

COLORADO LIMB CONSULTANTS

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Dear Patient:

Thank you for scheduling your appointment with Colorado Limb Consultants. Our physicians look forward to meeting with you. Please arrive 15-20 minutes prior to your appointed time to complete the registration process.

You will find the paperwork necessary for our pre-registration process attached. Please complete these forms and bring them to your appointment. Any questions you have will be answered at that time. Please do not attempt to fax, mail or E-mail your completed forms as this may delay the check in process.

If your insurance company requires a referral to see a specialist, it is your responsibility to arrange for this in advance. If you're unable to obtain a referral, you will be asked to sign a waiver of liability form at the time of your appointment. If a co-pay is owed for the visit in our office, payment is expected at the time of service, unless other arrangements are made in advance. It is also important that you bring your insurance card to your appointment. Please keep in mind that as a new patient, your appointment may last up to two hours.

It is imperative that you bring the following information to your appointment:

- **X-rays, (films, cd's/discs)**
- **MRI/CT and reports (films, cd's/discs)**
- **Pathology slides, if applicable**
- **Operative Note – if prior surgery is applicable to your current problem & your appointment**

The absence of this information may result in the need to reschedule your appointment. This information will eliminate delays and also help your physician establish a treatment plan.

If you have questions regarding any of this information, you may phone our staff prior to your appointment or you may address your questions in person during the pre-registration process.

Thank you.

**COLORADO LIMB CONSULTANTS
PATIENT INFORMATION**

Name (Last, First, Middle): _____ DOB: _____

Home Address: _____ City, State Zip: _____

Home Phone Number: _____ SS#: _____ Gender: _____

Marital Status: _____ E-mail Address (optional): _____

Cell Phone#: _____ Primary Care Provider: _____

Primary Employer Name: _____ Work Phone: _____

Address: _____ City, State Zip: _____

RESPONSIBLE/GUARANTOR INFORMATION (if different than above)

Name (Last, First, Middle): _____ SS#: _____

Home Address: _____ City, State Zip: _____

Home Phone Number: _____ Day Phone Number: _____

DOB: _____ Relationship to Patient: _____

PRIMARY INSURANCE INFORMATION

Name of Ins Company: _____ Member ID/Policy #: _____

Group #: _____ Ins Telephone #: _____

Ins Address: _____ City, State Zip: _____

SECONDARY INSURANCE INFORMATION (if applicable)

Name of Ins Company: _____ Member ID/Policy #: _____

Group #: _____ Ins Telephone #: _____

Ins Address: _____ City, State Zip: _____

Signature of Patient/Guardian _____ Date _____

Colorado Limb Consultants Registration Form

HOW WERE YOU REFERRED TO OUR OFFICE?

(PLEASE CHECK ONE FROM THE FOLLOWING)

EMERGENCY ROOM

PHYSICIAN

HEALTH PLAN

MEDIA

PATIENT

OTHER: _____

WHO SENT YOU TO US, OR WHO TOLD YOU ABOUT OUR OFFICE: _____

IF YOU SENT TO US BY A PHYSICIAN, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Referring Physician Name: _____

Phone: _____ Fax: _____

Address: _____

City, State, and Zip: _____

WHO IS YOUR PRIMARY CARE PHYSICIAN? (*The doctor that you see for check-ups and physicals*)

Primary Care Physician Name: _____

Phone: _____ Fax: _____

Address: _____

City, State, Zip: _____

IF YOU HAVE CONSULTED OTHER PHYSICIANS FOR THE PROBLEM YOU'RE PRESENTING TODAY, PLEASE PROVIDE:

Physician's Name: _____ Phone: _____

Address: _____

City, State, Zip: _____

IN CASE OF AN EMERGENCY, WHOM DO WE CONTACT?

Name _____ Phone: _____

Address: _____

City, State, and Zip: _____

Relationship: _____

If the patient is a minor or student, please provide the name of the responsible party:

Responsible Party Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Social Security Number: _____

Mother's Work Phone: _____

Father's Work Phone: _____

IS THE VISIT RELATED TO A WORK INJURY? YES NO

IS THE VISIT RELATED TO AN AUTOMOBILE INJURY? YES NO

If the above answer is YES, please complete the following:

Name of Auto or Work Comp. Insurance: _____

Name of Adjuster: _____

Adjuster's Phone: _____ Extension: _____

Claim Number: _____

Date of Injury: _____ Time: _____

Describe how the injury occurred: _____

Colorado Limb Consultants Orthopedic History

Name: _____ Age: _____ DOB: _____

SS#: _____ Today's Date: _____

Height: _____ Weight: _____ Have you had any recent weight gain or loss: YES NO

If yes, how much _____

Present Problem

What are your current symptoms? _____

What caused these symptoms? _____

What date did the symptoms begin? ___/___/___

Have you had problems like this before? YES NO If yes, when? _____

When did you first seek medical assistance for this problem? ___/___/___

From Whom? _____ What type of healthcare professional? _____

How would you rate your pain from Zero to Ten: (Zero = No pain, Ten = Intolerable, as bad as possible)

Pain on a good day: _____ Pain on a bad day: _____

Previous Treatment for this Condition

Medication or injections for *this* problem:

Name of Medication	Dose (i.e. mg)	Frequency (i.e. 2x/day, 3x/day)	Results
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Number of surgeries for *this* problem?

