:

Tuberculosis ☐No ☐Yes If yes, when ____

Stomach and Digestive:

Ulcer ☐No ☐Yes If yes, when ____

Stomach and rectal Bleeding ☐No ☐Yes If yes, when ____

Kidney and Gender Problems:

Renal Failure ☐No ☐Yes If yes, when ____

Prostate enlargement ☐No ☐Yes If yes, when ____

Are you pregnant? ☐No ☐Yes

Metal and Emotional:

Depression ☐No ☐Yes If yes, when ____

Anxiety ☐No ☐Yes If yes, when ____

Glands, Hormones, and Sugar Control:

Diabetes ☐No ☐Yes If yes, when ____

Thyroid deficiency ☐No ☐Yes If yes, when ____

Thyroid excess ☐No ☐Yes If yes, when ____

Blood and Lymph Node Problems:

Anemia ☐No ☐Yes If yes, when ____

Allergies, Immune and Infectious Problems:

HIV ☐No ☐Yes If yes, when ____

Infectious mononucleosis ☐No ☐Yes If yes, when ____

Hepatitis ☐No ☐Yes If yes, when ____

Neurologic Problems:

Stroke ☐No ☐Yes If yes, when ____

Seizure ☐No ☐Yes If yes, when ____

Eyes:

Cataracts ☐No ☐Yes If yes, when ____

Glaucoma ☐No ☐Yes If yes, when ____

Peripheral vision ☐No ☐Yes If yes, when ____

Other ______________________________

____

Have you ever been DIAGNOSED with any other major health problem not listed above ☐No ☐Yes If yes, please list diagnosis and year the diagnosis was made. ______________________________

SUGERIES AND HOSPITALIZATIONS

Have you been hospitalized for a medical problem before? ☐No ☐Yes If yes, list hospitalizations, the reason for admission and the date.______________________________

____

Have you ever had surgery? ☐No ☐Yes If yes, list any surgeries and when they were done. ____________

____

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐No ☐Yes If yes please list what sort of problems.______________________________

SERIOUS INJURIES (i.e. sports injury, auto accident)

Have you ever had a serious injury such as head, neck, back, or other injury? ☐No ☐Yes If yes, list and describe the type of injury and when it occurred.______________________________

____

FAMILY HISTORY

Specific Anesthesia Problem ☐Mother ☐Father ☐Brother ☐Sister

Ears:

Hearing loss before age 20 ☐Mother ☐Father ☐Brother ☐Sister

Hearing loss after age 20 ☐Mother ☐Father ☐Brother ☐Sister

Heart and Blood Vessel:

Heart Disease ☐Mother ☐Father ☐Brother ☐Sister

High Blood Pressure ☐Mother ☐Father ☐Brother ☐Sister

Lungs and Respiratory:

Lung Cancer ☐Mother ☐Father ☐Brother ☐Sister

Asthma ☐Mother ☐Father ☐Brother ☐Sister

Skin and/or Breast:

Breast Cancer ☐Mother ☐Father ☐Brother ☐Sister

Skin Cancer ☐Mother ☐Father ☐Brother ☐Sister

Brain and Nervous:

Dementia ☐Mother ☐Father ☐Brother ☐Sister

Neurotube disease ☐Mother ☐Father ☐Brother ☐Sister

Stroke ☐Mother ☐Father ☐Brother ☐Sister

Blood and Lymph Node problems:

Bleeding/clotting problem ☐Mother ☐Father ☐Brother ☐Sister

REVIEW OF SYSTEMS List any problems you have or have had recently in the following areas:

General Constitutional (Fatigue, Fever, Unintentional weight loss, Unintentional weight gain, or other problems) No Yes
If yes, please list problem:______________________________

Ear, Nose Mouth, Throat, Neck (Hearing loss, Ringing in ears, Visual loss, Allergies, Sinus trouble, Nose bleeds, Sore Throat, or other problems) No Yes
If yes, please list problem:______________________________

Heart and Blood Vessels (Chest pain, Irregular heart beat, Shortness of breath, or other problems) No Yes
If yes, please list problem:______________________________

Lungs and Respiratory System (Shortness of breath, Coughing up blood or sputum, Wheezing, or other problems) No Yes
If yes, please list problem:______________________________

Stomach and Digestive System (Difficulty swallowing, Heartburn, Nausea, Vomiting, Diarrhea, Abdominal pain, constipation, Blood in bowel movement, or other problems) No Yes
If yes, please list problem:______________________________

Bones, Joints, or Muscles (Cramping, Weakness, Fatigue of muscles, Change in size of muscle, Joint pain or inflammation, or other problems) No Yes
If yes, please list problem:______________________________

Kidneys or Bladder or Sexual Health (Frequency or pain with urination, Difficulty passing urine, Blood in urine Sexual dysfunction, Abnormal menstrual periods, Testicular pain or masses, Sexually transmitted diseases, or other problems) No Yes
If yes, please list problem:______________________________

Skin and Breast (Skin rashes, Skin or breast masses or lumps, or other problems No Yes
If yes, please list problem:______________________________

Please describe any other problems or concerns: ______________________________

This information is true and complete to the best of my knowledge.

______________________________ ______________________
Signature of Patient or Legal Guardian Date

______________________________ ______________________
Systems Reviewed by Medical Provider Date

****** I re-affirm that the above medical information is still true and complete as of the date signed below:

______________________________ ______________________
Signature of Patient or Legal Guardian Date

______________________________ ______________________
Systems Reviewed by Medical Provider Date

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

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 ________________________