

# Aspen Orthopaedic Associates

Please complete this ENTIRE form prior to appointment

Date \_\_\_\_\_

LAST NAME	YOUR EMPLOYER
FIRST NAME & MIDDLE INITIAL	ADDRESS
MAILING ADDRESS	CITY STATE ZIP CODE
CITY STATE ZIP CODE	TELEPHONE #
TELEPHONE #	SPOUSE'S NAME
LOCAL ADDRESS	
LOCAL PHONE #	NAME OF RELATIVE NOT LIVING WITH YOU
SEX MARITAL STATUS	ADDRESS
DATE OF BIRTH AGE	CITY STATE ZIP PHONE
SOCIAL SECURITY #	PRIMARY CARE PHYSICIAN

**GUARANTOR (IF DIFFERENT FROM PATIENT)**

NAME	SOCIAL SECURITY #	DATE OF BIRTH
ADDRESS	CITY	STATE ZIP CODE
RELATIONSHIP TO PATIENT	TELEPHONE #	

**PATIENT MEDICAL INFORMATION**

HAVE YOU EVER HAD X-RAYS TAKEN FOR THE PRESENT PROBLEM?	<input type="checkbox"/> YES <input type="checkbox"/> NO	WHEN AND WHERE?
DATE OF INJURY	AUTO ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	WORKERS' COMPENSATION <input type="checkbox"/> YES <input type="checkbox"/> NO
DESCRIBE INJURY OR PROBLEM		
REFERRING DOCTOR FOR THIS PROBLEM	PHONE #	<input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID

**HEALTH INSURANCE INFORMATION (CARD MUST BE PRESENTED AT EACH VISIT) ALL INFO REQUIRED IN ORDER TO FILE YOUR CLAIMS**

PRIMARY HEALTH INS. CO. NAME	SECONDARY HEALTH INS. CO. NAME		
ADDRESS	ADDRESS		
POLICY HOLDER'S NAME	DATE OF BIRTH	POLICY HOLDER'S NAME	DATE OF BIRTH
POLICY HOLDER'S EMPLOYER	SS #	POLICY HOLDER'S EMPLOYER	SS #
INSURANCE ID #	GROUP #	INSURANCE ID #	GROUP #

**WORKERS' COMPENSATION OR AUTO INSURANCE**

WORK COMP CARRIER OR AUTO INS. CO. NAME	CLAIM #	
ADDRESS	CITY STATE ZIP CODE	
WORK COMP CLAIMS ONLY: DATE OF INJURY	WAS INJURY REPORTED TO EMPLOYER? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE REPORTED
EMPLOYER	EMPLOYER'S PHONE #	
AUTO CLAIMS ONLY: DATE OF ACCIDENT	POLICY HOLDER'S NAME	

AUTHORIZATION FOR TREATMENT/RELEASE OF INFORMATION/FINANCIAL AGREEMENT: I, the undersigned, knowing that the patient and/or self is suffering from a condition requiring health care, diagnosis and medical treatment hereby voluntarily agree to such diagnostic procedures and health care and services, which may be administered to or performed on the patient and/or self for this injury under the instructions of the physician, his assistants or assignees. I authorize the release of medical information to my referring doctor, health agency, government agency, Medicare, insurance company or workmen's compensation employers. I assume full financial responsibility for all debts incurred in any treatment and follow-up care received. I understand that no guarantee or assurance has been made as to the results of the procedure and that it may not cure the condition. I, the patient, hereby consent to allowing my records to be stored in electronic format, and also consent to the destruction of the original manually signed copy of all forms.

Signature of patient or authorized person \_\_\_\_\_

\_\_\_\_\_ Date

**ASPEN ORTHOPAEDIC ASSOCIATES PATIENT HEALTH HISTORY**

**PATIENT'S NAME** \_\_\_\_\_ **DATE OF BIRTH** \_\_\_\_\_ **TODAY'S DATE** \_\_\_\_\_

*The following questions are very important and strictly confidential. Please answer as accurately as possible.*

**FAMILY/PRIMARY CARE PHYSICIAN** \_\_\_\_\_

<b>ALLERGIES</b> Please list below	<b>I have no known allergies</b> <input type="checkbox"/>

