Colorado Springs Orthopaedic Group

csog.net

PATIENT ACKNOWLEDGEMENT FORM

We are pleased that you have chosen our group of specialists for your orthopaedic care. We are providing this information to you ahead of time to make your visit to our office as convenient as possible.

REFERRALS

Based on your insurance plan, you may need a referral from your primary care physician (PCP) to see an orthopaedic physician. **Referrals are your responsibility** and are generated by your PCP's office, then submitted to the insurance company. Once approved, the insurance company will send you a copy—**Please bring a copy of your referral with you.** Your appointment will be rescheduled if you do not have a valid referral.

CONSENT TO TREAT

I voluntarily consent to and authorize the rendering of health care services, including routine clinical services, and/or physical and occupational therapy. I am aware that physical. Occupational therapy treatment utilized hands on techniques which require the therapist to touch my body as a part of the therapeutic process.

LATE OR MISSED APPOINTMENT/ NO SHOW

We take great care in crafting the schedules of the physicians/providers to accommodate as many people as possible. If you are late for your appointment, we will do our best to work you in when you arrive, but please understand that you may be asked to reschedule if we are unable to accommodate. Please call ahead and let us know if you will be late or need to reschedule an appointment at 719-632-7669. Please be aware 2 "no show" appointments with any and all practice physicians within a rolling 12 month period will result in not being seen by any physician for 1 year from the date of the last "no show" unless you are willing to pay a $100 fee.
We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting needed treatment. If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar ($50) fee. This fee will not be covered by your insurance company and is required to be paid at the time of your next visit.

SECTION 1557

Colorado Springs Orthopaedic Group complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

SERVICE & EMOTIONAL SUPPORT ANIMALS

Per ADA requirements, service animals are permitted at Colorado Springs Orthopaedic Group. Due to liability reasons, companion and emotional support animals will not be permitted.

MEDICAL RECORDS

Your Driver's License or Government issued photo ID is required when picking up prescriptions and medical records. Please be advised that a fee may be assessed for any medically related documents.

AUDUBON ORTHOTIC & PROSTHETIC SERVICES

If your Colorado Springs Orthopaedic Group provider refers you to AOPS for any orthotic or prosthetic care, please note that all paperwork included in this packet will be accepted and transmitted securely to AOPS. AOPS is a licensed DBA of Colorado Springs Orthopaedic Group.

ACKNOWLEDGEMENTS

_____ I acknowledge that I reviewed the **CSOG Cancellation, No-Show & Late Patient Policy**. I have read, understand and agree to the provisions of the policy.

_____ I acknowledge that I reviewed the **Notice of Privacy Practices.** I have read, understand and agree to the provisions of the policy.

_____ I acknowledge that I received a copy of **House Bill 19-1174 Out of Network**.

Patient or legally authorized individual signature Date

FINANCIAL AGREEMENT

Thank you for choosing Colorado Springs Orthopaedic Group as your orthopedic provider. We are committed to delivering outstanding healthcare and customer service. The following is our current financial policy.

FOR PATIENTS WITH HEALTH INSURANCE

Colorado Springs Orthopaedic Group will submit an accurate claim to all contracted insurance as a courtesy to our patients. This will require information to be provided by the patient at each visit to ensure timely payment processing . Should the patient not provide accurate insurance data, the bill will become due by the patient at the time the insurance denies payment.

Colorado Springs Orthopaedic Group CANNOT waive copays, deductibles, coinsurance, or non-covered service amounts defined as patient responsibility under the terms of our contact with your health insurance. Patient copays are expected at the time of service.

FOR OUT-OF-NETWORK PATIENTS

In cases where Colorado Springs Orthopaedic Group is not recognized as a participating provider and considered Out-of-Network (OON), Colorado Springs Orthopaedic Group may elect to notify and provide full disclosure upon submission of a claim to the patient's insurance carrier that Colorado Springs Orthopaedic Group will offer a discount to the patient as their insured member. Colorado Springs Orthopaedic Group will bill the patient's insurance carrier its full charge and then discount the patient portion of the payment to usual and customary as defined by the insurance carrier. Should the patient's insurance carrier offer payment to Colorado Spring Orthopaedic Group at the discounted rate offered to the patient, Colorado Springs Orthopaedic Group will accept the payment from the insurer as payment in full. At no time, is Colorado Springs Orthopaedic Group charging two different prices for the same service, nor is pricing based on the fact than an insurance company may be paying for all or a part of the service rendered. This is not a waiver or a discount of any copayment, coinsurance or deductible amounts owed for services rendered and is not offered and should not be interpreted as an "inducement" to have services rendered.

