CENTER for SPINE AND ORTHOPEDICS/CSO Wellness and Rehabilitation

Patient Name: _____
First Middle Last

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

Home Address: _____
Street Apt. City State Zip

Email Address: _____@_____

Phone: Home (_____)_____ Cell (_____)_____

Employer: _____ Ph: (_____) _____

Address: _____

Preferred Communications: Home phone____ Cell phone message____ text____ email____

Race_____ ☐ Declined **Ethnicity**_____ ☐ Declined **Preferred language**_____ ☐ Declined

REFERRING PHYSICIAN:
Name: _____ Phone: _____

PRIMARY CARE PHYSICIAN:
Name: _____ Phone: _____

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/Web Site
☐ Family/Friend ☐ ER ☐ Social Media ☐ Other_____

DISCLOSURE AGREEMENT AND CONSENT FOR TREATMENT:
I WILL UNDERTAKE NO AUDIO AND/OR VIDEO RECORDINGS WHILE AT THE CENTER FOR SPINE AND ORTHOPEDICS, Inc./CSO Wellness and Rehabilitation. I VOLUNTARILY CONSENT TO EXAMINATION AND TREATMENT FOR MYSELF AND/OR DEPENDENTS.
*Note: The providers at CSO 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.

ASSIGNMENT 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, Inc/CSO Wellness and Rehabilitation 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 n 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, Inc/CSO Wellness and Rehabilitation for services provided to me.

RECORDS RELEASE: I authorize the release of any information, including medical and billing information, by Center for Spine and Orthopedics, Inc/CSO Wellness and Rehabilitation to my referring doctor and insurance company.

NOTICE OF PRIVACY: A copy of this Notice of Privacy Practices has been made available to me by Center for Spine and Orthopedics, Inc./CSO Wellness and Rehabilitation

Patient Signature/Responsible Party: _____ Date: _____

CENTER FOR SPINE & ORTHOPEDICS

WELLNESS & REHABILITATION

PATIENT CORRESPONDENCE QUESTIONNAIRE

Please list any family member or persons with whom we can discuss your medical care.

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

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

_____ _____ _____
Patient printed name Patient/Guardian Signature Date

I authorize The Center for Spine and Orthopedics, Inc. to obtain this information and populate it into my record.

Center for Spine and Orthopedics also reserves the right to view my State wide prescription drug history. This is done through a registry known as per the Colorado Prescription Drug Monitoring Program or PDMP.

I hereby authorize The Center for Spine and Orthopedics to access and or download my prescription history.

_____ _____ _____
Patient printed name Patient/Guardian Signature Date

I authorize the Center for Spine and Orthopedics Inc./CSO Wellness and Rehabilitation 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 Patient/Guardian Signature Date

Office and Financial Policies

Financial
For your safety and protection, The Center for Spine and Orthopedics (CSO) requires a valid form of identification prior to services being rendered. If you are unable to provide insurance information at check in, payment in full will be required. CSO's relationship is with you, not your insurance company. If CSO is billing your insurance company, we require that you pay all co-pays, deductibles, and non-covered charges, the day of your service. Ultimately, it is the patient's responsibility to ensure payment in full for all services.

Self Payment, Private or Cash Payment
If you are uninsured, CSO requires an advance payment of $200.00 prior to services being rendered. The balance is to be paid after the appointment, prior to leaving the office.

Referrals, Non-Covered and Out of Network Services
It is the patient's responsibility to confirm that their provider is in network, and to determine if their insurance carrier requires a referral prior to the appointment. If you request an office visit without a required referral, your insurance carrier may deem charges as "Out of Network" or "Non-Covered". The patient is responsible for all "Out of Network" or "Non-Covered" charges.

Delinquent Balances
A patient with a past-due balance is required to make payment in full prior to their next appointment. If payment is not made, services will be refused. A finance charge of 1.5% per month will be assessed on all patient balances not paid within 30 days.

Returned Checks
Returned checks will incur a $40.00 service charge. To continue care with CSO, you will need to pay with cash or with a credit card for the amount of the check plus the $40.00, prior to scheduling your next appointment. Stop payments constitute a breach of payment and are subject to a $40.00 service fee and collections action.

Surgery and Injections
Prior to scheduling surgery or injections, patients must pay their estimated deductible, co-pay, co-insurance, non-covered charges and any outstanding account balance. Payment must be by cash or credit card. CSO contacts your insurance company to obtain your benefits, it is your responsibility to know your own benefits. We encourage you to contact them as well. CSO is not responsible for benefits that are misquoted by your insurance company. If pre-collected funds exceed the out-of-pocket expenses listed by your insurance company, CSO will refund the overpayment to you after final insurance reconciliation.

Nonpayment
Patient balances that are 90 days past due, with no response to our requests for payment, will be referred to a collection agency. If your account is referred to a collection agency, you will be dismissed from the practice. 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 minors 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 experience a life-threatening emergency, call 911 or go to the closest emergency room. If you have other after-hours emergencies, 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
CSO will not refill Narcotic prescriptions after hours or on weekends. Call during regular business hours with 48 hours 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 10 minutes late, you may be asked to reschedule.

Cancellations and No-Shows
CSO requests that you notify us as soon as possible if you need to change your appointment. We understand that sometimes unforeseen circumstances may arise on the day of your appointment but ask that you give 24-hour notice if you will not attend your appointment. If you do not give 24-hour notice, you will be charged a fee of $50.00. If you violate this Cancellation/No-Show policy three times, you will be discharged from our clinic. If you violate this Cancellation/No-show policy for a scheduled surgery/procedure, you will be charged a fee of $500.00.

Form Fees
CSO requires pre-payment for completing forms, copying medical records, notarizing forms 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 are $18.53 for pages 1-10, $0.85 per page for pages 11-40, $0.57 per page for pages 41 and over, plus postage.

I have read and understand the Office and Financial Policies and accept responsibility for all charges incurred from services rendered to me by my provider at The Center for Spine and Orthopedics.

_____ _____
Patient/Responsible Party Signature Date

_____ _____
Patient Name Printed Date of Birth

Center for Spine and Orthopedics

Health History Form

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:_____
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

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)?**		**Duration**	**Treatment**	**Did it help (yes / no)?**		**Duration**
□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 (duration)_____							

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**_____