<b>MEDICATIONS</b> Please list below (include birth control, herbals, vitamins, dietary supplements, and over the counter medications)	
<b>I am not taking any at this time</b> <input type="checkbox"/>	

**YOUR PRESENT HEALTH CONDITIONS (please check even if the condition is controlled by medication)**

	YES	NO		YES	NO		YES	NO
<b>RESPIRATORY</b>			<b>NEUROLOGIC</b>			<b>PSYCHOSOCIAL:</b>		
Asthma			Migraine Headaches			Anxiety		
Chronic Cough			Numbness/tingling in extremities			Depression		
Shortness of Breath			Epilepsy/seizures			Rapid weight change		
Emphysema						<b>GENERAL MEDICAL</b>		
Chronic Bronchitis			OTHER _____			Skin Disease: Type: _____		
<b>CARDIOVASCULAR</b>			<b>GASTROINTESTINAL</b>			Cancer Type: _____		
Heart Attack			Gallstones			Arthritis		
Irregular Heart Beat			Ulcers Site: _____			Osteoporosis		
Stroke			Liver Disease			Anemia/low blood cells		
Congestive Heart Failure			Prostate Problems			Gout		
High Blood Pressure			Kidney Disease Type _____			Diabetes/High blood sugar		
High Cholesterol			Kidney Stones			Glaucoma		
Heart Murmur			<b>IMMUNE DISORDERS</b>	HIV	AIDS	Bleeding disorder: Type: _____		
Blood Clot Lung/Leg			OTHER _____			Thyroid		
OTHER MEDICAL CONDITIONS						<b>ARE YOU PREGNANT?</b>		

**SURGERIES** Please check appropriate boxes below

YES	NO	SURGERIES	YES	NO	ORTHOPAEDIC SURGERIES	YEAR(S):
		Cataract: LT RT BOTH			Joint Replacement, Type:	
		Tonsillectomy (Tonsils Removed)				
		Neck Artery			Arthroscopic Joint, Type:	
		Open Heart/Catheterization				
		Appendectomy				
		Gallbladder Removal			Broken Bone Repair, Type:	
		Abdominal				
		Vasectomy				
		Hysterectomy				
		Prostate			Back/Spine, Type:	
		Hernia				
		Other:				

**\*\*CONTINUES ON BACK OF PAGE\*\***

**ASPEN ORTHOPAEDIC ASSOCIATES PATIENT HEALTH HISTORY**

PATIENT'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

**OTHER HISTORY**

**Please describe your physical activity:** (circle appropriate selections, be sure to add any that are not listed)

HIKE BIKE GOLF PILATES YOGA SWIM SKI SNOWBOARD RUN/JOG TENNIS

Other: \_\_\_\_\_

**Have you had the following vaccinations?** Please circle YES or NO

Hepatitis A	YES	NO		Tetanus	YES	NO	YEAR: _____	Pneumovax	YES	NO
Hepatitis B	YES	NO						Flu	YES	NO

**Nicotine/Alcohol Use**

Do you smoke or chew tobacco?	YES	NO	# YEARS _____	PER DAY _____	Packs _____	Cans _____
Number of Alcoholic beverages consumed (on average) in one week?						
Have you ever had a substance abuse problem?	YES				NO	
If yes, please specify						

**REVIEW OF SYSTEMS** Do you have or have you had within the past year: Please check YES OR NO

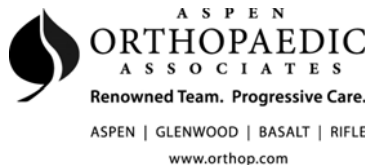
YES	NO	CONDITION	YES	NO	CONDITION	YES	NO	CONDITION
		Joint pains			Earaches			<b>Chest pain</b>
		Swelling of joints			Sinus trouble			<b>Pain in arm</b>
		Muscle spasms			<b>Chronic/frequent cough</b>			<b>High blood pressure</b>
		Weakness			<b>Shortness of breath</b>			Enlarged glands
		<b>Headaches</b>			Nausea or vomiting			Frequent infections
		<b>Tingling of hands/feet</b>			Stomach pain			Night sweats
		<b>Trembling of extremity</b>			Heartburn			<b>Changes in skin</b>
		Blurred vision			<b>Pain urinating</b>			<b>Changes in weight</b>
		Double vision			<b>Blood in urine</b>			Anxiety
		Spots before eyes			<b>Frequent urination</b>			Sadness

