Colorado Springs Orthopaedic Group

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PATIENT ACKNOWLEDGEMENT FORM

We are pleased that you have chosen our group of specialists for your orthopaedic care. We are providing this information to you ahead of time to make your visit to our office as convenient as possible.

REFERRALS

Based on your insurance plan, you may need a referral from your primary care physician (PCP) to see an orthopaedic physician. **Referrals are your responsibility** and are generated by your PCP's office, then submitted to the insurance company. Once approved, the insurance company will send you a copy—**Please bring a copy of your referral with you.** Your appointment will be rescheduled if you do not have a valid referral.

CONSENT TO TREAT

I voluntarily consent to and authorize the rendering of health care services, including routine clinical services, and/or physical and occupational therapy. I am aware that physical. Occupational therapy treatment utilized hands on techniques which require the therapist to touch my body as a part of the therapeutic process.

LATE OR MISSED APPOINTMENT/ NO SHOW

We take great care in crafting the schedules of the physicians/providers to accommodate as many people as possible. If you are late for your appointment, we will do our best to work you in when you arrive, but please understand that you may be asked to reschedule if we are unable to accommodate. Please call ahead and let us know if you will be late or need to reschedule an appointment at 719-632-7669. Please be aware 2 "no show" appointments with any and all practice physicians within a rolling 12 month period will result in not being seen by any physician for 1 year from the date of the last "no show" unless you are willing to pay a $100 fee.
We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting needed treatment. If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar ($50) fee. This fee will not be covered by your insurance company and is required to be paid at the time of your next visit.

SECTION 1557

Colorado Springs Orthopaedic Group complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

SERVICE & EMOTIONAL SUPPORT ANIMALS

Per ADA requirements, service animals are permitted at Colorado Springs Orthopaedic Group. Due to liability reasons, companion and emotional support animals will not be permitted.

MEDICAL RECORDS

Your Driver's License or Government issued photo ID is required when picking up prescriptions and medical records. Please be advised that a fee may be assessed for any medically related documents.

AUDUBON ORTHOTIC & PROSTHETIC SERVICES

If your Colorado Springs Orthopaedic Group provider refers you to AOPS for any orthotic or prosthetic care, please note that all paperwork included in this packet will be accepted and transmitted securely to AOPS. AOPS is a licensed DBA of Colorado Springs Orthopaedic Group.

ACKNOWLEDGEMENTS

_____ I acknowledge that I reviewed the **CSOG Cancellation, No-Show & Late Patient Policy**. I have read, understand and agree to the provisions of the policy.

_____ I acknowledge that I reviewed the **Notice of Privacy Practices.** I have read, understand and agree to the provisions of the policy.

_____ I acknowledge that I received a copy of **House Bill 19-1174 Out of Network**.

Patient or legally authorized individual signature Date

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PATIENT REGISTRATION

Today's Date: _____

Legal Last Name: _____ First: _____ MI: ____ DOB: _____ Age: ____

Mailing Address: _____ City: _____

State: _____ Zip Code: _____ SSN: _____ ☐Male ☐Female

Primary Phone Number: _____ Secondary Phone Number: _____

Email: _____ Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Emergency Contact: _____ Phone Number: _____ Relationship to Patient: _____

Race/Ethnicity:_____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

How did you hear about us? ☐Friend/Family ☐Physician ☐Web ☐TV ☐Seminar ☐School ☐Other _____

If other than a physician, to whom may we thank for your referral? _____

Pharmacy Preference & Address: _____

MINOR INFORMATION

Responsible Party Name: _____ DOB: _____

Best Contact Number: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip Code: _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy Holder: ☐ Self ☐ Other

If other, policy holder name: _____

DOB: _____Subscriber ID #:_____

Group # _____Copay Amount: _____

Secondary Insurance: _____

Policy Holder: ☐ Self ☐ Other

If other, policy holder name: _____

DOB: _____Member ID #: _____

Mailing Address (if different than above):

_____

INSURANCE AUTHORIZATION

Insurance Authorization and Assignment of Benefits:

I authorize the physicians and physicians' assistants at Colorado Springs Orthopaedic Group to treat my illness or injury. I hereby authorize the release of any medical information necessary to process my claim and I authorize payment of medical and surgical benefit to Colorado Springs Orthopaedic Group.

