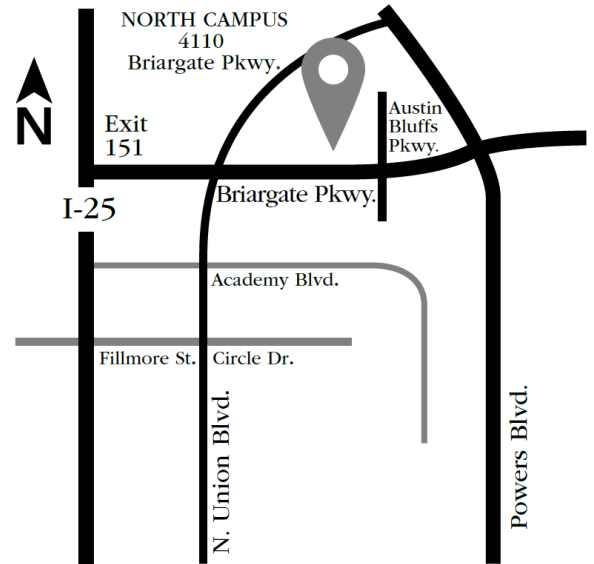


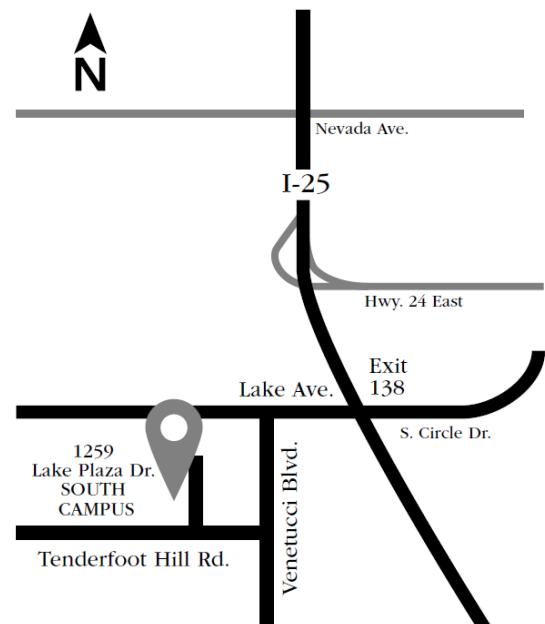
NORTH CAMPUS

4110 Briargate Parkway, Suite 300
Colorado Springs, CO 80920



SOUTH CAMPUS

1259 Lake Plaza Drive, Suite 100
Colorado Springs, CO 80906



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.

CO-PAYMENTS

These are the amounts that you have agreed with your insurance company to pay at each doctor's office visit.

INSURANCE CLAIMS

We will, for your convenience, submit your health claims using the insurance information that you have provided. If you change insurance coverage, please be sure to let us know when you come in. Be aware that many insurance plans include deductible amounts that are also your responsibility. Please be prepared to pay these amounts at your next visit.

LATE OR MISSED APPOINTMENT/ NO SHOW

We take great care in crafting the schedules of the physicians 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 twenty five dollar (\$25) 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 REGISTRATION

Today's Date: _____

Legal Last Name: _____ First: _____ MI: _____ DOB: _____ Age: _____

Mailing Address: _____ City: _____

State: _____ Zip Code: _____ SSN: _____ Male Female

Primary Phone Number: _____ Secondary Phone Number: _____

Email: _____ Marital Status: Single Married Separated Divorced Widowed

Emergency Contact: _____ Phone Number: _____ Relationship to Patient: _____

Race/Ethnicity: _____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

How did you hear about us? Friend/Family Physician Web TV Seminar School Other _____

If other than a physician, to whom may we thank for your referral? _____

Pharmacy Preference & Address: _____

MINOR INFORMATION

Responsible Party Name: _____ DOB: _____

Best Contact Number: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip Code: _____

