Name:

DOB:
Gender:

Consent for Treatment

Phreesia

Consent for Treatment

Consent for Treatment

Orthopedic Centers of Colorado
Consent for Evaluation and/or Treat

I, _____ for myself, or the patient named above, hereby consent to such medical evaluation and/or treatment and diagnostic procedures (e.g. x-rays) as necessary and appropriate for my condition or illness based on the judgment of my physician(s), to be performed by the physician(s), physician assistant(s), nurse(s) or other health care provider(s). I have had, and will continue to have, an opportunity to discuss treatment options with my healthcare provider, ask questions regarding such treatment options and understand the options discussed. I understand there may be additional risks associated with COVID-19 as well as any public health emergency.

I further understand Orthopedic Centers of Colorado has implemented employee and patient safety protocols to reduce the risk of spreading COVID-19, and I agree to notify staff prior to any appointment of any fever, symptoms, or exposure.

By signing below, I consent to medical treatment by Orthopedic Centers of Colorado.

Date: _____

Name_____

Name of Person with Patient: _____

Relationship to Patient: _____

☐ I Accept

☐ I Decline

_____
Patient Signature

Orthopedic Centers of Colorado
8101 E Lowry Blvd, Suite 120, Denver, CO,
80230

Name:
DOB:
Gender:

Financial Policy

Phreesia

Financial Policy

Financial Policy –

Orthopedic Centers of Colorado
Financial Policy

Thank you for choosing Orthopedic Centers of Colorado as your healthcare provider. We believe our financial policies represent sound business practices which allows us to provide high quality, cost-effective care to our patients. We do not want financial problems to be a barrier to your treatment, as quality care to you is our primary concern. However, please understand that payment of your account is an important aspect of the service you receive here. The following is our Financial Policy, which we require that you read and sign prior to your treatment. If you do not agree with this policy, you have the right to seek care elsewhere. However, failure or refusal to sign this form does not negate its applicability.

IDENTIFICATION
We require that you provide us with a current and valid government photo ID. This can be in the form of a driver license, state ID or military ID.

INSURANCE
We ask for your insurance card(s) at your first visit and keep a copy for our records. We may request a copy at a later date in order to update our records, so please bring your current insurance card with you every time you visit our office. Failure to provide complete insurance information may result in reduced insurance benefits and a higher financial responsibility for you, as will failure to update your insurance information with us when your coverage changes. **It is your responsibility to know your healthcare benefits and coverage limitations.**

IN-NETWORK INSURANCE PLANS
All co-pays are due prior to treatment as per your contract with your insurance company. We are under a contractual obligation to your insurance company to collect all deductibles, co-payments and co-insurance amounts which will be due and collected at the time of service.

INDEMNITY and NON-CONTRACTED INSURANCE
With complete insurance information, we will bill your insurance as a courtesy to you. Please note that your insurance policy is a contract between you and your insurance company. We are NOT a party to that contract. You are to direct any questions or concerns regarding your coverage to your insurance carrier.

SELF PAY ACCOUNTS
Self-Pay accounts are for patients without insurance coverage. It may also include patients covered by insurance plans in which Orthopedic Centers of Colorado does not participate with. It is your responsibility to know if Orthopedic Centers of Colorado is participating with your plan. A new patient who is self-pay is required to pay $400.00 which includes the visit and x-rays. An existing self-pay patient who is returning for a follow up visit is required to pay $150.00 for the visit and x-rays. The self-pay amount is paid prior to seeing the provider. For additional services: therapy, cast/splints/supplies, injections, etc. are paid at time of service but at a discounted rate in addition to the office visit/x-ray charge.

REFFERALS AND AUTHORIZATIONS
If your insurance requires a referral authorization, you will be expected to obtain a referral for each visit from your Primary Care Physician. Due to the constant changes in healthcare contracting, we will do our best to make sure we refer you to facilities within your network, however, it is the patient's final responsibility to know which facilities and providers are within your network and we cannot be responsible for any bills incurred outside our facility. If a valid referral or authorization cannot be obtained, you will be asked to reschedule your appointment.

WORKER'S COMPENSATION
We cannot bill your worker's compensation insurance without verification of your injury from your employer. We require billing address, claim number and the name and telephone of your adjuster. If you cannot provide this information or your claim has not been reported, all services rendered will be your financial responsibility and are payable at time of service.

