PATIENT REGISTRATION

Today's Date: _____ How did you hear about us?: _____

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

Mailing Address: _____ City: _____

State: _____ Zip: _____ SSN: _____ ☐ Male ☐ Female ☐ other

Primary Phone Number: _____ Secondary Phone Number: _____

Email: _____ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

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

Race/Ethnicity: _____ Pharmacy: _____

MINOR INFORMATION

Responsible Party Name: _____ DOB: _____

Best Contact Number: _____ Relationship to Patient: _____

Address: _____ City/State: _____ Zip: _____

REASON FOR VISIT

What is the reason for your visit? _____

When did your pain/injury start? _____ Height: _____ Weight: _____

What activities make your symptoms worse? _____

Have you had problems and/or surgery with this part of your body in the past? ☐ Yes ☐ No If so, when? _____

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

Have you filed a claim? ☐ Yes ☐ No

Current Medications: _____

Allergies: _____ Reaction: _____

PRIMARY CARE PROVIDER (PCP): _____ **PCP PHONE NUMBER**: _____

INSURANCE INFORMATION

Primary insurance: _____ Secondary Insurance: _____

Policy Holder: ☐ Self ☐ Other Policy Holder: ☐ Self ☐ Other

If other, policy holder name: _____ If other, policy holder name: _____

DOB: _____ Subscriber ID #: _____ DOB: _____ Subscriber ID #: _____

Group # _____ Copay Amount: _____ Mailing Address (if different from 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 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 if minor

FINANCIAL AGREEMENT AND PATIENT ACKNOWLEGMENT

REFERRALS/AUTHORIZATIONS

Based on your insurance plan, you may need a referral from your primary care physician (PCP) to see a specialist. **REFERRALS AND AUTHORIZATIONS ARE YOUR RESPONSIBILITY** and are generated by your PCP's office, then submitted to the insurance company. If no valid referral or authorization is on file your appointment could be rescheduled or you can opt to be self pay at the rate of $400.00, which covers the initial office visit and one X-Ray. Any DME or other service ordered will be an additional cost.

CO-PAYMENTS

These are the amounts that you have agreed with your insurance company to pay at each doctor's office visit. This amount is due at check in if applicable. **COLORADO SPRINGS ORTHOPAEDIC GROUP CANNOT** waive copayments, deductibles, coinsurance, or non-covered service amounts defined as patient responsibility under the terms of our contact with your health insurance. Patient copayments are expected at the time of service.

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.

SECTIONS 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.

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.

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 insurance 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 the Colorado Springs 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 copayments, coinsurances 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 companies to negotiate, discuss, and in any other way, communicate with my insurance company in those areas relative to OON reimbursement, 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.

PAST DUE ACCOUNTS

All patient responsible balances should be paid at the time the statement is received. After 90 days your account will become delinquent. If the account remains delinquent, the patient will be unable to schedule any further appointments until the debt has been settled.

I have read and understand the patient acknowledgments and financial policy of the practice and I agree to the terms. I also understand that the terms may be amended by the practice.

_____ _____

Patient or legally authorized individual signature | Printed name

_____ _____

Date | DOB