

# 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 # \_\_\_\_\_

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### RESPONSIBLE PARTY *(one who carries insurance)*

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Employer \_\_\_\_\_

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### INSURANCE INFORMATION

Primary Ins. \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_ Copay \$ \_\_\_\_\_

Secondary Ins. \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_ Copay \$ \_\_\_\_\_

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### 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 \_\_\_\_\_

**New Patient Medical History Form**

Name \_\_\_\_\_

Date \_\_\_\_\_

How did you hear about us?

- Primary Care Physician (list) \_\_\_\_\_  Emergency Department (list) \_\_\_\_\_  
 Peak Website  Insurance Website  SportZu  Yellow Pages  
 Your Health Monthly magazine  Family/Friend  Other \_\_\_\_\_

Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Occupation \_\_\_\_\_

- Right-handed  Left-handed  Ambidextrous

What is the reason for your visit?  injury  pain  numbness  other \_\_\_\_\_

Where is the location of your symptoms?  right  left Area of body \_\_\_\_\_

When did the problem begin? \_\_\_\_\_

How did the problem start?  no specific injury  injury  sports  fall  work related  car accident

Please explain: \_\_\_\_\_

Have you ever had similar symptoms in the past?  Yes  No

Are any other bones or joints painful or swollen?  Yes  No

What kind of pain do you feel?  sharp  dull  burning  throbbing  aching

How severe are the symptoms?  mild  moderate  severe

How often do the symptoms occur?  intermittent (on and off)  constant  when sleeping at night

What makes the symptoms worse? \_\_\_\_\_

Since the symptoms started, they are  getting better  getting worse  unchanged

The symptoms also include  pain  weakness  swelling  stiffness  numbness/tingling  Instability

Which treatments have you tried?

- |   |              |                              |                             |
|---|--------------|------------------------------|-----------------------------|
| <input type="checkbox"/> rest                               | Improvement? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| <input type="checkbox"/> physical therapy (how long?) _____ | Improvement? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| <input type="checkbox"/> medications (list) _____           | Improvement? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| <input type="checkbox"/> injection (how many?) _____        | Improvement? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| <input type="checkbox"/> splint                             | Improvement? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| <input type="checkbox"/> surgery (list) _____               | Improvement? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| <input type="checkbox"/> other (list) _____                 | Improvement? | <input type="checkbox"/> yes | <input type="checkbox"/> no |

What are your interests and hobbies? \_\_\_\_\_

**New Patient Medical History Form - PAGE 2**

**Medical History (your health issues)**

- Healthy
- Cancer
- Heart disease
- Diabetes
- Asthma
- High blood pressure
- Other \_\_\_\_\_

**Family History**

(What runs in your family?)

- DVT (blood clot)
- Acid Reflux
- Kidney disease
- Liver disease
- Thyroid disease
- Heart disease
- High blood pressure
- Diabetes
- Cancer
- Arthritis

**Surgical History**

(Please list surgeries)

- \_\_\_\_\_ date \_\_\_\_\_
- \_\_\_\_\_ date \_\_\_\_\_
- \_\_\_\_\_ date \_\_\_\_\_
- \_\_\_\_\_ date \_\_\_\_\_
- \_\_\_\_\_ date \_\_\_\_\_

**Medications (list current medication)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies to medications**

- NONE
- Penicillin
- Sulfa
- Aspirin
- Codeine
- Other \_\_\_\_\_

**Social History**

- Smoking:  no  yes \_\_\_\_ packs/day  
Alcohol:  none  occasional  frequent  
Marital status:  single  married  
 divorced  widowed

Do you currently experience any of the following? (Check all that apply.)

**General**

- weight loss
- fevers
- fatigue

**Cardiovascular**

- chest pain
- heart murmur
- irregular beat

**Gastrointestinal**

- heartburn
- stomach ulcer
- hepatitis

**Musculoskeletal**

- arthritis
- osteoporosis
- prior fracture

**Neurological**

- balance problems
- dizziness
- headaches

**Eyes**

- need glasses
- wear contacts
- glaucoma

**Ears/Nose/Throat**

- hearing loss
- sinus infections

**Respiratory**

- shortness of breath
- sleep apnea

**Urinary**

- painful
- frequent
- infection

seizures

- weakness

**Skin**

- rash
- blisters

**Hematologic**

- bleeding issue
- blood clots

**Immunologic**

- tuberculosis
- frequent infections

**Psychiatric**

- depression
- anxiety

**Endocrine**

- thyroid issue
- diabetes

To the best of my knowledge, the information is accurate.

Patient signature: \_\_\_\_\_

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

## **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](http://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 \_\_\_\_\_