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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New Patient Packet

Patient Information

Name (Last, First, Middle):_____D.O.B:_____

SSN:_____-_____-_____Gender_____Marital Status: _____

Mailing address: _____

City:_____State: _____ Zip code: _____ Phone: ( )_____-_____

Pharmacy(Name/Major cross Street): _____

Email:_____Primary Care Provider: _____

Race: ☐American Indian/Alaska Native ☐ Asian ☐Native Hawaiian/Pacific Islander
☐Black/African American ☐ White ☐ Declined

Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino ☐Decline

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Responsible/ Guarantor Information (If different from above)

Name (Last, First, Middle):_____D.O.B:_____
Mailing address: _____
City:_____State:_____ Zip code: _____
Phone: ( )_____-_____
Email:_____ Relationship to patient: _____

Emergency Contact Information

Name: _____ Relationship:_____

Phone: ( )_____-_____

Employer Information

Primary Employer Name:_____Work Phone: ( ) _____-_____

Insurance Information

Primary Insurance:_____ Member ID/ Policy #:_____

Group #_____Insurance Phone#: ( ) _____-_____

Insurance address:_____City, State, Zip Code: _____

Secondary Insurance Information (if applicable)

Second Insurance:_____Member ID/ Policy #: _____

Group #_____Insurance Phone#: ( ) _____ - _____

Insurance address:_____City, State, Zip Code: _____

Health ONE OrthoONE Physician Care™

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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's 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

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At Presbyterian/St. Luke's Medical Center

Patient Name: _____ Date_____

How did you hear about us?

Patient and/ or family counseling:

Name: _____

Relationship: _____

Address: _____

Referred by PCP/Specialist/ Physical Therapy/ Other medical professional:

Doctor Name: _____

Clinic Name: _____

Clinic Address: _____

Other:

Relation/Occupation: _____

Name: _____

Address: _____

Daniel M. Lerman, MD
Board-Certified Orthopedic Surgeon

David B. Hahn, MD
Board-Certified Orthopedic Surgeon

Kareem G. Sobky, MD
Board-Certified Orthopedic Surgeon

Cynthia M. Kelly, MD
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Mark S. Tuttle, MD
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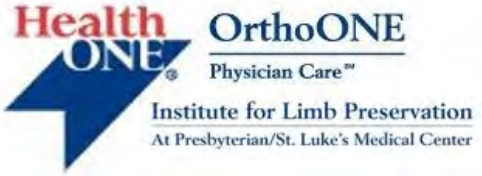

Patient Name:	**Date of Birth:**	**Patient's Phone:**	**Last 4 digit SSN (optional)**
Provider's Name:	**Recipient's Name:**		
Provider's Address:	**Address 1:**		
	Address 2:	**Recipient's Phone:**	
	City:	**State:**	**Zip:**

Request Delivery (If left blank, a paper copy will be provided): ☐ **Paper Copy** ☐ **Electronic Media, if available (*e.g.*, USB drive, CD/DVD, eDelivery)** ☐ **Encrypted Email** ☐ **Unencrypted Email**

NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (*e.g.*, paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (*e.g.*, virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address (If email checked above. Please print legibly):

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: **Event:**

Purpose of disclosure:

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	***Date(s):***	***Description:***	***Date(s):***	***Description:***	***Date(s):***
☐ All PHI in medical record		☐ Operative information		☐ Labor/delivery summary	
☐ Admission form		☐ Cath lab		☐ OB nursing assess	
☐ Dictation reports		☐ Special test/therapy		☐ Postpartum flow sheet	
☐ Physician orders		☐ Rhythm strips		☐ Itemized bill:	
☐ Intake/outtake		☐ Nursing information		☐ UB-04:	
☐ Clinical test		☐ Transfer forms		☐ Other:	
☐ Medication sheets		☐ ER information		☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? ☐ Yes ☐ No
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial remuneration in exchange for using or disclosing this information? ☐ Yes ☐ No
If yes, describe:
May the recipient of the PHI further exchange the information for financial remuneration? ☐ Yes ☐ No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**