New Patient Intake (Part I)
Patient Information

FIRST NAME	**MIDDLE INITIAL**		**LAST NAME**		
DATE OF BIRTH (D/M/YR)	**AGE**	**Gender (M/F)**	**Todays Date (M/D/YR)**		
Email Address	**Street Address**		**City**	**State**	**Zip Code**
Home Phone	**Cell Phone**		**Work Phone**		
Do We have permission to Call and text you? (Y/N)					
Primary Insurance	**Member Number**		**Insurance Phone Number (if known)**		
Secondary Insurance	**Member Number**		**Insurance Phone Number (if Known)**		
Pharmacy of Choice	**Pharmacy Cross Street**		**Pharmacy Phone (if known)**		
Primary Care Physician	**Physician's Office Name/Location**				
If Patient is a minor Please complete the Below					
Relationship to Patient (Circle One) **Father Mother Guardian Other (please state)_____**					
Parent First Name	**Parent Last Name**		**Parent Phone (if Different than Above**		
Address (if Different than above)	**Email (If Different than above)**				
Is the Patient using your insurance? If not what is the relationship between the patient and the insurance holder?					

New Patient Intake (Part II)
Privacy, Permissions, Disclosures and Certifications

Financial Policy and Assignment of Benefits

I, _____(Print Name) do hereby authorize Colorado Orthopedics and Sports to bill my health insurance company_____(name of Health Insurance Company) for services rendered by Colorado Orthopedics and Sports. I also agree to have any checks or payment made by said insurance company to be payable and deliverable to:

Lionel Gottschalk LLC
4386 Trail Boss Drive Suite B
Castle Rock, Colorado 80104

By signing this document, I also agree to the following statements below:

APPOINTMENTS
Copays and Deductibles: Copays and deductibles are due at the time of service, in accordance with your insurance carrier's plan. If you are unable to make your payment at the time of service, Colorado Orthopedics and Sports reserves the right to reschedule your appointment until such time that you can make your payment.

Procedure and Payment: As a courtesy to our patients, this office will bill third party payers, accept assignment, and wait to be paid for some portion of our patients' financial responsibility. Colorado Orthopedics and Sports may collect prepayment based on an **estimate** of your expected financial responsibility. We will help you make the best estimate of your coverage for recommended services. **This service is a courtesy to you and is not a guarantee of coverage**. You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurance carrier will be your responsibility. In the event of overpayment, you may request a refund.

Self-Pay: If you do not have health insurance, or if your health insurance will not pay for services from Colorado Orthopedics and Sports or if you notify us to not contact or bill your insurance company, you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule which can be made available on request. It is our office policy that payment for services is due at the time of service.

Missed Appointments and Late Arrivals: You will be charged a fee for each incident according to Colorado Orthopedics and Sports fee schedule. These charges are your responsibility and will not be billed to the insurance carrier.

Coverage changes and timely submission: It is the patient's responsibility to timely inform Colorado Orthopedics and Sports of any change in demographics, marital status, or coverage. Your insurance carrier places a time limit within which Colorado Orthopedics and Sports can submit a claim on your behalf. If Colorado Orthopedics and Sports is unable to process your claim within this period due to your providing incorrect information or not responding to insurance carriers' inquiries, you will be responsible for all charges.

BENEFITS AND AUTHORIZATION
Insurance Plan Participation: We participate in most major health insurance companies, however, there may be select plans that we do not participate with. It is your responsibility to contact your insurance carrier to verify that your assigned provider participates in your plan. If we do not participate with your specific plan, we will work with you to determine the amount of coverage and estimate your responsibility.

Referrals: Referral requirements vary among insurance providers. If your insurance requires a referral, it is the patient's responsibility to obtain referrals for Colorado Orthopedics and Sports, prior to your appointment.

Prior Authorization and Non-Covered Services: Colorado Orthopedics and Sports may perform services that require pre-authorization. As a courtesy to our patients, we will make a good faith effort to determine if the services we provide are covered by your insurance plan; if so, determine if prior authorization is required. It is determined that prior authorization is required we will attempt to obtain authorization on your behalf. It is ultimately your responsibility to ensure treatments are covered by your insurance plan.

ACCOUNT BALANCES AND PAYMENTS
Reassignments of Balances: If your insurance has not paid on an assigned bill within 60 days, you will be notified. Since we do not own your policy, we ask that you stay in communication with our office and take action with your insurance company at that time. If it remains unpaid within 120 days, the balance will be transferred to your responsibility, and it will become due and payable immediately and your assignment is revoked. Balances are due 30 days after receiving the initial statement.

Collection of Balances and Unpaid Accounts: Should you discontinue care for any reason, other than discharge by the doctor, any and all balances will become due and payable at that time. If you are on a predetermined payment plan, that plan will continue to be in effect until your balance is zero. If you have an outstanding balance over 12o days old and have failed to make payment arrangements, we may turn your balance over to a collection company for collection. **Colorado Orthopedics and Sports reserves the right to refuse treatment to patients with outstanding balances over 120 days.**

Returned Checks: Should payment be refused by your bank for any check written, this office will charge a fee of $25 to offset the charges we will incur as a result of the returned check.

