1601 E 19th Ave., Suite 3300
Denver, CO 80218
P: (303) 837-0072
F: (303) 837-0075
www. OrthoONEDenver.com

At Presbyterian/St. Luke's Medical Center

Dear Patient:

Thank you for scheduling your appointment with Colorado Limb Consultant and OrthoONE at Presbyterian St. Luke's. Our physicians look forward to meeting with you. **Please arrive 30 minutes prior to your appointment time** to complete the registration process.

You will find the paperwork necessary for our pre-registration process attached. Please complete these forms and bring them to your appointment. Any questions you have will be answered at the time of your appointment.

If your insurance company requires a referral and/or an authorization to see a specialist, it is your responsibility to arrange for this in advance. If you're unable to obtain a referral and/or an authorization, you will be asked to sign a waiver of liability form at the time of your appointment. If a co-pay is to be collected at the time of your appointment, payment is expected at the time of service unless other arrangements are made in advance. **Please bring a valid ID and most current insurance card to your appointment.**

It is important that you bring the following items to your appointment:

- Operative notes, Office notes that are applicable to your current problem and your appointment
- Any Labs and/or pathology slides or results
- Any Images such as x-rays, MRI, CT on CD's/Discs with results

The absence of this information may result in the need to reschedule your appointment. This information will eliminate delays and help the physician establish a treatment plan.

If you have any questions regarding any of this information, you may call our office prior to your appointment or address your questions in person during the pre-registration process.

Thank you.

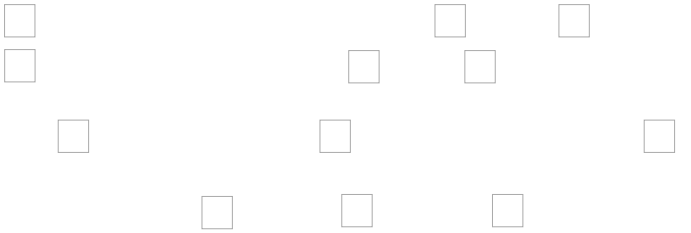
Cynthia M. Kelly, MD
Board-Certified Orthopedic Surgeon

David B. Hahn, MD
Board-Certified Orthopedic Surgeon

Kareem G. Sobky, MD
Board-Certified Orthopedic Surgeon

Daniel M. Lerman, MD
Board-Certified Orthopedic Surgeon

Mark S. Tuttle, MD
Board-Certified Orthopedic Surgeon



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HIPAA Acknowledgement and Consent Form

Notice of Privacy Practices

I, _____ (*patient's name*) acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted use and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically but the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

Release of Information

I, _____ (*Patient's name*) herby permit the practice, the physicians, or other health professionals involved in the inpatient or outpatient care to release health information for purposes of treatment, payment or healthcare operations.

_____ (*initial*) Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA- affiliated admitting facilities to coordinate patient care for case management purposes. Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment healthcare information may also be released to my employer's designee when the services delivered arc related to a claim under worker's compensation.

_____(*initial*) Federal and State laws may permit this facility to participate in organizations with other healthcare providers, insurers, and / or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplished goals that may include but not be limited to improving the accuracy and increasing the availability my health records decreasing the time needed to access my information, aggregating and comparing my information for quality improvement purposes and such other purposes may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/ or infectious diseases including but not limited to blood borne diseases such as HIV and AIDS.

*****FOR MEDICAID/ MEDICARE PATIENT'S ONLY*****

_____ (*initial*) I am covered by Medicaid or Medicare. I authorized the release of healthcare information to the Social Security Administration, its intermediaries, carries for payment of a Medicare claim, or to the appropriate state agency for laboratory reports, operative reports, physician progress notes nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.

_____ _____

Signature of patient/guardian Date

HealthONE OrthoONE Physician Care℠
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Permission to Disclose

☐ **NO**, I would not like to disclose any medical information to any friends/ family individuals

☐ **YES**, I would like to disclose my medical information/condition to friend/ family individuals.

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, finding, and care decisions to the family members and other listed below:

Name	**Relationship**	**Contact number**

Patient/ Representative may revoke or modify this special authorization and that revocation or modification must be in writing.

Note: This clinic uses an Electronic Health Record that will update all your demographics to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.

Signature of patient/guardian _____ Date _____

Consent for Photographing or Other recording for Security and/or Health Care Operations

_____ **YES**, I consent to photographs, digital, or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (i.e. quality improvement activities). I understand that the facility retains the ownership rights to the images/ and or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recording will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

_____ **NO**, I do not consent to photographs, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (i.e., quality improvement activities).

