ORTHOPEDIC CENTERS OF COLORADO

PATIENT INTAKE AND HISTORY FORM

Today's Date: _____

Name: _____ **Date of Birth:** _____
Primary Care Physician: _____ **Tel:** _____
Primary Care Physician City: _____ **ZIP:** _____
Referral Source: _____ **Tel:** _____

Have you been treated at any Orthopedic Centers of Colorado division in the last 3 years?

☐ Advanced Orthopedic ☐ Cornerstone Orthopaedics ☐ Orthopedic Associates
☐ CCOE ☐ Denver Spine Specialists ☐ Peak Orthopedics
☐ Colorado Orthopedic Consultants ☐ Hand Surgery Associates

Local Pharmacy: _____
(Name/City/Phone #)

Mail Order Pharmacy: _____
(Name/City/Phone #)

REASON FOR COMING TO THE DOCTOR TODAY:

Reason for Today's Visit: _____
Hand Dominance: ☐ Left Hand ☐ Right Hand ☐ Ambidextrous **Shoe Size:** _____
How did the problem start? ☐ Gradual ☐ Suddenly ☐ Exacerbation of an old injury/issue
When did the problem start? _____hour(s) ago _____day(s) ago _____week(s) ago _____month(s) ago
Where did the injury take place? ☐ at home ☐ at work ☐ at school ☐ while playing sports ☐ while playing ☐ during recreational activities ☐ in a motor vehicle accident
Please describe the progression of the problem: ☐ unchanged ☐ fluctuating ☐ resolved ☐ stable ☐ improving ☐ worsening
Describe the severity of the symptoms/pain: ☐ mild ☐ mild to moderate ☐ moderate ☐ moderate to severe ☐ interfering with sleep ☐ incapacitating
How would you describe your pain? ☐ aching ☐ a deep ache ☐ shooting ☐ a burning sensation ☐ throbbing ☐ superficial ☐ a discomfort ☐ a dull ache ☐ burning ☐ cramping ☐ sharp ☐ stabbing
How often does your pain occur? ☐ intermittently ☐ occasionally ☐ frequently ☐ constantly ☐ rarely ☐ during the day ☐ nocturnally
What makes the condition feel worse? _____
What makes the condition feel better? _____
Have you seen another physician for this issue? ☐ no ☐ yes, when and who? _____
_____
What treatments have you tried in the past? ☐ none ☐ application of ice ☐ application of heat ☐ physical therapy ☐ exercise ☐ activity modification ☐ a brace ☐ NSAID ☐ other medication _____ ☐ corticosteroid injections ☐ acupuncture ☐ chiropractic care ☐ other non-surgical treatment:_____ ☐ surgical repair: _____

ALLERGY HISTORY:

☐ **None** ☐ **NKDA (No Known Drug Allergies)**

Metal Allergies: ☐ No ☐ Yes (Details/Reaction): _____

Latex Allergies: ☐ No ☐ Yes (Details/Reaction): _____

Cement Allergies: ☐ No ☐ Yes (Details/Reaction): _____

Medication Allergies: ☐ No ☐ Yes (Details/Reaction): _____

_____

_____

_____

_____

Other Allergies: ☐ No ☐ Yes (Details/Reaction): _____

MEDICATION HISTORY:

☐ I am not currently taking any medications

List any medications, vitamins, minerals, supplements, and alternative/herbal medications that you are currently taking:

Name of Medication	**Dose**	**Frequency**	**Reason**

PROBLEM LIST/PAST MEDICAL HISTORY:

Have you been diagnosed with any of the following (currently or in the past)?

___ Alzheimer Disease
___ Anemia
___ Arthritis
___ Asthma
___ Blood Clots/DVT
___ Cancer: _____
___ Chest Pains
___ Congestive Heart Failure
___ COPD
___ Coronary Disease
___ Crohn's Disease
___ Degenerative Disc Disease
___ Depression
___ Diabetes
___ Drug Abuse
___ Fibromyalgia
___ Fracture
___ Gout
___ Headache
___ Heart Disease
___ Heart Murmur
___ High Blood Pressure
___ High Cholesterol
___ IBS
___ Liver Disease
___ Lupus
___ Lyme Disease
___ Heart Attack (MI)
___ Obesity
___ Osteoporosis
___ Parkinson Disease
___ Peptic Ulcer
___ Psoriasis
___ Scoliosis
___ Seizures
___ Sleep Apnea
___ Spinal Stenosis
___ Spondyloarthropathy
___ Stroke
___ Thyroid Disease
___ Vascular Disease
___ Hist. of Diabetes
___ Other: _____

Do you have any of the following:

___ History of Joint Infection? **___ History of Benign Tumor?** **___ History of Cancer?**

If yes, please give detailed information, including body location and time period:

_____

_____

_____

FAMILY HISTORY:

Place an "X" under the correct family member with the condition and indicate "P" if the family member passed away due to that condition.