**FAMILY HISTORY** Please check appropriate boxes below

YES	NO	Condition	Relationship to You	YES	NO	Condition	Relationship to You
		Heart Attack				Bleeding Problems	
		High Blood Pressure				Sickle Cell Anemia	
		High Cholesterol				Diabetes / High Blood Sugar	
		Tuberculosis				Thyroid Problems	
		Liver Disease				Cancer, Type _____	
		Kidney Disease				Alcohol Abuse	
		Gout / Arthritis				Anxiety / Depression	
		Osteoporosis				Glaucoma	
		Stroke				Hepatitis	
		Asthmas				HIV	
		Epilepsy / Seizures				Other:	

**The above information is current and correct to the best of my knowledge.**

PATIENT/GUARDIAN SIGNATURE	DATE	REVIEWED BY	DATE
PATIENT/GUARDIAN SIGNATURE	DATE	REVIEWED BY	DATE
PATIENT/GUARDIAN SIGNATURE	DATE	REVIEWED BY	DATE
PATIENT/GUARDIAN SIGNATURE	DATE	REVIEWED BY	DATE



## Financial Policy

Welcome to our office! We are pleased that you have chosen Aspen Orthopaedic Associates to provide your care and service. We are committed to providing you with the best possible care. Your clear understanding of our Financial Policy is important to our professional relationship.

### **Forms of Payment:**

We accept cash, checks, Visa, MasterCard, Discover, and American Express. We will request to see your insurance card on every visit to keep our information current and accurate. **At check out, any amount of monies collected is ESTIMATED ONLY.**

Services provided by your physician will be presented to our billing department for proper coding and filing of insurance (if applicable). Statements will be sent out as needed.

### **Self-Pay Patients AND Out-of-Network (non-contracted) Insurance Plans, Including MVA and Liability Insurance:**

We will require payment at the time of service. This will be an estimated amount due until your services have been calculated by the billing department. (This amount may vary depending on the services you received.) Many private insurance companies, in an effort to set physician fees, restrict payment indicating that fees are over their "Usual and Customary" allowable. We will not allow insurance companies to set our fees for us based on their willingness to pay.

As a service to our patients, we will file with your insurance carrier (if applicable). Not all liability or MVA insurance plans accept claims from our office. Patients may have to file their own claims.

### **In Network (Contracted) Insurance:**

We will collect your co-pay and any known fees applicable toward your deductible at the time of service. You will be responsible for any services or supplies that are not a covered benefit.

### **Workers' Compensation Cases:**

Workers' compensation laws require the employee to report injuries to the employer. Please make sure you have done this. You must notify us of the date of injury, claim number, insurance company name and address, phone number, and the adjuster's name. If your workers' compensation claim is denied or you do not provide the required information, you are responsible for payment at the time of service. (We will file your health insurance if applicable.)

### **Medicare/Medicaid/Government Programs:**

We are participating providers with Medicare, and some Colorado Medicaid and government programs. You are responsible for your co-pays and deductibles at time of service. Medicaid patients MUST present their cards at each time of service.

### **Nonpayment/Outstanding Balances:**

**NOTE:** You can set up payment plans for your outstanding balances.

If you have an outstanding balance, we expect you to make payment or payment arrangements before your next scheduled appointment. Nonpayment may result in discharge from the practice. You will be responsible for any costs involved in collection of your account, to include interest, rebilling fees, court costs, attorney fees, and collection costs. A collection agency may be used to collect on delinquent accounts.

You are responsible for any amounts not covered by your insurance, including deductibles, non-covered/non-allowed services, and any bundled services that do not follow the American Academy of Orthopaedic Surgery (AAOS) coding guidelines. If your insurance denies or bundles a service that is appropriately coded following AAOS guidelines, you are responsible for payment of those services. Additionally, not all surgical services are known prior to surgery. If services are not covered by your insurance, you will be financially liable.