Signature of patient/guardian _____ Date _____

Consent to email or text message:

We want to stay connected with our patients. Patients in our practice may be contacted via email and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. If at any time you proved an email address or text number below you understand that you may get these communications from the practice. You may opt out of these communications at any time. Our facility or physicians does not charge to text messages but standard text messaging rate may apply as provided in your wireless plan *(contact your carrier for pricing plans and details).*

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Patient Financial Agreement

We would like to thank you for choosing **OrthoONE at Presbyterian/ St. Luke's Medical Center** for your care. We are committed to providing you with the best possible care. We want you to be informed of our office's financial policy and require a signature to document that you have read and understand our policy. Please Let us know if you have questions or concerns.

_____ *(initial)* **SERVICE**: You are here to receive a service. There are charges associated with the services we provide. Services include, but are not limited to: consultation, evaluation, and procedures. Services provided outside of our office will be charged by the entity providing the service. (i.e: labs, MRIs, CT Scans, and DEXA Scans)

_____ *(initial)* **MISSED APPOINTMENT/LATE CANCELLATION**: Our office will call to confirm your appointment two (2) business days prior to the appointment date. **ANY No-show or cancellation less than 24 hours will have a $70.00 charge.** Broken appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. In order to maintain our schedule, we request **24 hour** notice for cancellations or rescheduling of appointments.

_____ *(initial)* **CHECK IN:** We respect and value your time. If you are more than 15 minutes late for your appointment, we may need to reschedule. We apologize for any inconvenience this may cause you, but we do our best to run on time and by being punctual, everyone will be served in a timely and efficient manner while receiving the highest quality care. **ESTABLISHED PATIENTS:** We request that all of our established patients arrive 15 minutes prior to their appointment for any paperwork process that may be required at check in. **NEW PATIENTS:** If it is your first time to our office, please arrive 30 minutes prior to your appointment time with your paper work completed. If you were unable to complete the paperwork, we still request that you come in 30 minutes early to ensure that appropriate paperwork is completed.

_____ *(initial)* **PAYMENT**: For patients with a co-pay plan, payment is expected at the time of service. When you check in for the appointment, we will collect the amount indicated on your card unless otherwise instructed. We accept credit cards Visa/MasterCard/ Discover/ AMEX, checks and cash. All insurance carriers have a fee schedule from which they will reimburse. Any services not covered such as deductibles and coinsurance are your responsibility and will be billed to you by our office. Payment is due within 30 days upon receipt.

_____ *(initial)* **CONSENT TO TELEPHONE CALLS FOR FINANCIAL COMMUNICATIONS:** I agree that, in order for OrthoONE at Presbyterian/ St. Luke's Medical Center, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that OrthoONE at Presbyterian/ St. Luke's Medical Center or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or OrthoONE at Presbyterian/ St. Luke's Medical Center or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

_____ _____

Signature of patient/guardian Date

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******Insured Patient ONLY******

_____ *(initial)* **UNDERSTANDING INSURANCE COVERAGE:**

- I acknowledge, that as a courtesy, OrthoONE at Presbyterian/ St. Luke's Medical Center may bill my insurance company for services provided to me.
- It is my responsibility to understand my insurance benefit plan
- It is my responsibility to understand if my insurance requires a Referral/Prior-Authorization for my visit at OrthoONE at Presbyterian/ St. Luke's Medical Center
- I agree to pay for services that are not covered or covered chargers not paid in full including, but not limited to any co-payment, co-insurance and/or deductibles, or charges not covered by insurance.
- I understand there is a fee for returned checks.

_____ *(initial)* **ASSIGNMENT OF BENEFITS**: I hereby assign to OrthoONE at Presbyterian/ St. Luke's Medical Center any insurance benefits available for health care services provided to me. I understand OrthoONE at Presbyterian/ St. Luke's Medical Center has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to OrthoONE at Presbyterian/ St. Luke's Medical Center, I agree to forward all health insurance payments that I receive for services rendered to me immediately upon request.

_____ *(initial)* **INSURANCE REFERRALS:** It is your responsibility to understand the requirements of your insurance policy. If a referral is needed prior to seeing a specialist, you will need to obtain one through your primary care doctor office before an appointment can be made. If you choose to be seen without a valid referral in place, you will be responsible for any charges not covered by your insurance company.

****** Self-Pay Patient ONLY******

If you do not have insurance, payment is required at the time of service. If special circumstances make immediate payment impossible, payment arrangements must be approved in advance by speaking with one of our staff. Once your bill is processed through our system, there may be an additional balance due to us, or due back to you.

_____ *(initial)* I understand I have no health insurance coverage of any kind, Including federal and state health care programs such as Medicare and Medicaid or other insurance coverage provided by school, AFLAC, or from an employer.