	Mother	Father	Sibling		Mother	Father	Sibling
Alcohol Abuse				Gout			
Anemia				Heart Disease			
Arthritis				Hypertension			
Anesthetic Complications				High Cholesterol			
Anxiety				Kidney Disease			
Asthma				Lung/Resp Disease			
Birth Defects				Migraines			
Blood Disorder				Osteoporosis			
Cancer _____				Seizure Disorder			
Depression				Severe Allergies			
Diabetes, Type I				Stroke			
Diabetes, Type II				Substance Abuse			
Genetic Disease				Thyroid Problems			

Other: _____

PAST SURGICAL HISTORY: ☐ **None** (Please mark as applicable, date does not need to be exact)

Procedure	Year	Procedure	Year	Procedure	Year
☐ ACL Repair – Left		☐ Cardiac Bypass Surgery		☐ Knee Replacement – Left	
☐ ACL Repair – Right		☐ Cardiac Pacemaker Insertion		☐ Knee Replacement – Right	
☐ Amputation		☐ Cardiac Valve Replacement		☐ Meniscus – Left	
☐ Angioplasty		☐ Carpal Tunnel Surgery – Left		☐ Meniscus – Right	
☐ Appendectomy		☐ Carpal Tunnel Surgery – Right		☐ ORIF Fracture – Left	
☐ Arthroscopic Ankle – Left		☐ Cataract Surgery		☐ ORIF Fracture – Right	
☐ Arthroscopic Ankle – Right		☐ Cholecystectomy/Gallbladder		☐ Rotator Cuff Repair – Left	
☐ Arthroscopic Knee – Left		☐ Colectomy		☐ Rotator Cuff Repair – Right	
☐ Arthroscopic Knee – Right		☐ Colostomy		☐ Small Bowel	
☐ Arthroscopic Shoulder – Left		☐ Gastric Bypass		☐ Thyroidectomy	
☐ Arthroscopic Shoulder – Right		☐ Hernia Repair		☐ Orthopedic: _____	
☐ Back Surgery		☐ Hip Replacement – Left		☐ Other: _____	
☐ Blood Transfusion		☐ Hip Replacement – Right		☐ Other: _____	

Have you experienced any adverse events associated with surgery or anesthesia?

☐ **No** ☐ **Yes, if so, please give pertinent details:**

_____

_____

_____

_____

SOCIAL HISTORY:

Please describe your current smoking habits:

☐ Never ☐ Former

Current: ☐ Cigarettes ☐ Vaping ☐ Marijuana ☐ Marijuana Edibles ☐ Chew/Dip

Frequency: ☐ Current every day ☐ Light Occasional ☐ Heavy

Do you drink alcoholic beverages? ☐ Yes ☐ No

If yes, please indicate what type of beverage and how many servings per day: _____

Have you ever used any illicit drugs? ☐ Yes ☐ No

If yes, please indicate what type of drug and how often: _____

How would you rate your exercise level? ☐ Sedentary ☐ Mild ☐ Moderate ☐ Vigorous

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REVIEW OF SYSTEMS:

Please place a check mark in the box next to any of the following symptoms or problems if you have experienced them recently or have concerns about them. Your doctor will discuss any positive responses with you.