Date	Surgery Type	Surgeon
___/___/___	_____	_____
___/___/___	_____	_____
___/___/___	_____	_____

Other Treatment for this problem (circle all that apply):

Cast Splint Exercise Physical Therapy Other: _____

General Health – Review of Symptoms No Problems

Please check if you have ever had any of the following conditions: Hypertension/High Blood Pressure

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Headache | <input type="checkbox"/> Rash |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> CANCER | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Urinary Pain/Frequency |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Intolerance to Hot/Cold | <input type="checkbox"/> Weight Gain/Loss |
| <input type="checkbox"/> Asthma/Breathing Problems | <input type="checkbox"/> Digestive Problem | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Other |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nasal Congestion | <input type="checkbox"/> |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Fever/Chills | <input type="checkbox"/> Poor General Health | |

Colorado Limb Consultants

Orthopedic History

Are you currently under another physician's care? YES NO

If yes, for what reason? _____

Significant past and current medical problems: _____

Please list previous surgeries not already listed:

Date	Surgery Type	Surgeon
____/____/____	_____	_____
____/____/____	_____	_____
____/____/____	_____	_____

Please list all medications, vitamins or herbal supplements you are taking on a regular basis:

Name of Medication	Dose	Frequency	Reason for Medication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any allergies to medications or to the environment?

FAMILY HISTORY

Please check any health problems diagnosed in your current family

<u>Condition</u>	<u>Who?</u>	<u>Condition</u>	<u>Who?</u>
Arthritis/Rheumatism	_____	Sciatic/Back Problems	_____
Hypertension	_____	Liver Problems	_____
Breathing Problems	_____	Kidney Disease	_____
Bleeding Problems	_____	Heart Problems	_____
Cancer	_____	Diabetes	_____
Angina	_____	Other	_____

SOCIAL HISTORY

Occupation: _____ Interests: _____

Which is your dominant hand? Left/Right _____ Exercise/Sports History: _____

Tobacco use: Never used tobacco Currently use tobacco Smoke Chew
 I quit using tobacco _____ months/years ago

Alcohol use: Never used alcohol Currently have _____ drinks per day

Is there anything else you feel that the doctor should know about your lifestyle or medical history?

Please be aware that if you are taking herbal medications or supplements, you will need to advise your physician. You may need to stop taking them for two weeks prior to any scheduled surgery.

COLORADO LIMB CONSULTANTS
CONSENT & INFORMATION DISCLOSURE

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient/Patient Representative Signature: _____

Date: _____ *Time:* _____

Consent to E-mail Usage for Appointment Reminders and Other Healthcare Communications:

Patients of Colorado Limb Consultants may be contacted via email to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health information. If at any time I provide an email address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email address from the Practice.

_____(Patient initials) I consent to receive email communication as stated above. All electronic communications sent to the E-mail address listed on page two of the patient information form will become a part of my permanent medical record at Colorado Limb Consultants. I understand that this request to receive emails will apply to all future appointment reminders, feedback and/or health information unless I request a change in writing. Revocation to receive email communications to be provided upon request.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

_____(Patient initials) I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practices health care operations purposes (e.g. quality improvement activities). I understand that the practice retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representatives unless it is for the treatment, payment or healthcare operations purposes or otherwise permitted or required by law.

_____(Patient initials) I do not consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practices health care operations purposes, (e.g. quality improvement activities).

COLORADO LIMB CONSULTANTS
WAIVER FOR SURGICAL PROCEDURES

Please be advised of the following information:

Every attempt will be made by this office to pre-certify or obtain authorization for your surgery, if required by your insurance company. We will also go through the steps required to determine if your surgery is a benefit of your policy. However, this is not a guarantee of payment. Benefits are determined at the time of claim submission. If your insurance company does deny payment, you will be responsible for payment of any services rendered.

Policy coverage information such as benefits, exclusions, co-pays, co-insurance, etc, can be obtained by calling the member service number on your insurance card. If your insurance is an HMO or requires referrals/authorizations, you are ultimately responsible for obtaining referrals/authorizations from your primary care physician, if and when they are needed.

SURGICAL ASSISTANT

The physicians may require a surgical assistant to perform your surgery safely. In some cases, two surgical assistants will be required. The surgical assistant aides the physician in performing procedures which are more complicated and therefore lessen the amount of time that you are in the operating room under a general anesthesia. Every effort will be made by the office to obtain authorization with your insurance company for the use of surgical assistant(s).

If your insurance policy does not have benefits which reimburse for a surgical assistant, you will be responsible for payment of the surgical assistant's fee. However, since benefits are not determined until the claim is submitted, all patients will be required to sign this waiver even if a surgical assistant has been pre-authorized. In most cases, the PA's at Colorado Limb Consultants are available to assist with your surgery. Every effort will be made to collect payment from your insurance company for these services. In the event the SA charge is denied, a first level appeal will be submitted, when applicable. If your insurance company denies the appeal, you will be responsible for this service. The most you would be expected to pay for the SA fee is \$175.

In some cases, the use of independent surgical assistants is required. When this occurs, the independent surgical assistants will submit their claim to your insurance company for payment. SA fees are typically 20% of the primary surgeon's fee. In the event your insurance company denies the charge, the staff at Colorado Limb Consultants will assist the SA billing company with any appeal efforts. However, you are ultimately responsible for any amounts they deem reasonable. As such, you will receive a statement/bill directly from the surgical assistant and are obligated to make payment arrangements directly with them.

I agree to accept full responsibility for fees not paid by my insurance company

Patient Signature

Date

Signature of legal guardian

Date