INSURANCE INFORMATION

Primary Insurance: _____	Secondary Insurance: _____
Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Other	Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Other
If other, policy holder name: _____	If other, policy holder name: _____
DOB: _____ Subscriber ID #: _____	DOB: _____ Member ID #: _____
Group # _____ Copay Amount: _____	Mailing Address (if different than above): _____

INSURANCE AUTHORIZATION

Insurance Authorization and Assignment of Benefits:

I authorize the physicians and physicians' assistants at Colorado Springs Orthopaedic Group to treat my illness or injury. I hereby authorize the release of any medical information necessary to process my claim and I authorize payment of medical and surgical benefit to Colorado Springs Orthopaedic Group.

Patient or legally authorized individual signature

Date

Relationship to Patient:

Section 1557, Affordable Care Act: 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.

PATIENT HISTORY

TODAY'S VISIT

Patient Name: _____ DOB: _____

Reason for today's visit: _____

Body part for injury/pain? _____ What date did the current pain/injury start? _____

How long have you had these symptoms? _____ Pain level on a scale from 1-10, 10 being worst? _____

Height: _____ Weight: _____ Hand Dominance: Left Right Ambidextrous

Describe the injury or symptoms and include where it is located (specify left or right side): _____

Is this a work-related injury/pain? Yes No

Have you had surgery for this problem? Yes No

Is this an auto-related injury/pain? Yes No

Have you filed a claim? Yes No

Date of injury: _____

Employer: _____

Employer Contact: _____

Phone Number: _____

MEDICATIONS

Please list any medication(s) you are currently taking including prescribed medications, vitamins, supplements and over-the-counter medications.

Medication	Dosage/Directions	How Often	Reason

Chronic Pain Management? Yes No Treating Physician: _____ How often? _____

ALLERGIES

Please list all medical allergies and tell us how you react to them.

Allergy	Reaction

Are you allergic to latex? Yes No

Are you allergic to iodine or Betadine? Yes No

Are you allergic to adhesive tape? Yes No

Are you allergic to metal? Yes No

Are you allergic to contrast dye? Yes No

Are you allergic to birds/feathers/eggs? Yes No

PATIENT HEALTH HISTORY

PAST MEDICAL HISTORY

Please check all conditions you have now or have had in the past.

CARDIOVASCULAR

- Angina (chest pain)
- Arrhythmia/Irregular Heartbeat
- Blood Clot/DVT (Deep Vein Thrombosis)

Date Occurred: _____

- Heart Disease/Coronary Artery Disease
- High Cholesterol/Hyperlipidemia
- MVP (Mitral Valve Prolapse)
- Pacemaker
- Varicose Veins/Peripheral Vascular Disease
- Hypertension/High Blood Pressure
- Stent - Date Inserted: _____
- AICD (Automatic Implantable Cardioverter Defibrillator)

PULMONARY (Lungs & Respiratory)

- Asthma
- COPD (Chronic Obstructive Pulmonary Disease)
- PE (Pulmonary Embolism/Blood Cot in Lung)

BONES, JOINTS & MUSCLES

- Arthritis
- Degenerative Joint Disease
- Fibromyalgia
- Gout
- Osteoporosis
- Scoliosis

CANCER

- Type: _____

Date Occurred: _____

- Sleep Apnea
- TB (Tuberculosis)

GENITOURINARY (Kidneys & Urinary Tract)

- Renal Failure
- Renal Insufficiency
- UTI (Urinary Tract Infection)
- Currently Pregnant

GASTROINTESTINAL

- Gastric Ulcer
- GERD
- Hepatitis—Type: _____
- Hernia
- Peptic Ulcer
- Liver Disease

HEMATOLOGIC (Blood & Lymph Node)

- Anemia
- Edema
- Lupus
- Hemophilia
- Sickle Cell Disease
- Clotting Disorders

HEENT (Head, Ears, Eyes, Nose & Throat)

