Center for Spine and ORTHOPEDiCS

Patient Name: _____
First Middle Last

Birth Date: _____ **Age:** _____ **Sex:** _____ **SSN:** _____ **Marital Status:** _____

Home Address: _____
Street Apt. City State Zip

Email Address: _____@_____

Phone: Home (_____)_____ mobile (_____)_____

Employer: _____ Ph: (_____) _____

Address: _____

Preferred Communications: Home phone_____ Mobile phone message_____ mobile phone text_____ email_____

Race:_____ ☐ Declined **Ethnicity:**_____ ☐ Declined **Preferred language**_____ ☐ Declined

REFERRING PHYSICIAN:

Name: _____ph_____

PRIMARY CARE PHYSICIAN:

Name: _____ph_____

TYPE OF INJURY: ☐ Work Comp ☐ Auto Accident ☐ Other Date of Injury: _____

PRIMARY INSURANCE :_____

Claim/ID#: _____

Group#: _____

Co-Pay: _____

Policy Holder (if different from self)

Name: _____

SSN: _____

Birth Date: _____

SECONDARY INSURANCE: _____

Claim/ID#: _____

Group#: _____

Co-Pay: _____

Policy Holder (if different from self)

Name: _____

SSN: _____

Birth Date: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? ☐ Insurance Co ☐ MD Referral ☐ Internet/Website ☐ Family/Friend ☐ ER ☐ Other

EMERGENCY CONTACT INFORMATION:

Name: _____ Relation: _____ ph # _____

Is this person authorized to receive information regarding your medical condition? ☐ Yes ☐ No

DISCLOSURE AGREEMENT AND CONSENT FOR TREATMENT:

I WILL UNDERTAKE NO AUDIO AND/OR VIDEO RECORDINGS WHILE AT THE CENTER FOR SPINE AND ORTHOPEDICS, P.C. I VOLUNTARILY CONSENT TO EXAMINATION AND TREATMENT FOR MYSELF AND/OR DEPENDANTS.
*Note: The providers at CSD may have a financial interest in surgery centers, hospital facilities, imaging centers, and medical-surgical implant distributors
Please Note: Our surgical physicians **do not prescribe pain medications for chronic pain management**. Thank you for your consideration in this matter.

Patient Signature/
Responsible Party: _____ Date: _____

ASSIGNMENTS OF BENEFITS: I understand that I am responsible for payment of services rendered to me. I understand that the office of Center for Spine and Orthopedics, PC does not accept responsibility for collecting of insurance. We may bill insurance as a courtesy, but have no obligation to do so. Any balance left over or co-pay from insurance will be my financial responsibility. A finance charge will be charged at an interest rate of 1.5% per month on any outstanding balance. Should my account be referred to an attorney for collection, I agree to pay attorney fees, costs and collection expenses. I authorize payment of medical benefits to Center for Spine and Orthopedics, PC for services provided to me.

Patient Signature/Responsible Party_____ Date_____

RECORDS RELEASE: I authorize the release of any information, including medical and billing information, by Center for Spine and Orthopedics, PC, to my referring doctor and insurance company.
Patient signature/Responsible Party_____ Date_____

NOTICE OF PRIVACY: A copy of the Notice of Privacy Practices has been made available to me by Center for Spine and Orthopedics, PC.
Patient signature/Responsible party _____Date_____

CENTER for SPINE & ORTHOPEDICS

PATIENT CORRESPONDENCE QUESTIONNAIRE

Please list any family members or other persons, if any, whom we may discuss your general medical condition or your diagnosis with (including treatment, payment and health care operations) on your behalf. This contact will also be used in case of an emergency.

Printed Name:_____ Relationship:_____
Phone Number:_____ Phone Number:_____

Printed Name:_____ Relationship:_____
Phone Number:_____ Phone Number:_____

Patient Printed Name:_____Date:_____

Patient/Guardian Signature:_____

In order to provide quality care, we like to have a comprehensive list of your medications. We have the ability to access information provided by your insurance company to populate your medication history directly into your electronic medical record. I authorize The Center for Spine and Orthopedics, P.C. to obtain this information and populate it into my record.