General: ☐Normal
- ❑ Fatigue
- ❑ Chills
- ❑ Fever
- ❑ Unexplained Weight Loss
- ❑ Unexplained Weight Gain

Skin: ☐Normal
- ❑ Blisters
- ❑ Rash
- ❑ Infection or history of MRSA
- ❑ Ulcer

HEENT: ☐Normal
- ❑ Blurred Vision
- ❑ Vision Loss

Respiratory: ☐Normal
- ❑ Cough
- ❑ Wheezing
- ❑ Shortness of Breath
- ❑ Difficulty Breathing
- ❑ Recent Respiratory Infection
- ❑ Sleep Apnea

Cardiovascular: ☐Normal
- ❑ Chest Pain
- ❑ Fainting
- ❑ Dizziness
- ❑ Murmur

Gastrointestinal: ☐Normal
- ❑ Nausea
- ❑ Vomiting
- ❑ Stomach Ulcer
- ❑ Heartburn

Neurological: ☐Normal
- ❑ Headaches
- ❑ Numbness
- ❑ Dizziness
- ❑ Frequent Falls
- ❑ Fainting
- ❑ Seizures
- ❑ Weakness
- ❑ Tremors
- ❑ Unsteadiness

Psychiatric: ☐Normal
- ❑ Anxiety
- ❑ Depression
- ❑ Drug/Alcohol Abuse

Endocrine/Glands: ☐Normal
- ❑ Unexplained Weight Loss
- ❑ Unexplained Weight Gain
- ❑ Fever
- ❑ Thyroid Problems
- ❑ Diabetes

Hematology: ☐Normal
- ❑ Anemia
- ❑ Easy Bleeding
- ❑ Blood Clots

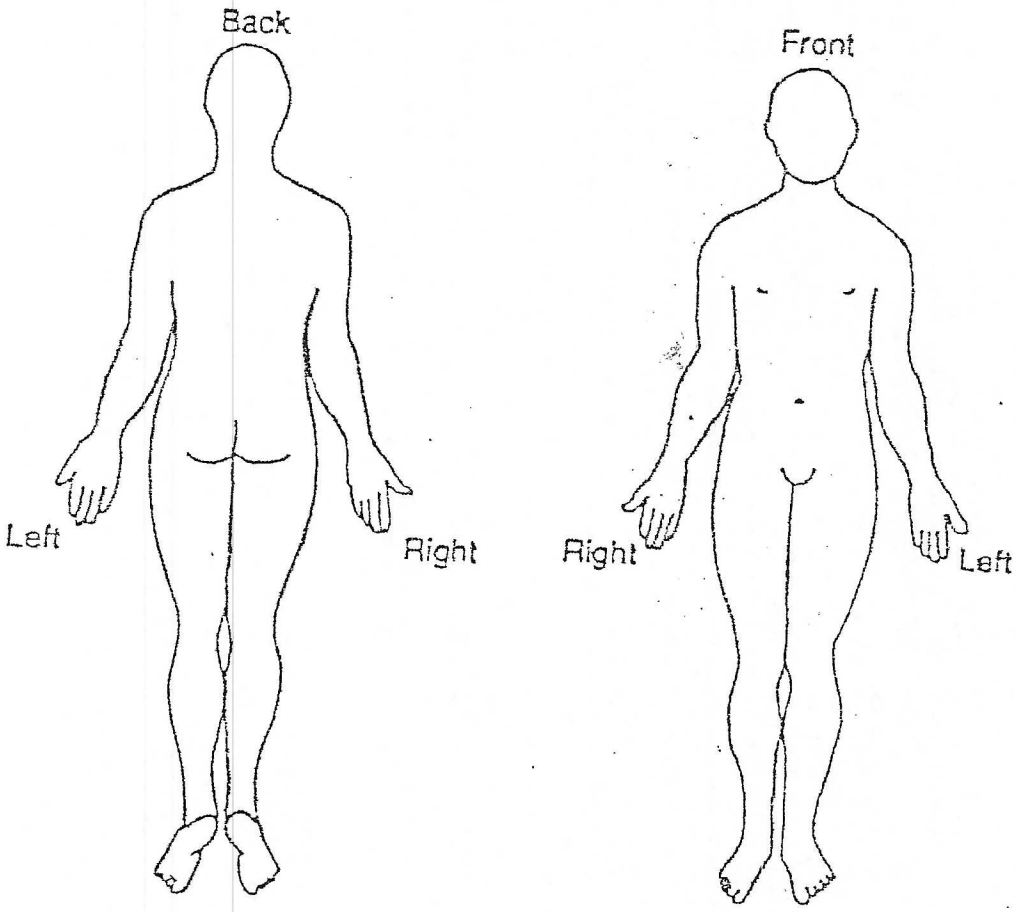
MSK: ☐Normal
- ❑ Negative except noted in reason for visit
- ❑ Arthritis
- ❑ Osteoporosis

PAIN DIAGRAM

Name: _____ Date: _____

Please use the symbols below to show the area, upon the body outlines, in which you are experiencing pain.