_____ *(initial)* I understand as self-pay I am required to pay full payment at the time of check-in. If additional charges, such as labs and x-ray, are incurred a 35% discount will be assessed to the patient balance.

_____ _____

Signature of patient/guardian Date

Health ONE OrthoONE Physician Care™
1601 East 19th Ave. Suite 3300
Denver, Colorado 80218
Phone: 303-837-0072
Fax: 303-837-0075

New Patient Medical Profile

Patient Name:_____

Date of Birth: ____/____/____ Age: _____

Visit Information

Reason for visit: _____ Primary Care Physician: _____
(Body part)(Left/Right)
How did you hear about us? _____

Type of pain: ☐ Ache ☐ Sharp ☐ Throb ☐ Shooting ☐ Dull ☐ Click/Pop Date of Injury: ___ /___ /___

Severity: None ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Intolerable Duration of pain: _____ Location: _____

Hand Dominance: ☐Right ☐Left

Pain Aggravated By: _____

_____

Treatments Attempted:

☐Pain Medication ☐NSAID ☐ Rest ☐ Injection
☐ Cane/Walker ☐Wheelchair ☐ Ice
☐Physical Therapy ☐Surgery ☐ NONE

Medical History

☐ **NONE** Please list any heath problems that you are currently diagnosed with:

☐Diabetes ☐High Blood Pressure ☐ Heart Disease ☐DVT (blood clots)
☐Liver Disease ☐ Kidney Disease ☐Cancer ☐ Pulmonary Embolism
☐Lung Disease ☐Asthma ☐ Stomach Ulcers ☐ Rheumatoid Arthritis
☐Thyroid Problems ☐ Depression ☐Chronic Headache ☐ Osteoarthritis/Gout

☐Infections: Please explain: _____ Height _____

☐Other Illnesses: _____ Weight _____

Surgical History

Please list any previous surgeries and approximate date.

Surgery:	Date:	Surgery:	Date:
_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___

☐**NONE** Known Allergies to Anesthesia: ☐ Y ☐ N Describe: _____

Medications

Please list any medication you currently use, including prescription, over the counter, vitamins, herbs.

Medication:	Dose:	Medication	Dose:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

☐ **NONE**

Allergies

Known Drug Allergies:

☐ **None Known** ☐Penicillin ☐ Sulfa ☐ Iodine ☐Metal/Jewelry (earings)
☐ Latex ☐ Aspirin ☐Codeine ☐ Ibuprofen ☐Adhesives/glue/acrylic nails
☐Other: _____

Family History

Please indicate if your have family members with these problems (father, mother, sibling, child):

Diabetes ☐ Yes ☐ No _____ Blood Clots ☐ Yes ☐ No _____

Heart Disease ☐ Yes ☐ No _____ Sleep Apnea ☐ Yes ☐ No _____-

Hip Problems ☐ Yes ☐ No _____ Arthritis ☐ Yes ☐ No _____

Cancer ☐ Yes ☐ No _____

Social History

Occupation: _____ ☐ Disabled Reason for disability:_____

☐ Retired _____

Do you live alone: ☐ Yes ☐ No With whom: _____

Do you smoke? ☐ Yes ☐ No _____ packs/day Quit: _____ Months Ago _____ Years Ago

Do you drink Alcohol? ☐ Yes ☐ No Number of drinks_____ ☐ Daily ☐ Monthly ☐ Infrequently

Do you use recreational drugs? ☐ Yes ☐ No Please List: _____

Review of Systems

General	☐ Fever	☐ Weight Loss	☐ Fatigue	☐ Decreased appetite
	☐ Chills	☐ Weight Gain	☐ Night Sweats	
Eyes	☐ Blurred Vision	☐ Pain	☐ Sore	☐ Vision Loss
	☐ Glaucoma	☐ Glasses	☐ Contacts	
Ear, Nose, Throat	☐ Hearing Loss	☐ Sore	☐ Inflammation	☐ Dentures
Cardiovascular	☐ High Cholesterol	☐ Heart Attack/Stents	☐ Chest Pain	☐ Leg Swelling
	☐ Palpitations	☐ Heart Murmur	☐ Shortness of Breath	☐ Aortic Aneurysm
Respiratory	☐ Sleep Apnea	☐ Emphysema	☐ Tuberculosis	☐ Sputum
	☐ COPD	☐ Wheezing	☐ Coughing	
Gastrointestinal/ Urinary	☐ Bladder Infections	☐ Kidney Stones	☐ Hemorrhoids	
	☐ Incontinence	☐ Burning		
Musculoskeletal	☐ Injury	☐ Joint Pain	☐ Muscle Pain	☐ Swelling
Skin	☐ Rash	☐ Cellulitis	☐ Color change	☐ Bruising
Neurologic	☐ Dizziness	☐ Numbness	☐ Headaches	☐ Stroke
	☐ Fainting	☐ Tingling	☐ Balance Trouble	☐ Memory Trouble
Hematologic/Lymph	☐ Edema	☐ Anemia	☐ Bleeding Disorder	☐ Leukemia
Immunologic	☐ HIV	☐ AIDS	☐ Hepatitis	☐ Sexually Transmitted Disease
Psychological	☐ Depression	☐ Sleep Trouble	☐ Personality Disorder	☐ Mania
	☐ Anxiety			
☐ **NONE**	☐ **Other:**			