Patient Printed Name:_____Date:_____

Patient/Guardian Signature:_____

I authorize the Center for Spine and Orthopedics P.C. to send me automated messages regarding my medical care (including treatment, payment, and health care operations). This may include phone calls, text messages or emails which may be generated from our electronic medical records system.

Patient Printed Name:_____Date:_____

Patient/Guardian Signature:_____

9005 Grant Street, Suite 200 | Thornton, CO 80229 | Ph. 303.287.2800 | Fax 303.287.7357
www.centerforspineandortho.com

CENTER for SPiNE & ORTHOPEDiCS

Office and Financial Policies

We would like to thank you for choosing The Center for Spine and Orthopedics, PC (CSO) as your healthcare provider. We are committed to providing you with the best possible medical care. The following information outlines our Office and Financial policies.

Financial
For the safety and protection of our patients and CSO, patients are required to present a valid form of identification upon check-in and prior to services being rendered. If you can not provide your insurance card at check in for your appointment you will be responsible for payment in full for all visits until you provide the information and insurance coverage can be verified. ***It is the patient's responsibility to see that the bill is paid in full.*** We must emphasize that, as your medical care provider, our relationship is with you and not your insurance company. The filing of a medical claim is an expensive process that we extend to you at no charge as a courtesy however; we do require that you pay all co-pays, deductibles, and non-covered charges the day of your service. If payments for these amounts are not made at your check-in for your appointment your office visit will be rescheduled.

Self Payment, Private or Cash Payment
If you do not have insurance coverage we ask that you coordinate your care with our billing office prior to your visit. We require an advance payment of $200.00 prior to services being rendered and the balance of the charges to be paid once services have been rendered and prior to leaving the office.

Referrals, Non-Covered and Out of Network Services
It is your responsibility as the insured to confirm that we are an in network provider with your insurance carrier, if you need a referral prior to being seen and what your benefits are. If you request an office visit without a referral authorization, without checking to confirm that we are in-network provider or without knowing your benefits your plan may deem charges as "Out of Network" or "Non-Covered". If a claim is processed as out of network or non-covered the charges will be your responsibility.

Delinquent Balances
Patients with a delinquent balance are required to make payment in full prior to any appointments. A delinquent account is defined as a patient balance that has received two statements without payment or contacting the billing office for payment arrangements. If such payment is not made, services will be refused. A finance charge of 1.5% will be assessed on all patient balances not paid within 30 days.

Returned Checks
Returned checks will incur a $40.00 service charge. You will be asked to bring cash, certified funds or a credit card for the amount of the check plus the $40.00 service charge to pay the balance prior to scheduling or receiving any further services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $40.00 service fee and collections action. All bad checks written to this office are subject to collections.

Surgery and Injections
We require that you pay the following prior to surgery or procedures being scheduled: estimated deductible, co-pay, co-insurance, non-covered charges plus any outstanding balances on your account. This payment must be made by certified check, cash or credit card. Although we contact your insurance company to obtain your benefits, it is your responsibility as the insured, to know your own benefits; therefore, we encourage you to contact them as well. We are not responsible for benefits that are misquoted to us by your insurance company. If the pre-collected funds exceed the out-of-pocket expenses on the explanation of benefits from your insurance company, they will be refunded following final reconciliation with your insurance company.

Nonpayment
All patient balances that remain delinquent after 90 days, with no response to our requests for payment may be referred to a collection agency. Please be aware that if your account is referred to a collection agency you will be dismissed from the practice.

CENTER for SPINE & ORTHOPEDICS

If your account is referred to a collection agency, any additional fees incurred due to placement will be added to your outstanding balance. This includes but is not limited to late fees, collection agency fees, court costs, interest and fines.

Divorced Parents of Patients
Responsibility for payment for the treatment of minor children whose parents are divorced rests with the parent who seeks the treatment. Any court ordered responsibility judgment must be determined between the individuals involved without the inclusion of CSO.