Ache-A
Burning-B
Numbness-N
Pins and Needles-P
Stabbing-S
Other-O



The line below represents the intensity of the pain you are experiencing. Please make an "X" at the position on the scale which indicates how much pain you are feeling ***at this time***.

Date: _____

1 — 10

NO PAIN — WORST PAIN IMAGINABLE

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:_____

ORTHOPEDIC CENTERS OF
COLORADO

NOTICE OF PRIVACY PRACTICES

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.

This Notice of Privacy Practices is not an authorization. This Notice of Privacy Practices describes how our Business Associates, their subcontractors and we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected Health Information (PHI) is information about you including demographic information that may identify you and that relates to your past, present and future physical or mental health condition (if applicable) and related health care services.

This notice will be effective for all PHI that we maintain at this time. You may obtain any revised Notice of Privacy Practices by contacting our office to request a revised copy to be sent to you or coming by our office and asking for a copy.

USES AND DISCLOSURE OF PHI:
We collect health information from you and store it on a DICOM server. This is your medical record. Your medical record is the property of Orthopedic Centers of Colorado, but the information in the medical record belongs to you. Orthopedic Centers of Colorado protects the privacy of your PHI.

The law permits Orthopedic Centers of Colorado to use or disclose your PHI for the following purposes:

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we will disclose PHI to other physicians who may be treating you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may require before it approves or pays for the health care services that have been requested by your physician (e.g., making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity and undertaking utilization review activities).

Health Care Operations: We may use and disclose, as needed, your PHI to support the business activities of our company and our affiliates. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities.

We will share your PHI with third party "business associates" who, in turn, may disclose this information to subcontracting business associates that perform various activities (for example: billing or transcription services) for our company. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

Health Information Exchange: We endorse, support, and participate in electronic Health Information Exchanges (HIE) as a means to improve the quality of your health and health care experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the HIE or cancel an opt-in option choice at any time.

Other permitted and required uses and disclosures that may be made without your authorization or opportunity to agree or object: We may use or disclose your PHI in the following situations without your authorization or providing you the opportunity to agree or object.

These situations include as required by law, public health risk issues for purposes related to preventing or controlling disease,

injury or disability, reporting elderly or child abuse or neglect, or reporting domestic violence. Reporting to the Food and Drug Administration (FDA) regarding adverse events, product defects or problems, or to conduct post-marketing surveillance, as required. In the event of legal proceedings, we may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in responses to a subpoena, discovery request, or lawful process. Releasing PHI to law enforcement so long as applicable legal requirements are met, for law enforcement purposes. Criminal activity disclosure will be made as long as it is consistent with applicable federal and state laws, we may disclose your PHI, and if we believe that, the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. Military activity and national security when the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel as required by military command authorities. We may disclose your PHI as authorized to comply with workers compensation laws and other similar legally established programs. In the event that a Orthopedic Centers of Colorado entity is sold or merged with another organization, your health record will become the property of the new owner.

For Data Breach Notification Purposes: You will be notified immediately is an unauthorized acquisition, access, use or disclosure of your PHI is resulting in the compromise or security of your PHI (a "breach") is detected. We will follow the Department of Health and Human Services' Breach Notification Rule (74FR 42740), which includes timing, method and content requirements for breach notification.

Use and Disclosures of PHI based Upon Your Written Authorization: Other uses and disclosures of your PHI not specifically described in this notice will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. Please understand that we are unable to take back any disclosures already made with your authorization, and we are required to keep records of the care that we provided to you. We must obtain your written authorization before disclosing your PHI in the following situations:

- Disclosure that constitute a sale of your PHI- A "sale" of PHI includes any disclosure of PHI in exchange of remuneration, even if the ownership of the PHI remains with our company; and
- Uses and disclosure of your PHI for marketing and fundraising purposes.

You have the opportunity to agree or object, in writing, to the use or disclosure of all or part of your PHI. We may use and disclose your PHI in the following instances:

Others involved in your health care of payment for your care: Unless you object, we may disclose to a member of your family, relative, close friend, or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgement. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition, or death.