_____

Patient or legally authorized individual signature Date

_____

Relationship to Patient:

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PATIENT HISTORY

TODAY'S VISIT

Patient Name: _____ DOB: _____

Reason for today's visit: _____

Body part for injury/pain? _____ What date did the current pain/injury start? _____

How long have you had these symptoms? _____Pain level on a scale from 1-10,10 being worst? _____

Height:_____ Weight: _____ Hand Dominance: ☐ Left ☐ Right ☐ Ambidextrous

Describe the injury or symptoms and include where it is located (specify left or right side): _____

_____

_____

Is this a work-related injury/pain? ☐ Yes ☐ No Have you had surgery for this problem? ☐ Yes ☐ No

Is this an auto-related injury/pain? ☐ Yes ☐ No Have you filed a claim? ☐ Yes ☐ No

Date of injury: _____ Employer: _____

Employer Contact: _____ Phone Number: _____

MEDICATIONS

Please list any medication(s) you are currently taking including prescribed medications, vitamins, supplements and over-the-counter medications.

Medication	Dosage/Directions	How Often	Reason

Chronic Pain Management? ☐ Yes ☐ No Treating Physician:_____ How often? _____

ALLERGIES

Please list all medical allergies and tell us how you react to them.

Allergy	Reaction

Are you allergic to latex? ☐ Yes ☐ No

Are you allergic to adhesive tape? ☐ Yes ☐ No

Are you allergic to contrast dye? ☐ Yes ☐ No

Are you allergic to Iodine or Betadine? ☐ Yes ☐ No

Are you allergic to metal? ☐ Yes ☐ No

Are you allergic to birds/feathers/eggs? ☐ Yes ☐ No

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PATIENT HEALTH HISTORY

PAST MEDICAL HISTORY

Please check all conditions you have now or have had in the past.

CARDIOVASCULAR
- ☐ Angina (chest pain)
- ☐ Arrhythmia/Irregular Heartbeat
- ☐ Blood Clot/DVT (Deep Vein Thrombosis)
  Date Occurred: _____
- ☐ Heart Disease/Coronary Artery Disease
- ☐ High Cholesterol/Hyperlipidemia
- ☐ MVP (Mitral Valve Prolapse)
- ☐ Pacemaker
- ☐ Varicose Veins/Peripheral Vascular Disease
- ☐ Hypertension/High Blood Pressure
- ☐ Stent - Date Inserted: _____
- ☐ AICD (Automatic Implantable Cardioverter Defibrillator

PULMONARY (Lungs & Respiratory)
- ☐ Asthma
- ☐ COPD (Chronic Obstructive Pulmonary Disease)
- ☐ PE (Pulmonary Embolism/Blood Cot in Lung)
  Date Occurred: _____
- ☐ Sleep Apnea
- ☐ TB (Tuberculosis)

GENITOURINARY (Kidneys & Urinary Tract)
- ☐ Renal Failure
- ☐ Renal Insufficiency
- ☐ UTI (Urinary Tract Infection)
- ☐ Currently Pregnant

GASTROINTESTINAL
- ☐ Gastric Ulcer
- ☐ GERD
- ☐ Hepatitis—Type: _____
- ☐ Hernia
- ☐ Peptic Ulcer
- ☐ Liver Disease

NEUROLOGIC DISORDER
(Brain & Nervous System)
- ☐ Alzheimer's Disease
- ☐ Dementia
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Seizure Disorder
- ☐ Stroke/CVA
  Date Occurred: _____
- ☐ Myasthenia Gravis
- ☐ Muscular Dystrophy

BONES, JOINTS & MUSCLES
- ☐ Arthritis
- ☐ Degenerative Joint Disease
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Osteoporosis
- ☐ Scoliosis

CANCER
- ☐ Type: _____

HEMATOLOGIC (Blood & Lymph Node)
- ☐ Anemia
- ☐ Edema
- ☐ Lupus
- ☐ Hemophilia
- ☐ Sickle Cell Disease
- ☐ Clotting Disorders

HEENT (Head, Ears, Eyes, Nose & Throat)
- ☐ Blind
- ☐ Deaf
- ☐ Hearing Loss

METABOLIC (Endocrine, Hormones & Metabolic)
- ☐ Diabetes—Type I
- ☐ Diabetes—Type II
- ☐ Thyroid Dysfunction
  - o Hypothyroidism
  - o Hyperthyroidism

PSYCHIATRIC DISORDER
(Mental Health)
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Depression

REVIEW OF SYSTEMS

Please check all conditions you are currently experiencing.