ADDITIONAL FEES:

Medication refill requests: All medication refill requests are to be approved by your provider. If approved by your provider, a fee will be charged according to the Public Fee Schedule for lost prescriptions and refills processed after a missed appointment, with a **one-time** exception.

The undersigned does agree to observe and abide by all of the statements made above

Patients Signature (or guardian's signature): _____Date_____

HIPPA (Health Insurance Portability and Accountability Act

1. The Practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me and also necessary for the Practice to obtain payment for that treatment and to carry our tis heath care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent
2. The practice reserves the right to change it privacy practices that are described in its Privacy Notice, in accordance with applicable law. I understand and consent to, the following appointment reminders that will be used by the Practice: a) telephoning my home or cell phone and leaving a message on the answering system or with the individual answering the phone, b) sending an email message to the email address I have provided
3. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
4. I understand that I have the right to request that the practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and /or health care operations. However, the Practice is not required to any restrictions that I have requested. If the Practice agrees to a requested restriction, the restriction is binding on the practice
5. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
6. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
7. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Act Notice, then the Practice will not treat me.

Patients' Signature (or Guardians' signature_____ Date__ _____

HIPAA DISCLOSURES

Would you like our correspondence with you to be marked confidential? YES NO

May we identify ourselves to the person answering the phone number you provided? YES NO

I, the Patient, hereby authorize Colorado Orthopedics and Sports to release my medical information (appointments, lab/X-Rays and Results, diagnosis, treatments, medications, surgeries, etc.). via postal mail, telephone, fax, or email to the following family:

Name_____ DOB_____ Relationship_____

Name_____ DOB_____Relationship_____

Name_____ DOB_____ Relationship_____

I further release my medical information maintained by Colorado Orthopedics and Sports to the following physicians, clinics and/or hospitals

Doctor_____ Clinic_____ Phone_____

Doctor_____ Clinic_____ Phone _____

Doctor_____ Clinic_____ Phone _____

This information is important in the doctor obtaining a clinical picture to make an appropriate diagnosis and treatment plan. Please sign below authorizing that the information in this form has been read and filled out completely and accurately to the best of your understanding. Also, understand that the information in this form is considered confidential and for use by your doctor at Colorado Orthopedics and Sports. Any disclosure is outlined in our privacy policies.

Patient Printed Name (or guardian printed name) _____ Date_____

Patient Signature (or guardian signature) _____Date_____

Surprise/Balance Billing Disclosure Form

Surprise Billing — Know Your Rights

Beginning January l, 2020, Colorado state law protects you* from "surprise billing," also known as "balance billing." These protections apply when:

- You receive covered emergency services, other than ambulance services, from an out-of-network provider in Colorado, and/or
- You unintentionally receive covered services from an out-of-network provider at an in-network facility in Colorado

What is surprise/balance billing, and when does it happen?

If you are seen by a health care provider or use services in a facility or agency that is not in your health insurance plan's provider network, sometimes referred to as "out-of-network," you may receive a bill for additional costs associated with that care. Out-of network health care providers often bill you for the difference between what your insurer decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

When you CANNOT be balance-billed:

Emergency Services

If you are receiving emergency services, the most you can be billed for is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility where you receive emergency services and any providers that see you for emergency care. Nonemergency Services at an In-Network or Out-of-Network Health Care Provider

The health care provider must tell you if you are at an out-of-network location or at an in-network location that is using out-of network providers. They must also tell you what types of services that you will be using may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. In this case, the most you can be billed for covered services is your in-network cost-sharing amount, which are copayments, deductibles, and/or coinsurance. These providers cannot balance bill you for additional costs.

Additional Protections

- Your insurer will pay out-of-network providers and facilities directly.
- Your insurer must count any amount you pay for emergency services or certain out-of-network services (described above) toward your in-network deductible and out-of-pocket limit.
- Your provider, facility, hospital, or agency must refund any amount you overpay within sixty days of being notified.
- No one, including a provider, hospital, or insurer can ask you to limit or give up these rights.

I(you receive services from an out-of-network provider or facility or agency OTHER situation. You may still be balance billed, or you mav be responsible (or the entire bill. If you intentionally receive non emergencv services from an out-of-network provider or facility. You mav also be balance billed.If you want to file a complaint against your health care provider, you can submit an online complaint by visiting this website: https:/mww.colorado.gov/pacific/dora[DPO File Complaint.If you think you have received a bill for amounts other than your copayments, deductible, and/or coinsurance, please contact the billing department, or the Colorado Division of Insurance at 303-894-7490 or 1-800-930-3745.