- Blind
- Deaf
- Hearing Loss

NEUROLOGIC DISORDER

(Brain & Nervous System)

- Alzheimer's Disease
- Dementia
- Multiple Sclerosis
- Parkinson's Disease
- Seizure Disorder
- Stroke/CVA

Date Occurred: _____

- Myasthenia Gravis
- Muscular Dystrophy

METABOLIC (Endocrine, Hormones & Metabolic)

- Diabetes—Type I
- Diabetes—Type II
- Thyroid Dysfunction
 - Hypothyroidism
 - Hyperthyroidism

PSYCHIATRIC DISORDER

(Mental Health)

- Anxiety
- Bipolar Disorder
- Depression

REVIEW OF SYSTEMS

Please check all conditions you are currently experiencing.

CONSTITUTIONAL

- Unexpected weight loss
- Weight gain
- Fever
- Chills
- Fatigue

EYES

- Corrective lenses
- Blurred/double vision
- Eye pain
- Redness/watering

ENT

- Headache
- Difficulty swallowing
- Nose bleeds
- Ringing in ears
- Earaches

CARDIOVASCULAR

- Chest pain
- Palpitations
- Fainting
- Murmurs

ALLERGIC

- Reaction to foods/environment

RESPIRATORY

- Shortness of breath
- Wheezing
- Cough
- Tightness
- Inspiration pain
- Snoring

GASTROINTESTINAL

- Heartburn
- Nausea
- Vomiting
- Constipation
- Diarrhea
- Bloody/tarry stool

GENITOURINARY

- Difficult/painful urination
- Frequent urination
- Blood in urine

MUSCULOSKELETAL

- Joint pain
- Swelling
- Instability
- Stiffness
- Redness
- Muscle pain

SKIN

- Skin changes
- Poor healing
- Rash
- Location: _____
- Itching/redness

NEUROLOGIC

- Numbness/tingling
- Unsteady gait
- Dizziness
- Tremors
- Seizure

PSYCHIATRIC

- Nervousness
- Anxiety
- Depression
- Hallucinations

HEMATOLOGIC

- Easy bleeding
- Bruising

ENDOCRINE

- Excessive thirst/urination
- Heat/cold intolerable

OTHER MEDICAL CONDITIONS NOT LISTED ABOVE: _____

PATIENT HEALTH HISTORY

PAST SURGICAL HISTORY

Heart Surgery: Stent Bypass Other : _____

Please list other surgeries (Left/Right as appropriate);

FRACTURES: _____

PROBLEMS WITH PAST ANESTHESIA (IF YES, PLEASE LIST): _____

PROBLEMS WITH PAST BLOOD CLOTS

FAMILY HISTORY

Check the boxes if a **blood relative** has been diagnosed with the following and indicate if s/he is deceased Y/N

	Relationship	Deceased		Relationship	Deceased
<input type="checkbox"/> Anesthesia Problems	_____	Y/N	<input type="checkbox"/> Osteoporosis	_____	Y/N
<input type="checkbox"/> Arthritis	_____	Y/N	<input type="checkbox"/> Diabetes	_____	Y/N
<input type="checkbox"/> Bleeding/Clotting Problems	_____	Y/N	<input type="checkbox"/> Family History Unknown		
<input type="checkbox"/> Cancer: type _____	_____	Y/N	<input type="checkbox"/> No Significant Family History		
<input type="checkbox"/> Heart Disease	_____	Y/N	<input type="checkbox"/> Muscular Dystrophy		

SOCIAL HISTORY

Do you currently use tobacco? Yes No Which kind: _____

Do you currently vape? Yes No

Do you currently use CBD products? Yes No

Do you currently drink alcohol? Yes No Quantity per day: _____

Do you use marijuana? Yes No

Current/Former Illicit Drug Use: No Current: Type: _____ Past Type: _____

Date Quit: _____

Are you currently employed? Yes No Retired Disabled, temporarily Disabled, permanently

Occupation: _____ Employer: _____

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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.

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