CONSTITUTIONAL
- ☐ Unexpected weight loss
- ☐ Weight gain
- ☐ Fever
- ☐ Chills
- ☐ Fatigue

EYES
- ☐ Corrective lenses
- ☐ Blurred/double vision
- ☐ Eye pain
- ☐ Redness/watering

ENT
- ☐ Headache
- ☐ Difficulty swallowing
- ☐ Nose bleeds
- ☐ Ringing in ears
- ☐ Earaches

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Palpitations
- ☐ Fainting
- ☐ Murmurs

ALLERGIC
- ☐ Reaction to foods/environment

RESPIRATORY
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough
- ☐ Tightness
- ☐ Inspiration pain
- ☐ Snoring

GASTROINTESTINAL
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bloody/tarry stool

GENITOURINARY
- ☐ Difficult/painful urination
- ☐ Frequent urination
- ☐ Blood in urine

MUSCULOSKELTAL
- ☐ Joint pain
- ☐ Swelling
- ☐ Instability
- ☐ Stiffness
- ☐ Redness
- ☐ Muscle pain

SKIN
- ☐ Skin changes
- ☐ Poor healing
- ☐ Rash
  Location:_____
- ☐ Itching/redness

NEUROLOGIC
- ☐ Numbness/tingling
- ☐ Unsteady gait
- ☐ Dizziness
- ☐ Tremors
- ☐ Seizure

PSYCHIATRIC
- ☐ Nervousness
- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations

HEMATOLOGIC
- ☐ Easy bleeding
- ☐ Bruising

ENDOCRINE
- ☐ Excessive thirst/urination
- ☐ Heat/cold intolerable

OTHER MEDICAL CONDITIONS NOT LISTED ABOVE: _____

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PATIENT HEALTH HISTORY

PAST SURGICAL HISTORY

☐ Heart Surgery: ☐ Stent ☐ Bypass ☐ Other : _____

Please list other surgeries (Left/Right as appropriate);

_____

_____

_____

_____

_____

_____

FRACTURES: _____

_____

_____

_____

☐ **PROBLEMS WITH PAST ANESTHESIA (IF YES, PLEASE LIST):** _____

☐ **PROBLEMS WITH PAST BLOOD CLOTS**

FAMILY HISTORY

Check the boxes if a **blood relative** has been diagnosed with the following and indicate if s/he is deceased Y/N

	Relationship	Deceased		Relationship	Deceased
☐ Anesthesia Problems	_____	Y/N	☐ Osteoporosis	_____	Y/N
☐ Arthritis	_____	Y/N	☐ Diabetes	_____	Y/N
☐ Bleeding/Clotting Problems	_____	Y/N	☐ Family History Unknown		
☐ Cancer: type _____	_____	Y/N	☐ No Significant Family History		
☐ Heart Disease	_____	Y/N	☐ Muscular Distrophy		

SOCIAL HISTORY

Do you currently use tobacco? ☐ Yes ☐ No Which kind:_____

Do you currently vape? ☐ Yes ☐ No

Do you currently use CBD products? ☐ Yes ☐ No

Do you currently drink alcohol? ☐ Yes ☐ No Quantity per day: _____

Do you use marijuana? ☐ Yes ☐ No

Current/Former Illicit Drug Use: ☐ No ☐ Current: Type: _____ ☐ Past Type: _____

☐ Date Quit: _____

Are you currently employed? ☐ Yes ☐ No ☐ Retired ☐ Disabled, temporarily ☐ Disabled, permanently

Occupation: _____ Employer: _____

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AUTHORIZATION TO USE OR DISCLOSE MY HEALTH INFORMATION/ PATIENT ACKNOWLEDGEMENT FORM

Patient name:_____ DOB: _____

MY AUTHORIZATION

You may use or disclose the following health care information (check all that apply): (fees may apply)