_____

Name of Patient or Responsible Party_____

Signature of Patient or Responsible Party_____ Date_____

COLORADO ORTHOPEDICS & SPORTS

Patient Intake form

Part III Patient Clinical and Demographics

Patient Name_____

History of Present Illness			
Referring Physician		**Primary Care Physician**	
Reason For Todays Visit			
Date in which injury or symptoms occured		**I am right left Handed (circle one)**	
Did you have similar symptoms prior to the Injury? Or Previous Injury to the same area		**Yes NO**	
Previous Diagnostic Testing			
Xray of the _____ Date _____ Facility_____			
MRI of the _____ Date_____ Facility_____			
EMG/NCV Study of the _____ Date_____ Facility_____			
Ultrasound of the_____ Date_____ Facility_____			

Hospitalizations and Surgeries		
Date	**Surgery (if Applicable)**	**Reason**

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Patient Intake form
Part III Patient Clinical and Demographics
(Page 2)

Please List any Medications you are currently on. Include over the counter meds		
Medication Name	**Dose**	**Times per day**

DRUG ALLERGIES (PLEASE CIRCLE)				
NONE	**PENICILLIN**	**CODEINE**	**DEMEROL**	**ASPRIN**
OTHER				
IF YES TO ANY ABOVE EXPLAIN REACTION (Rash etc)				

WHAT ARE YOUR OTHER ALERGIES AND YOUR REACTIONS	
ALLERGY	**REACTION**

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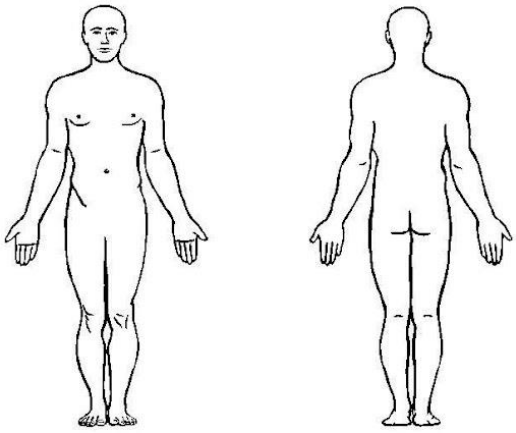
Patient Intake form
Part III Patient Clinical and Demographics
(Page 3)

Using the appropriate symbols below, please mark the affected areas
N=Numbness W=Weakness B=Burning Pain S=Shooting Pain A=Aches T=Tingling



USING THE SCALE BELOW PLEASE INDICATE YOUR <u>CURRENT</u> PAIN

0 1 2 3 4 5 6 7 8 9 10
NONE MILD PAIN MODERATE SEVERE WORST POSSIBLE

Is this the result of an injury? If so please explain how the injury occurred below:

_____

How long ago did the injury Occur?_____

What activity makes the pain better?_____
What activity makes the pain worse?_____

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Patient Intake form
Part III Patient Clinical and Demographics
(Page 4)

PLEASE CIRCLE ANY OF THE FOLLOWING SYMPTOM CONDITIONS THAT MAY APPLY TO YOU

Eyes

Blurred Vision **Double Vision** **Loss of Vision** **Contacts/Glasses/Lasik**

Ears/Nose/Throat

Hearing Loss **Trouble Swallowing** **Loss of Smell** **Loss of Taste**

Cardiovascular

Chest pain **Palpitations** **Irregular Heartbeat** **High Blood Pressure**
History of Heart Attack **History of Heart Failure** **Pacemaker**

Respiratory

Shortness of Breath **Asthma** **Emphysema** **Sleep Apnea**

Hematologic

Bleeding Problems **Bruise Easily** **Use of Blood Thinners** **Swollen Glands**

Musculoskeletal

Joint Pain **Osteoporosis** **Arthritis** **Rheumatoid Disease** **Swelling of Joints**

Muscle aches and pains **Muscle weakness** **Back Pain**

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Patient Intake form
Part III Patient Clinical and Demographics
(Page 5)

Neurologic

Headaches/Migraine Dizziness Unsteadiness Numbness Tingling Weakness

Phycological

Depression Sleep Disorder Addiction

Gastrointestinal

Frequent Nasua or Vomiting Frequent Heartburn Non-Digestion Frequent Diarrhea

Abdominal Pain Constipation

Social Lifestyle (Please circle where appropriate)

Marital Status Married Single Divorced Widowed Separated

Other Please Explain _____

Are you a Smoker Yes No If ever a smoker how long ago and for how long_____

Do you Drink Alcohol Yes No Drinks per day_____ Week_____ Month_____

At this time I am: Working Full Time Working Part Time Unemployed Retired

History of Addiction or Substance Abuse, overdose or family history of abuse Yes No

Do you exercise? Yes No If so how many days per week_____

What type of exercise do you preform Walking Cycling Cardio Strength Swimming

Other exercise type, please explain_____

Female only

Are you currently pregnant Yes No. If you are pregnant how many weeks?_____

The information I have provided is true and complete to the best of my knowledge:

Patient (or legal guardian) Signature_____Date_____