Miscellaneous

Is there any other information relevant to your visit today?

Signatures

Patient Signature: _____ ___/___/___

Physician Signature: _____ ___/___/___

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Patient Name: _____ Date: _____

FIRST POINT OF CONTACT:

Symptoms over the past 7 days

O Open sores in your mouth	O Open sores on your skin	O Fever
O Severe headache	O Sneezing or runny nose	O Stiff neck
O Swelling in the eyes	O Unexplained bleeding	O Vomiting
O Joint pain	O Discharge from eyes	O New rash
O Coughing	O Diarrhea	O Night sweats
O Redness in the eye	O Other_____	O None applied

Have you traveled outside of the U.S. in the last 3 weeks?
_____ Yes _____ No

In the past 3 weeks have you had close contact with someone who has traveled outside the U.S.?
_____ Yes _____ No

Have you had the Flu vaccine this year?
_____ Yes _____ No
If NO, please explain:_____

FALLS RISK ASSESSMENT

Increased Fall Risk Factors: *(select those that apply)*

_____ Had history in past 3 months
_____ Incontinence (uncontrolled bladder)
_____ Visual Impairment (difficult with vision)
_____ Environmental hazard (stairs/ loose rug in home, etc...)
_____ Polypharmacy (takes 3 or more medications that adversely affect muscle function, coordination, and physical stability)
_____ Pain affecting level of function, pain impacts activities of daily living
_____ Cognitive impairment
_____ No falls risk
_____ 3 or more predisposing conditions or diagnosis on problem list
_____ Difficulty ambulating (walks with cane or walker)

History Falls in Past Year:

O No falls in the past year	O One fall with injury in the past year	O One fall without injury in the past year
O Two or more falls without injury in past year	O Two or more falls with injury in the past year	

Dear Patient:

The physicians at OrthoOne at Presbyterian St. Luke's Medical Center (P/SL) work closely with The Limb Preservation Foundation, a nonprofit organization founded in 1986 by P/SL physicians Dr. Ross Wilkins and the late Dr. Tom Arganese. The mission of the Limb Preservation Foundation is to support the prevention and treatment of limb-threatening conditions due to tumor, trauma or infection. The goal of The Foundation is to enhance the quality of life for individuals facing limb-threatening conditions through patient assistance, educational programs and research.

As a patient of OrthoOne (formerly Colorado Limb Consultants) we would like to give you the opportunity to learn more about the important work of The Foundation and how you might benefit from its complimentary services. Dr. Wilkins and Dr. Arganese shared a belief that all people with complex extremity problems should have access to the best medical care, regardless of their ability to pay.

Learn more by receiving informational newsletters and other communications regarding patient financial assistance programs (emergency distress funds, medical transport gas cards, bus/taxi vouchers, outpatient treatment support, patient/caregiver lodging funds), extremity scholarship education funds, adaptive and recreational equipment grants and updates on research, patient and community resources.

Following the co-founders vision, a unique model was created bringing together world-class physicians and researchers, passionate healthcare professionals and patients to advance research, support care and enhance lives. Research funded by The Foundation has increased the survival rate of both adult and pediatric bone cancer patients from 60% to 92%.

Since its inception, The Foundation has funded over $1.5 million through the Patient Assistance program to thousands of patients across the Rocky Mountain Region. These programs provide patients the hope and help they need in times of financial uncertainty. The Limb Preservation Foundation also funds life changing research that is accelerating improvements in the treatments and outcomes for patients with limb-threatening conditions.

Please understand that your personal contact information (home address and /or email address) will not be released to The Limb Preservation Foundation without your consent below. The Foundation will not share your information with any other entity.

We hope this gives you an opportunity to learn more about the mission and resources of The Limb Preservation Foundation.

☐ By checking this box, patient/guardian agrees to receive communications from The Limb Preservation Foundation.

☐ By checking this box, you have elected not to receive communications from The Limb Preservation Foundation.

_____

Print Full Name

_____ _____

Patient/Guardian Signature Date