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Signature of Responsible Party over 18 years of age

Date

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## NOTICE OF PRIVACY PRACTICES

### Aspen Orthopaedic Associates / Orthopaedic Associates of Aspen & Glenwood

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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.**

Allowed uses and disclosures of your medical information:

- Treatment – such as ordering diagnostic tests, other health care providers (ex: PCP), pharmacy, etc.
- Payment – such as submitting billing information to your insurance company, disclosures to consumer reporting agencies (limited to specified identifying information about the individual, his or her payment history, and identifying information about the covered entity).
- Health Care Operations – such as quality assurance review, coordination of care, eligibility verification.
- Public Health Activities – communicable diseases are reported to the state's public health department.
- Law Enforcement – such as government audits and inspections to facilitate law-enforcement investigations.
- Our office – Your health information will be used by our staff to send you appointment reminders or to send you information that you may find interesting on the treatment of your medical condition or recalled medications.

In addition to the above, your medical information may be used or disclosed for emergency treatment; when we are required by law to treat you, we attempt to obtain consent, and are unable to do so; we are unable to obtain consent due to substantial communication barriers and consent for treatment is implied under the circumstances; or we created or received the information in treating an inmate.

You have a right to:

- Request restriction on certain uses and disclosures, however, we are not required to agree to any restriction.
- Receive confidential communications from us, upon written request.
- Inspect and request copies of your medical information.
- Request to amend incorrect or incomplete medical information.
- Receive an accounting of any disclosures made, upon written request.
- Receive a paper copy of the notice upon request or review our entire policy.

We are responsible for:

- Maintaining the privacy of your medical information.
- Providing you this notice and obtaining written acknowledgement.
- Abiding by the terms of this notice.

Complaints:

You may complain to us or to the Health & Human Services secretary if you believe that your privacy has been violated. If you wish to file a complaint with us, please provide the office manager with written notice of how you believe we violated your privacy. All notices received will be investigated and reviewed by a physician. We will respond to all notices within two (2) weeks of receipt, and we will not retaliate for any allegations you make. We have a form you can request to fill out.

Authorizations:

Upon your authorization, we may disclose your medical information to a requesting entity, such as an attorney, another insurance company (applying for life insurance), or a relative. You may revoke any authorization you make at any time, except to the extent that it was already relied on.

Patient contact:

We need to contact you to provide test results, appointment reminders, treatment information, or for patient satisfaction surveys. Our appointment reminders are done by telephone. If you want to request alternative or confidential communication, please ask to speak with the office manager or privacy officer.

For more information, contact: The Office Manager or Executive Director at (970) 927-8611.

Effective Date November 1, 2009

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## Consent and Acknowledgement of Receipt of Notice of Privacy Practices for Purposes of Payment and Healthcare Operations

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I consent to the use or disclosure of my protected health information by Aspen Orthopaedic Associates / Orthopaedic Associates of Aspen & Glenwood for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Aspen Orthopaedic Associates.

I have the right to revoke this consent, in writing, at any time, except to the extent that Aspen Orthopaedic Associates has taken action in reliance on this consent.

My "protected health information" (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Aspen Orthopaedic Associates' Notice of Privacy Practices (NPP) prior to signing this document. The Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Aspen Orthopaedic Associates. The Notice of Privacy Practices for Aspen Orthopaedic Associates is also provided **in the lobby** and on the group website at [www.orthop.com](http://www.orthop.com). This Notice of Privacy Practices also describes my rights and the Aspen Orthopaedic Associates duties with respect to my protected health information.

**Electronic Format:** I acknowledge that my records are stored in an electronic format. I understand Aspen Orthopaedic Associates maintains their patient records in electronic format only. Original documents are destroyed after being converted to an electronic format.

Aspen Orthopaedic Associates reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the group's website, calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment. I acknowledge I have received a copy of the Notice of Privacy Practices.

Release of Information: I hereby give Aspen Orthopaedic Associates permission to release information on my medical condition to the following people:

\_\_\_\_\_  
(Name & Relationship).

I understand the areas discussed with these people could include treatment options, side effects, prescriptions, financial information, test results, etc.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Patient or Personal Representative

Parent or Personal Representative  
refused to sign acknowledgement

\_\_\_\_\_  
Staff Initials

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Rep's Authority

*Trade Name Disclosure: Aspen Orthopaedic Associates is a legal trade name of Orthopaedic Associates of Aspen & Glenwood, PC*

Practice copy is filed in patient's chart  
Patient will receive a copy upon request