APPOINTMENTS
To best serve all our patients, we ask a for 24 hours' notice if you are unable to keep an appointment. In the event you cancel an appointment without 24 hours advance notice, you can be charged a Missed Appointment fee.

COLLECTIONS
In the event you fail to pay your balance and we feel at our discretion that we have exhausted our efforts to obtain payment from you, we may send your account to an outside collection agency to pursue payment on our behalf. The collection agency fee that is charged to us

will be transferred to your outstanding balance.

GENERAL INFORMATION

- Financial Hardship – We recognize there may be financial hardship situations and offer options that can be discussed with the Billing Department
- Returned checks will be assessed a fee
- Making a payment. You can make a payment on your account through our check-in portal, by mail, calling the office or through the online option: **PayMyDoctor.com**

Patient Authorization, Acknowledgement & Agreement

I hereby assigned my health insurance benefits (and if applicable, government benefits) directly to Orthopedic Centers of Colorado for services rendered. I authorize this office to bill my insurance company directly for services. In the event I receive payment from my insurance carrier, I agree to endorse any payment I receive over to my physician for which these fees are payable.

I understand, acknowledge, and agree that I am financially responsible for my deductible, co-pay, co-insurance, and any amount exceeding what my insurance company pays, except where exempt by contractual agreement. I further understand that I am responsible for complying with any requirements my insurance carrier may have regarding referrals, prior approvals, and pre-authorizations.

Date:

Responsible Party: _____ Relationship to patient: _____

Patient Name: _____

Name of Person with Patient: _____

Relationship to Patient: _____

☐ I accept

☐ I decline

_____
Patient Signature/Responsible Party

Consent to Contact

Phreesia

Consent to Contact

Consent to Contact

Orthopedic Center of Colorado
Consent to Contact

Help us communicate with you better! Please use this form to tell us when you would like us to leave messages or discuss your health with others, and how we should contact you with non-urgent news.

1. What name would you prefer to be called? _____

2. How can we contact you about your health? _____

3. Who is okay to discuss your health with?

Name:
Relationship:
Phone:
Release: ☐ Appointment Information ☐ Clinical Information ☐ Financial Information

Name:
Relationship:
Phone:
Release: ☐ Appointment Information ☐ Clinical Information ☐ Financial Information

Name:
Relationship:
Phone:
Release: ☐ Appointment Information ☐ Clinical Information ☐ Financial Information

4.What is okay to discuss or leave a message about? This may include detailed personal information, including medical services to be provided, refills, etc.:

Printed Patient Name:
Date:

Name of Person with Patient:
Relationship to Patient:

This consent will remain in effect until revoked by the patient/representative, or in the case of a minor, on the date the minor becomes an under the state law. Please advise us of changes.

☐ **I Accept**
☐ **I Decline**

Signature _____

ORTHOPEDIC CENTERS OF COLORADO

PATIENT INTAKE AND HISTORY FORM

Today's Date: _____

Name: _____ **Date of Birth:** _____
Primary Care Physician: _____ **Tel:** _____
Primary Care Physician City: _____ **ZIP:** _____
Referral Source: _____ **Tel:** _____

Have you been treated at any Orthopedic Centers of Colorado division in the last 3 years?
☐ Advanced Orthopedic ☐ Cornerstone Orthopaedics ☐ Orthopedic Associates
☐ CCOE ☐ Denver Spine Specialists ☐ Peak Orthopedics
☐ Colorado Orthopedic Consultants ☐ Hand Surgery Associates

Local Pharmacy: _____
(Name/City/Phone #)
Mail Order Pharmacy: _____
(Name/City/Phone #)