I authorize Colorado Springs Orthopaedic Group and their billing company to negotiate, discuss, and in any other way, communicate with my insurance company in those areas relative to OON reimbursements, methodology used in OON negotiation and affair negotiation of final payment. I authorize Colorado Springs Orthopaedic Group and its billing company to accept or reject agreements, to enter into contracts binding upon final adjunction of claims and negotiations, and to act in whatever way necessary so as to accomplish that which is being undertaken.

FOR AUTO ACCIDENTS/LIABILITY PATIENTS

Colorado Springs Orthopaedic Group does not bill third party insurance.

METHODS OF PAYMENT

Colorado Springs Orthopaedic Group accepts all major credit cards, checks and cash.

PAST DUE ACCOUNTS

All patient responsible balances should be paid at the time the statement is received. After 90 days your account will be become delinquent. If the account remains delinquent, the patient will be unable to schedule any further appointments until the debt has been settled.
Thank you for your understanding of our financial policy. If you have any questions regarding this policy or you account, please contact our billing department at 719-867-9346 or email statements@csog.net.
I have read and understand the financial policy of the practice and I agree to its terms. I also understand that the terms may be amended by the practice.

Patient or legally authorized individual signature

Date

Printed name

Date of birth

Colorado Springs Orthopaedic Group

Quick DASH

TODAY'S VISIT

Patient Name: _____ Date: _____

Please rate your ability to do the following activities in the last week by circling the corresponding number.

	NO DIFFICULTY	MIL D DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
Open a tight or new jar	1	2	3	4	5
Do heavy household chores (e.g. wash walls, floors)	1	2	3	4	5
Carry a shopping bag or briefcase	1	2	3	4	5
Wash your back	1	2	3	4	5
Use a knife to cut food	1	2	3	4	5
Recreational activities in which you take some force or Impact through your arm, shoulder or hand (e.g. golf, hammering, tennis, etc.)	1	2	3	4	5

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTERMELY
During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities ?	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMTED	MODERATELY LIMITED	VERY LIMITED	UNABLE
During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5

Please rate the severity of the following symptoms in the last week by circling the corresponding number.

	NONE	MILD	MODERATE	SEVERE	EXTREME
Arm, shoulder or hand pain	1	2	3	4	5
Tingling (pins & needles) in your arm, shoulder or hand	1	2	3	4	5

	NO DIFFICULTY	MIL D DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand?	1	2	3	4	5

FOR OFFICE USE ONLY

Quick Dash DISABILITY/SYMPTOM SCORE = (sum of n responses/n-1) x25, where n is = to the number of completed responses. A Quick Dash score many not be calculated if there is greater than 1 missing item.

SCORING THE OPTIONAL MODULES: Add assigned values for each response; divide by 4(number of items); subtract 1; multiply by 25. An optional module score may not be calculated if there are any missing items.

SCORE: _____

Colorado Springs Orthopaedic Group

Date:_____ Name: _____ Age: _____

Primary Care MD:_____ Height:_____ Weight:_____

Condition	Yes	No	Condition	Yes	No	List all medications you
Tuberculosis			Fainting/dizziness/falls/imbalance			
Cancer			Pregnancy			
Ulcers			Hernia			
Low/High Blood Pressure			Fracture			
Bowel or Bladder Problems			Alcoholism/chemical dependency			
Neck Injury			Blood clots			
Back Injury			Kidney disease			
Arthritis/Joint Swelling			Epilepsy/Seizures			
Headaches/Migraines			Hearing loss/ringing in ears			
Hepatitis			Cataracts/Glaucoma/Macular Degeneration			
Allergies/Asthma			Do you exercise regularly?			
Heart problems/Pacemaker/Chest Pain			Do you smoke?			
Diabetes/Neuropathy			Are you in a relationship where you are being hit, kicked, slapped or otherwise			
HIV/AIDS			Do you feel safe at home?			
Stroke/head/brain injury			Other:			
Shortness of breath						

If you checked yes to any of the above, please comment:

_____

_____

Number of time you have fallen in the past year: _____

Please mark your area of discomfort or dysfunction on the body diagrams:

When did you first notice pain/problem or have functional limitations due to this condition?

First Episode: _____

Subsequent Episode: _____

Most Recent Episode:_____

How did your Injury/Symptoms Occur? _____

If you have pain please complete the follow pain scale:
(0-No Pain: 10-The Worst Pain You Can Imagine)

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