After-Hours Emergencies
If you should experience a life-threatening emergency, please call 911 or go to the closest emergency room. If you have other after-hours emergencies, you can contact the physician on-call by calling our main number. This service is for emergency or potential emergency care only. Please call during regular business hours for non-urgent questions or concerns.

After-Hours Narcotics
There will be no refills of any narcotics after hours or on weekends. Please call during regular business hours with 48 hours advance notice.

Tardiness
If you arrive late for your appointment, we may need to see other patients before we can see you. In addition, if you are more than 15 minutes late, you may be asked to reschedule.

Cancellations and No-Shows
As a courtesy to other patients, we request that you notify us as soon as possible if you need to change your appointment. This allows us to offer that appointment time to another patient. We understand that sometimes unforeseen circumstances may arise on the day of your appointment but ask that you give us 24 hours notice if you will not make your appointment. If you do not give sufficient notice you will be charged a "No Show" fee of $50.00. If you have missed your appointment 3 times and have not called to cancel or reschedule, you may be discharged from our clinic.

Form Fees
Completing insurance forms, copying medical records, etc. requires office staff time and time away from patient care for our Providers. CSO requires pre-payment for completing forms, copying medical records, notarizing or for extra written communication from the Provider. The charge is determined by the complexity of the form, letter, or communication. Our base fee for forms starts at $55.00 per form. CSO will have 7-10 business days in which to complete the form. Our fees for medical records is as follows $18.53 for pages 1-10, 85 cents per page for pages 11-40, 57cents per page for pages 41 and over, plus postage.

The Center for Spine and Orthopedics strives to offer you the very best medical care therefore we have implemented these policies in order to continue providing premium care.

I have read and understand the office/financial policies and accept responsibility for all charges incurred from services rendered to me by The Center for Spine and Orthopedics.

_____ _____
Patient/Responsible Party Signature **Date**

_____ _____
Patient Name Printed **Date of Birth**

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www.centerforspineandortho.com

CENTER for SPINE & ORTHOPEDICS

Name: _____

What are we seeing you for today? Please be specific.

Body Part _____

_____

_____

Left _____ Right _____ Bilateral _____

Is this a result of an injury? ____ Yes _____ No
Were you injured at work _____ Yes ____ No
Is this the result of an auto accident? ____ Yes _____ No

How did the injury occur?_____
_____

Where did the injury occur? _____
_____

When did the injury occur? _____
_____

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Center for Spine and Orthopedics

Health History Form

Welcome to our office. We value maintaining a current medical record in order to provide you with quality patient care. Please review and answer all questions below. Your healthcare provider may have additional questions based on your responses and may ask you to fill out additional information if necessary. Thank you.

Patient name:_____

Age:_____ Date of Birth:_____

Height_____ Weight: _____ Male Female

Preferred pharmacy:_____ address: _____ phone:_____

PAST/ CURRENT MEDICAL HISTORY (Circle all that apply) **Comments**

Do you have a bleeding disorder? Yes No _____

Are you currently pregnant or believe that you may be pregnant Yes No

Have you been diagnosed with any of the below?

Anemia	Yes	No	High Blood Pressure	Yes	No
HIV AIDS	Yes	No	High Cholesterol	Yes	No
Aneurysm	Yes	No	Hypoglycemia	Yes	No
Anxiety disorder	Yes	No	Kidney Disease / Stones	Yes	No
Arthritis	Yes	No	Leg or Foot Ulcers	Yes	No
Asthma	Yes	No	Liver Disease	Yes	No
Bleeding Disorder	Yes	No	Lung Disease	Yes	No
Blood Clots (leg or lung)	Yes	No	Migraines	Yes	No
Cancer and type	Yes	No	MRSA/skin infections	Yes	No
Circulation Problems	Yes	No	Osteoporosis	Yes	No
Coronary Artery disease	Yes	No	Pacemaker	Yes	No
Depression	Yes	No	Prostate Disease	Yes	No
Diabetes	Yes	No	Pulmonary Embolism	Yes	No
Fibromyalgia	Yes	No	Rheumatoid Arthritis	Yes	No
Foot Ulcers	Yes	No	Seizures / Epilepsy	Yes	No
GERD/Reflux	Yes	No	Sleep Apnea	Yes	No
Gout	Yes	No	Stomach Ulcers	Yes	No
Head Injury	Yes	No	Stroke/TIA	Yes	No
Heart Attack (MI)	Yes	No	Thyroid Problems	Yes	No
Heart Disease	Yes	No	Tuberculosis	Yes	No
Hepatitis	Yes	No	Urinary Tract Infections	Yes	No