REASON FOR COMING TO THE DOCTOR TODAY:
Reason for Today's Visit: _____
Hand Dominance: ☐ Left Hand ☐ Right Hand ☐ Ambidextrous **Shoe Size:** _____
How did the problem start? ☐ Gradual ☐ Suddenly ☐ Exacerbation of an old injury/issue
When did the problem start? _____hour(s) ago _____day(s) ago _____week(s) ago _____month(s) ago
Where did the injury take place? ☐ at home ☐ at work ☐ at school ☐ while playing sports ☐ while playing ☐ during recreational activities ☐ in a motor vehicle accident
Please describe the progression of the problem: ☐ unchanged ☐ fluctuating ☐ resolved ☐ stable ☐ improving ☐ worsening
Describe the severity of the symptoms/pain: ☐ mild ☐ mild to moderate ☐ moderate ☐ moderate to severe ☐ interfering with sleep ☐ incapacitating
How would you describe your pain? ☐ aching ☐ a deep ache ☐ shooting ☐ a burning sensation ☐ throbbing ☐ superficial ☐ a discomfort ☐ a dull ache ☐ burning ☐ cramping ☐ sharp ☐ stabbing
How often does your pain occur? ☐ intermittently ☐ occasionally ☐ frequently ☐ constantly ☐ rarely ☐ during the day ☐ nocturnally
What makes the condition feel worse? _____
What makes the condition feel better? _____
Have you seen another physician for this issue? ☐ no ☐ yes, when and who? _____
_____
What treatments have you tried in the past? ☐ none ☐ application of ice ☐ application of heat ☐ physical therapy ☐ exercise ☐ activity modification ☐ a brace ☐ NSAID ☐ other medication _____ ☐ corticosteroid injections ☐ acupuncture ☐ chiropractic care ☐ other non-surgical treatment: _____ ☐ surgical repair: _____

ALLERGY HISTORY:

☐ **None** ☐ **NKDA (No Known Drug Allergies)**

Metal Allergies: ☐ No ☐ Yes (Details/Reaction): _____

Latex Allergies: ☐ No ☐ Yes (Details/Reaction): _____

Cement Allergies: ☐ No ☐ Yes (Details/Reaction): _____

Medication Allergies: ☐ No ☐ Yes (Details/Reaction): _____

Other Allergies: ☐ No ☐ Yes (Details/Reaction): _____

MEDICATION HISTORY:

☐ I am not currently taking any medications

List any medications, vitamins, minerals, supplements, and alternative/herbal medications that you are currently taking:

Name of Medication	Dose	Frequency	Reason

PROBLEM LIST/PAST MEDICAL HISTORY:

Have you been diagnosed with any of the following (currently or in the past)?

___ Alzheimer Disease
___ Anemia
___ Arthritis
___ Asthma
___ Blood Clots/DVT
___ Cancer: _____
___ Chest Pains
___ Congestive Heart Failure
___ COPD
___ Coronary Disease
___ Crohn's Disease
___ Degenerative Disc Disease
___ Depression
___ Diabetes
___ Drug Abuse
___ Fibromyalgia
___ Fracture
___ Gout
___ Headache
___ Heart Disease
___ Heart Murmur
___ High Blood Pressure
___ High Cholesterol
___ IBS
___ Liver Disease
___ Lupus
___ Lyme Disease
___ Heart Attack (MI)
___ Obesity
___ Osteoporosis
___ Parkinson Disease
___ Peptic Ulcer
___ Psoriasis
___ Scoliosis
___ Seizures
___ Sleep Apnea
___ Spinal Stenosis
___ Spondyloarthropathy
___ Stroke
___ Thyroid Disease
___ Vascular Disease
___ Hist. of Diabetes
___ Other: _____

Do you have any of the following:

___ **History of Joint Infection?** ___ **History of Benign Tumor?** ___ **History of Cancer?**

If yes, please give detailed information, including body location and time period:

FAMILY HISTORY:

Place an "X" under the correct family member with the condition and indicate "P" if the family member passed away due to that condition.

	Mother	Father	Sibling		Mother	Father	Sibling
Alcohol Abuse				Gout			
Anemia				Heart Disease			
Arthritis				Hypertension			
Anesthetic Complications				High Cholesterol			
Anxiety				Kidney Disease			
Asthma				Lung/Resp Disease			
Birth Defects				Migraines			
Blood Disorder				Osteoporosis			
Cancer _____				Seizure Disorder			
Depression				Severe Allergies			
Diabetes, Type I				Stroke			
Diabetes, Type II				Substance Abuse			
Genetic Disease				Thyroid Problems			

Other: _____

PAST SURGICAL HISTORY: ☐ None (Please mark as applicable, date does not need to be exact)