YOUR RIGHTS TO PHI

You have the right to inspect and copy your PHI: This means you may inspect and obtain a copy of PHI about you for so long as we maintain the PHI in the form and format in which you request it, including electronically if readily producible in the requested format within thirty (30) days of our receipt of your written request, unless extended by agreement to sixty (60) days. You may obtain your medical record that contains medical and billing records and any other records that we may use for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however you may not inspect or copy the following records: information compiled in reasonable anticipation of, or use in civil, criminal, or administrative action or proceeding that are subject to law that prohibits access to PHI. Please contact our Compliance Officer if you have questions about access to your medical record.

You have the right to request a restriction of your PHI: You may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment of health care operations. You may restrict disclosure to your health plan for services of which you pay out of pocket. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Compliance Practices. *If you would like to request a restriction of your PHI, please ask our front desk team to provide you with a Request for Restriction form. Your request must state the specific restriction requested and to whom you want the restriction to apply.*

You have the right to request to receive confidential communication from us by alternative means or at an alternative location: We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. Please make this request in writing to our Compliance Officer.

You may have the right to have us amend your PHI: This means you may request an amendment of PHI about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Compliance Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures: You have the right to receive an accounting of disclosures, paper or electronic , except for disclosures: pursuant to an authorization, for purposes of treatment, payment, health care operations; to family members or friends involved in your care. You have the right to specific information regarding these disclosures that have occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions, and limitations.

You have the right to obtain a paper copy of this notice from us: You may ask for a copy of this notice at any time. You may view a copy of this notice on our website at www.occ-ortho.com.

Confidentiality and security: We maintain physical, electronic, and procedural safeguards in compliance with state and federal standards to guard your PHI and personal financial information. These measures include computer safeguards, file security, and restrictions on who may access your information.

Changes to this notice: We reserve the right to amend this Notice of Compliance at any time in the future. Until such amendment is made, Orthopedic Centers of Colorado is required by law to comply with this notice. In the event, there is a material change to this notice. The revised notice will be made available; you may request a copy of the revised notice at any time.

Complaints: You may file your complaint with our Division Manager or our VP, HR & Compliance. You may file a complaint with the Secretary of Health and Human Services if you believe that we violated your privacy rights in any way. We will not retaliate against you for filing a complaint.

You may contact our VP, HR & Compliance at (303) 649-8993 or via email at LaNee.Reynolds@occ-ortho.com for further information on the complaint filing process.

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_____

Authorization for Release of Information

Patient Name; _____ Birthdate:____/____/_____
Last First MI

Maiden Name, If applicable_____ SSN _____

Physician or Facility to release:
_____
_____
_____
_____

Release to:
Orthopedic Centers of Colorado
145 Inverness Drive East #220
Englewood, CO 80112
Phone (303) 699-7325
Fax (303) 699-5486

Release the following:
_____ Fax copy of Office chart notes
_____ Films (MRI, CT, X-rays) Ready for pick up by patient
_____ Fax copy of OR reports and Procedures (ESI, Facet block, RF etc.)

For the purpose of :

_____ Transfer of care

_____ other

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 and Spine in writing. I understand any request for revocation will not have any effect on actions taken prior to submission.

_____ _____
Patient Name (Print) Authorized representative for the patient

_____ _____
Patient Signature Signature

Date ____/_____/_____ Relationship to Patient:_____

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:

Impulse Neuromonitoring, LLC and

Neuro Interpretive Services LLC

NIS are a skilled team of Neurologists that we have chosen to read and evaluate the neuromonitoring data provided by Impulse Neuromonitoring during surgery. 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. Neuromonitoring has become the standard of care during spine surgery.

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 care 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.

Implant Royalty (Medacta)

Your physician may receive a royalty for implants and procedures they have developed to help advance medical science. 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 privileges or where imaging, or similar services mentioned above can be obtained. In furnishing this list we are not endorsing any alternate facilities. Please verify your financial responsibility and expected payment with these providers.

DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY

Patient name _____

I hereby instruct and direct _____ Insurance company, to pay by checks made payable to Peak Orthopedics and Spine.

If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it to:
Orthopedic Centers of Colorado
145 Inverness Drive East #220
Englewood, CO 80112

In payment for the professional and medical expenses benefits allowable and otherwise payable to me under my current insurance

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