Colorado Orthopaedics
Excellence | Experience | Compassion

PATIENT REGISTRATION

Last Name ______________________________ First Name___________________________ Middle Initial ______

Address_____________________________________City_____________________State__________Zip __________

Home Phone _____________________ Work Phone ____________________ Cell Phone ___________________

SS# ____________________________ Date of Birth ___________________ Sex ______________

Marital Status_________________Race_____________Preferred Language_____________Religion ___________

Email ____

Employers Name_______________________________ Phone ________________________________

Employer Address______________________________City____________________State________Zip __________

Preferred Pharmacy_____________________________City_________________________Phone _

How did you hear about our office?____

PCP Name____Phone ___________________________________

Emergency Contact____________________________________Phone ___________________________________

INSURANCE INFORMATION

Primary Insurance

Insurance Name________________________Policy #_________________________Phone ____________________

Name of Insured_______________________________________Relationship________________________________

SS#___________________________Date of Birth ___________________________

Employers Name_______________________________Phone __________________________________

Employer Address ______________________________ City__________________State________Zip __________

Secondary Insurance

Insurance Name________________________Policy #_________________________Phone ____________________

Name of Insured_______________________________________Relationship________________________________

SS#___________________________Date of Birth ___________________________

Employers Name_______________________________ Phone ________________________________

Employer Address______________________________City____________________State________Zip __________

I hereby authorize all providers of Colorado Orthopaedics, PC to treat the patient identified above. I acknowledge that I am responsible to pay all charges for all treatments administered by the physician to the patient. I understand that insurance may not pay for all charges and I understand that I am obligated to pay for all charges not paid by insurance. I also agree to pay reasonable attorney fees if my account is turned over to an attorney or collection agency. I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for non covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims.

I acknowledge that I received a copy of Colorado Orthopaedics Notice of Privacy Policies and Practices.
I acknowledge that I received a copy of Colorado Orthopaedics Notice of Nondiscrimination.

Signature of Patient / Authorized Person____Date _________________

PATIENT HIPAA QUESTIONNAIRE

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

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II. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name___________________________________ Phone___________________________

Name___________________________________ Phone___________________________

III. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

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IV. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":

YES_______________NO_______________

V. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number:
( )_____________________________

* **I am fully aware that a cell phone is not a secure and private line.**

** **I am fully aware my health information can be transmitted by facsimile (fax), mail or the internet.**

VI. Can confidential messages (i.e., appointment reminders) be left on your home answering machine or voicemail?

YES______________ NO ______________

PATIENT NAME____

PATIENT/GUARDIAN SIGNATURE____

DATE _______________________________________

Financial Policy

Our commitment is to provide the very best care to our patients while recognizing the need to limit services to only those that are necessary for each patient. To meet this commitment, we recognize the need for a definite understanding and agreement concerning our patient's health care and financial arrangements for that medical care. Your clear understanding of our financial policies is important to our professional relationship. Please contact our billing office regarding any questions about our fees, financial policies, or your insurance coverage and your responsibilities.

Professional fees: Our fees for medical services are comparable to other similarly trained physicians in the community and reflect the complexity of your specific needs, the physician time dedicated to your care, the specialized nature of the doctor's training and education, supplies, and support costs associated with providing and coordination your care.

Patient Payments: Co-payment, deductibles, services not covered by your insurance plan or outstanding balances are due at the time of your appointment (per your contract with the insurance). Payment may be made by: cash, check, or credit card.

Insurance Payments: We participate and assignment of payment with **specific** insurance plans in the area. When the correct insurance information is provided, we will submit your claims as a courtesy to you, our patient. Your insurance coverage is a contract between you and your insurance plan. You are responsible for unpaid balances left on your account regardless of the amount your insurance coverage.

Referrals/Authorization: It is your responsibility to obtain any referral/authorization required by your insurance carrier prior to services being rendered. Failure to obtain required referral/authorization will result in you being responsible for the full balance.

Self-Pay
Patients who are not billing a third party or health insurance are required to pay at the time of service for all office services at the time of service and will receive a 15% discount off our fee schedule. All procedures requiring services at a facility (hospital or surgery center) are pre-paid to the office within one (1) business day and will receive a 15% discount. If payment is not received within the specified time period, the procedure will need to be rescheduled.

Additional Fees:

Missed appointments: As a courtesy, we will make our best effort to provide you with a reminder call at least 48 hours in advance of your appointment. Please understand your appointment is time that has been reserved for your needs and that your lack of attendance at that visit prevents others from receiving care at that particular time. To assist patients with access to our physicians, we will charge a fee of $50.00 for any office appointment not canceled 24 hours in advance.

Medical Forms: The completion of disability forms, attending physician statements and other supplemental insurance forms require additional physician and staff time. A fee of $20.00 will be charged for these forms.

Collection Agencies: If it becomes necessary to place your account with a third party collection agency due to your non payment, the account of the person responsible will be turned over to collections, and the patient will be dismissed from our practice.

Checks not honored (returned checks) by your financial institution may incur **a** $20.00 charge or be placed immediately with a third party collection agency for collection.

Your signature on this page constitutes an agreement to this policy.

____ ____________
Patient or Guarantor Signature **Date**

Printed Name ____

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For Our Patient's Information: An Explanation of Medical Insurance

Misunderstandings about medical insurance have become increasingly common since "managed care" revolutionized the medical insurance industry. At one time it was not unusual for insurance to cover 100% of the cost of services provided during a medical visit. However, this is rarely the case at the current time. The discussion that follows will help you evaluate your insurance coverage for treatment obtained through this office.

Your Insurance Contract

A claim from our office for all services provided to you (office visits, procedures, surgery, etc.) will be sent to your insurance company. The amount that your insurance pays to the physician (provider) as reimbursement for these services – **and the amount that must be paid by you** – is determined by the contractual agreement between you and your insurance company. That agreement most likely states that you, the insured, are responsible for several types of payments. These include:

- **Copayment**
  Copayment is the amount that your insurance company requires you to pay to the physician at the time of the service (office visit). Depending on the type of service being rendered, you may be required to pay a copay with each visit.

- **Deductible (per calendar year)**
  The deductible is the amount that your insurance requires **you to pay** for services rendered before the insurance company will begin paying for benefits.

- **Co-Insurance (per calendar year)**
  After your deductible has been met, your insurance company will pay for all or part of the expenses according to your agreement with the insurance company. The amount that your insurance company pays will vary from 0% to 100%, with common options being 90% / 10% and 80% / 20%. This means that you (the patient) will be responsible for a percentage of the expenses (up to a maximum) beyond the deductible and your insurance company will be responsible for a percentage. The percentage amount is determined by your contract with your insurance company.

The terms under which insurance policies establish these limitations on reimbursement vary widely among policies and depend on your individual contract and plan benefits. We will contact your insurance company and verify your individual plan benefits (copay, deductible, co-insurance) and inform you of these benefits. We also encourage you to contact your insurance company to verify your plan benefits.

EFFECTIVE IMMEDIATELY – IT IS OUR OFFICE POLICY TO COLLECT YOUR COPAY and ACCOUNT BALANCES WHEN YOU CHECK-IN FOR YOUR APPOINTMENT.

ACKNOWLEDGEMENT OF NOTICE

I acknowledge receipt of Colorado Orthopaedics Notice of Privacy Policies & Practices.

I acknowledge receipt of Colorado Orthopaedics Notice of Nondiscrimination.

Patient's Printed Name____

Patient Signature ____

Date ___________________________________