Procedure	Year	Procedure	Year	Procedure	Year
☐ ACL Repair – Left		☐ Cardiac Bypass Surgery		☐ Knee Replacement – Left	
☐ ACL Repair – Right		☐ Cardiac Pacemaker Insertion		☐ Knee Replacement – Right	
☐ Amputation		☐ Cardiac Valve Replacement		☐ Meniscus – Left	
☐ Angioplasty		☐ Carpal Tunnel Surgery – Left		☐ Meniscus – Right	
☐ Appendectomy		☐ Carpal Tunnel Surgery – Right		☐ ORIF Fracture – Left	
☐ Arthroscopic Ankle – Left		☐ Cataract Surgery		☐ ORIF Fracture – Right	
☐ Arthroscopic Ankle – Right		☐ Cholecystectomy/Gallbladder		☐ Rotator Cuff Repair – Left	
☐ Arthroscopic Knee – Left		☐ Colectomy		☐ Rotator Cuff Repair – Right	
☐ Arthroscopic Knee – Right		☐ Colostomy		☐ Small Bowel	
☐ Arthroscopic Shoulder – Left		☐ Gastric Bypass		☐ Thyroidectomy	
☐ Arthroscopic Shoulder – Right		☐ Hernia Repair		☐ Orthopedic: _____	
☐ Back Surgery		☐ Hip Replacement – Left		☐ Other: _____	
☐ Blood Transfusion		☐ Hip Replacement – Right		☐ Other: _____	

Have you experienced any adverse events associated with surgery or anesthesia?

☐ No ☐ Yes, if so, please give pertinent details:

_____

_____

_____

_____

SOCIAL HISTORY:

Please describe your current smoking habits:

☐ Never ☐ Former

Current: ☐ Cigarettes ☐ Vaping ☐ Marijuana ☐ Marijuana Edibles ☐ Chew/Dip

Frequency: ☐ Current every day ☐ Light Occasional ☐ Heavy

Do you drink alcoholic beverages? ☐ Yes ☐ No

If yes, please indicate what type of beverage and how many servings per day: _____

Have you ever used any illicit drugs? ☐ Yes ☐ No

If yes, please indicate what type of drug and how often: _____

How would you rate your exercise level? ☐ Sedentary ☐ Mild ☐ Moderate ☐ Vigorous

---

REVIEW OF SYSTEMS:

Please place a check mark in the box next to any of the following symptoms or problems if you have experienced them recently or have concerns about them. Your doctor will discuss any positive responses with you.

General: ☐Normal
- ☐ Fatigue
- ☐ Chills
- ☐ Fever
- ☐ Unexplained Weight Loss
- ☐ Unexplained Weight Gain

Skin: ☐Normal
- ☐ Blisters
- ☐ Rash
- ☐ Infection or history of MRSA
- ☐ Ulcer

HEENT: ☐Normal
- ☐ Blurred Vision
- ☐ Vision Loss

Respiratory: ☐Normal
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Difficulty Breathing
- ☐ Recent Respiratory Infection
- ☐ Sleep Apnea

Cardiovascular: ☐Normal
- ☐ Chest Pain
- ☐ Fainting
- ☐ Dizziness
- ☐ Murmur

Gastrointestinal: ☐Normal
- ☐ Nausea
- ☐ Vomiting
- ☐ Stomach Ulcer
- ☐ Heartburn

Neurological: ☐Normal
- ☐ Headaches
- ☐ Numbness
- ☐ Dizziness
- ☐ Frequent Falls
- ☐ Fainting
- ☐ Seizures
- ☐ Weakness
- ☐ Tremors
- ☐ Unsteadiness

Psychiatric: ☐Normal
- ☐ Anxiety
- ☐ Depression
- ☐ Drug/Alcohol Abuse

Endocrine/Glands: ☐Normal
- ☐ Unexplained Weight Loss
- ☐ Unexplained Weight Gain
- ☐ Fever
- ☐ Thyroid Problems
- ☐ Diabetes

Hematology: ☐Normal
- ☐ Anemia
- ☐ Easy Bleeding
- ☐ Blood Clots

MSK: ☐Normal
- ☐ Negative except noted in reason for visit
- ☐ Arthritis
- ☐ Osteoporosis