☐ My entire medical record maintained by Colorado Springs Orthopaedic Group

☐ My health information relating to the following treatment or condition _____

☐ My health information for the date(s): _____

You may disclose/request this health information to:

Full Name	Phone	Fax	Medical Records	RX pick up
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

I wish to be contacted in the following manner (check all that apply):

Primary Telephone:

☐ Leave message with detailed information

☐ Via text/ email communication—auto opt in (can always opt out)

☐ Leave message with call back number only

Secondary Telephone:

☐ Leave message with detailed information

☐ Leave message with call back number only

Email and Email Address: _____

MY RIGHTS

I may revoke this authorization in writing. If I revoke this authorization, it would not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. The form is available from the office;
  or
- Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may be able to redisclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature | Date | Time

Printed name if signed on behalf of the patient | Relationship (parent, legal guardian, personal representative, etc.)

* This authorization will expire 1 year from the date of signing.

STOP — For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

☐ Individual refused to sign

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Communication barriers prohibited obtaining the acknowledgement

☐ Other _____

Colorado Springs Orthopaedic Group Employee Signature

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FINANCIAL AGREEMENT

Thank you for choosing Colorado Springs Orthopaedic Group as your orthopedic provider. We are committed to delivering outstanding healthcare and customer service. The following is our current financial policy.

FOR PATIENTS WITH HEALTH INSURANCE

Colorado Springs Orthopaedic Group will submit an accurate claim to all contracted insurance as a courtesy to our patients. This will require information to be provided by the patient at each visit to ensure timely payment processing . Should the patient not provide accurate insurance data, the bill will become due by the patient at the time the insurance denies payment.

Colorado Springs Orthopaedic Group CANNOT waive copays, deductibles, coinsurance, or non-covered service amounts defined as patient responsibility under the terms of our contact with your health insurance. Patient copays are expected at the time of service.

FOR OUT-OF-NETWORK PATIENTS

In cases where Colorado Springs Orthopaedic Group is not recognized as a participating provider and considered Out-of-Network (OON), Colorado Springs Orthopaedic Group may elect to notify and provide full disclosure upon submission of a claim to the patient's insurance carrier that Colorado Springs Orthopaedic Group will offer a discount to the patient as their insured member. Colorado Springs Orthopaedic Group will bill the patient's insurance carrier its full charge and then discount the patient portion of the payment to usual and customary as defined by the insurance carrier. Should the patient's insurance carrier offer payment to Colorado Spring Orthopaedic Group at the discounted rate offered to the patient, Colorado Springs Orthopaedic Group will accept the payment from the insurer as payment in full. At no time, is Colorado Springs Orthopaedic Group charging two different prices for the same service, nor is pricing based on the fact than an insurance company may be paying for all or a part of the service rendered. This is not a waiver or a discount of any copayment, coinsurance or deductible amounts owed for services rendered and is not offered and should not be interpreted as an "inducement" to have services rendered.

I authorize Colorado Springs Orthopaedic Group and their billing company to negotiate, discuss, and in any other way, communicate with my insurance company in those areas relative to OON reimbursements, methodology used in OON negotiation and affair negotiation of final payment. I authorize Colorado Springs Orthopaedic Group and its billing company to accept or reject agreements, to enter into contracts binding upon final adjunction of claims and negotiations, and to act in whatever way necessary so as to accomplish that which is being undertaken.

FOR AUTO ACCIDENTS/LIABILITY PATIENTS

Colorado Springs Orthopaedic Group does not bill third party insurance.

METHODS OF PAYMENT

Colorado Springs Orthopaedic Group accepts all major credit cards, checks and cash.

PAST DUE ACCOUNTS

All patient responsible balances should be paid at the time the statement is received. After 90 days your account will be become delinquent. If the account remains delinquent, the patient will be unable to schedule any further appointments until the debt has been settled.
Thank you for your understanding of our financial policy. If you have any questions regarding this policy or you account, please contact our billing department at 719-867-9346 or email statements@csog.net.
I have read and understand the financial policy of the practice and I agree to its terms. I also understand that the terms may be amended by the practice.

Patient or legally authorized individual signature

Date

Printed name

Date of birth