Other / Comments_____

_____

LIST CURRENT MEDICATIONS AND DOSES (Please include over the counter, vitamins and supplements)

_____ _____

_____ _____

ALLERGIES AND ADVERSE REACTIONS to medications, contrast dyes used in diagnostic tests, or Latex? Please list allergy and reaction. (IF NONE WRITE NONE)

ALLERGY REACTION

_____ _____

_____ _____

FAMIILY MEDICAL HISTORY			Relationship to you				Relationship to you
Alcohol abuse	Yes	No		Heart Attack	Yes	No	
Asthma	Yes	No		High Blood Pressure	Yes	No	
Anxiety	Yes	No		High Cholesterol	Yes	No	
Back Problems	Yes	No		Kidney Disease	Yes	No	
Bleeding Disorder	Yes	No		Liver Disease	Yes	No	
Cancer	Yes	No		Osteoporosis	Yes	No	
Depression	Yes	No		Scoliosis	Yes	No	
Diabetes	Yes	No		Sick Cell Anemia	Yes	No	
Epilepsy/Seizures	Yes	No		Stroke	Yes	No	
Glaucoma	Yes	No		Thyroid Problem	Yes	No	
Gout	Yes	No		Tuberculosis	Yes	No	

Other:_____

PAST SURGICAL HISTORY (Please list all surgeries/procedures and dates that you have had since childhood and indicate left or right when appropriate)

_____
_____
_____
_____
_____
_____
_____

SOCIAL HISTORY

Occupation_____
Smoking Status □ Never □ Former □ Current everyday □ Current somedays
Have smoked since what age? _____
Smoking / How much? _____
Chewing Tobacco □ Yes □ No
Alcohol Intake □ None □ Yes, how much _____type of alcohol_____
Caffeine Intake □ None □ Yes, how many cups a day _____
Illicit Drugs □ Yes □ No If yes what type:_____
Do you use Medical Marijuana □ Yes □ No How much_____
Do you use Recreational Marijuana □ Yes □ No How much_____
Have you ever been treated for drug, alcohol or prescription abuse in the past? □ Yes □ No
Exercise Level □ Never □ Yes what type and how often

_____
Hand Dominance □ Right □ Left □ Both
Education:_____
Live alone or with others? □ Live Alone □ With Others □ Married □ Single □ Divorced □ Child
Is this an accident related injury?
Work related injury? □ Yes □ No
Auto related injury? □ Yes □ No
If injured, is litigation ongoing? □ Yes □ No

Patient name:_____

Chief Complaint/ History of Present illness:
What are you being seen for today? _____
Left_____Right_____N/A_____
Is it due to an injury? Yes No Were you hurt at work? Yes No Were you in a car accident? Yes No
How long has your problem or pain been present?_____
Date of injury?_____

Previous Health care providers you have seen for this problem?

_____

Injury / Pain to? Left Right Both
Arm Shoulder Elbow Wrist Hand Leg Knee Ankle Foot Neck Back
Other_____

How did your pain begin?
□ Abruptly, getting better □ Gradually, getting better
□ Abruptly, remaining the same □ Gradually, remaining the same
□ Abruptly, and getting worse □ Gradually, getting worse

Which best describes the quality of your current pain complaint (check all that apply)
□ Sharp □ Burning □ Throbbing □ Shooting □ Aching □ Stabbing □ Dull □ Numb □Tingling
Other_____

How often do you have pain?
□ Constantly □ Intermittently(several times per day)
□ Occasionally(several times per week) □ Rarely(a few times per month)

What makes your pain WORSE (check all that apply)?
□ Sitting □ Coughing □ Sneezing □ Looking up
□ Lifting □ Twisting □ Bending Forward □ Looking down
□ Standing □ Walking □ Bending Backward □ Weather Changes
□ Lying down □ Exercise □ Stress □ Bowel movements
□ Looking over your shoulder(R or L)
□ Other_____

What makes your pain BETTER (check all that apply)?
□ Standing □ Lying down □ Heat
□ Sitting □ Cold □ Nothing
□ Exercise/activity □ Rest
□ Medications- if yes which one(s):_____
□ Other:_____
□ Nothing

Is your pain associated with other symptoms?
□ Weakness – if yes, where?_____
□ Numbness – if yes, where?_____
□ Bowel or bladder changes – if yes describe:_____
□ Fine motor control problems(ie. Buttoning your shirt, using a pencil, etc)
□ Other:_____

Please check off any of the following treatments that you have had for your current symptoms:

Treatment	Did it help (yes / no)?		Treatment	Did it help (yes / no)?	
□Physical therapy	Yes	No	□Psychiatric Care	Yes	No
□Chiropractic care or manipulations	Yes	No	□TENS Unit	Yes	No
□Psychological Care	Yes	No	□Accupuncture	Yes	No
□Pain Program / Pain Clinic	Yes	No	Other:_____		
□ Medications					

Patient name:_____

REVIEW OF SYSTEMS (Please check symptoms you are having today)

CONSTITUTIONAL: □ no problem
□ poor appetite □ weight loss Amount_____ □ weight gain Amount_____ □ fevers □ night sweats

□ other _____

EYES: □ No problem
□ visual changes □ double vision □ color vision changes □ eye irritation □ other_____

EAR, NOSE, THROAT: □ No problem
□ hearing loss □ ringing in ears □ nosebleeds □ other _____

CARDIOVASCULAR: □ no problem
□ chest pain □ swelling in legs/feet □ palpitations □ fainting □ shortness of breath □ other _____

RESPIRATORY: □ no problem
□ chronic cough □ shortness of breath □ wheezing □ home oxygen □ other _____

GASTROINTESTINAL: □ no problem
□ nausea/vomiting □ change in bowel movement □ bloody/black tarry stools □ constipation □ abdominal pain
□ diarrhea □ other _____

GENITOURINARY: □ no problem
□ incontinence of urine □ changes in urinary pattern □ difficulty with erections □ kidney stones □ blood in urine

□ other _____

MUSCULOSKELETAL: □ no problem
□ limited range of motion_____ □ muscle joints/aches □ muscle loss where?_____ □ stiffness in Joints □ other _____

INTEGUMENTARY (SKIN): □ no problem
□ rash □ tumors □ discoloration □ itching □ eczema/psoriasis □ changes in moles □ other _____

NEUROLOGIC : □ No problem
□ Poor appetite □ frequent/severe headaches □ weakness-where?_____ □ difficulty walking □ poor memory
□ difficulty chewing/swallowing □ poor coordination □ dizziness □ recent falls □ other_____

PSYCHIATRIC: □ no problem
□ frequent sadness/depression □ anxiety □ loss of interest □ excessive worry □ low energy level □ suicidal thoughts

□ other_____

ENDOCRINE: □ no problem
□ glucose/sugar changes □ excessive urination □ excessive thirst □ heat/cold intolerance □ other _____

HEMATOLOGIC : □ no problem
□ easy bruising □ Anemia (low blood count) □ trouble controlling bleeding □ other _____

ALLERGIC/ IMMUNOLOGIC : □ no problem
□ difficulty breathing □ swelling pain at groin, axilla, neck □ rash/itch to materials, food, animals □ other_____

Patient signature_____ **Provider**_____ **Date**_____