PLEASE FILL IN ALL HIGHLIGHTED SPACES BELOW

Today's Date________________________ Patient's SSN#______________________________

Legal First Name__________________________ Last Name_______________________ M.I._____ DOB__________ Gender_____

Parent/Guardian Name (for pediatrics) ____DOB_________________________

Address____City_______________________________State_________Zip___________

Home Phone____________________________ Cell Phone______________________________ Work Phone__________________

Email____

Have any members of your family been seen in our office before: ☐ Yes ☐ No

*If Yes, Please list the following names: ____

Emergency Contact Name______________________________ Relationship to Patient _______________Phone_________________

Race: ☐ White ☐ Asian ☐ Black/African American ☐ American Indian/Alaskan Native
☐ Native Hawaiian/Other Pacific Islander ☐ Refuse to Report

Ethnicity: ☐ Hispanic / Latino ☐ Not Hispanic/Latino ☐ Refuse to Report

Language: ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French
☐ German ☐ Russian ☐ Other: ____

Pharmacy Name: ________________________________Address: _____________________________ Phone: _______________

Primary Insurance Co.

Name ____Phone______________________________

Policy Holder Name_________________________________ Relationship to Patient____________ SSN___________ DOB________

(If Insurance is Medicaid, Policy Holder is Patient)

Policy Holder's Address (If Different): ____________________________________City__________State_________Zip__________

Employer Name____ ID#________________________ Group #_________________

Secondary Insurance Co.

Name ____Phone______________________________

Policy Holder Name_________________________________ Relationship to Patient____________ SSN___________ DOB________

Policy Holder's Address (If Different): ____________________________________City__________State_________Zip__________

Employer Name____ ID#________________________ Group #_________________

PRIMARY CARE PHYSICIAN

Name of Practice____

Physician Name____

Address ____

City/State/Zip____

Phone____

Fax____

School District:____

HOW DID YOU LEARN ABOUT US?

☐ Primary Care Physician ☐ Self ☐ Family/Friends ☐ Website ☐ Healthgrades.com ☐ Blog
☐ Vitals.com ☐ Search Engine ☐ Facebook ☐ Yelp.com ☐ Physician Directory ☐ Twitter
☐ Google Places ☐ Sport Organization: _________________________________ ☐ Other: ______________________
☐ Emergency Room/ Urgent Care/ Emergency Department **(Please circle):**

P/SL Rocky Mountain Hospital for Children Centennial Medical Center of Aurora Sky Ridge Swedish
Rose North Suburban North East ER Avista Littleton Porter St. Anthony's Parker

Other: ____

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Relationship to Patient**
Printed Name of Witness	Employee Job Title
Signature of Witness	**Date**

Patient/Parent Consent for Financial Communications

Patient Name: ____ DOB: ____

We would like to thank you for choosing **Rocky Mountain Pediatric Orthopedics, Scoliosis & Spine, Youth Sports Medicine and Center for Concussion** for your and or your child's care. We are committed to providing you with the best possible care. We want you to be informed of our office financial policy and require a signature to document that you have read and understand our policy. You will be given a copy for your records upon request.

1. **SERVICE**

Your/ your child is 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)

___________ Patient/ Representative Initials

2. **MISSED APPOINTMENT/LATE CANCELLATION**

Our office will call to confirm your/ your child's appointment two (2) business days prior to the appointment date. 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.

___________ Patient/ Representative Initials

3. **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.

___________ Patient/ Representative Initials

4. **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, 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 with-in 30 days upon receipt.

___________ Patient/ Representative Initials

5. **SELF PAY**

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.

___________ **Patient/ Representative Initials**

6. **INSURANCE**

- I acknowledge, that as a courtesy, Rocky Mountain Pediatric Orthopedics may bill my insurance company for services provided to me.
- 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.

___________ **Patient/ Representative Initials**

7. **ASSIGNMENT OF BENEFITS**

I hereby assign to Rocky Mountain Pediatric Orthopedics any insurance benefits available for health care services provided to me. I understand Rocky Mountain Pediatric Orthopedics has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Rocky Mountain Pediatric Orthopedics, I agree to forward all health insurance payments that I receive for services rendered to me immediately upon request.

___________ **Patient/ Representative Initials**

8. **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.

___________ **Patient/ Representative Initials**

9. **FRACTURE CARE**

If we treat you or your dependent for a fracture your insurance company requires that we bill our services to you using a coding system known as CPT (Current Procedure Terminology). The codes used to describe the services we completed for you are found in the "surgery" section of the CPT code book. This does not mean that you had an operation. This is merely the way the CPT code book is organized for ease of use by both insurance companies and physicians. This code is used for most closed fracture treatments with or without any kind of manipulation. In some cases closed treatment may just mean the specialist has diagnosed a fracture and recommends keeping the fractured arm in a sling.
According to the CPT guidelines, fracture care is billed as a "packaged" service.

This means that at the time of initial care, a bill is generated that includes:

1. Treatment of the fracture
2. The first cast or splint application
3. 90 days of normal, uncomplicated, follow up care

The procedures and other items NOT included in the package are:

1. X-rays
2. All casting supplies (including those used with the first cast application)
3. Any replacement cast application
4. The evaluation and management of any additional problems or injuries
5. The treatment of complications

There will be a separate charge for these services.

Your insurance company may cover the care rendered for fractures differently than for office visits. Therefore, when you receive the explanation of insurance benefits, the services may be paid as a surgical procedure with deductible and co-insurance guidelines applied. We are using the most appropriate code available to describe the care rendered. We are required legally to use this code to bill for this service. As always, we encourage you to check with your insurance company and verify the benefits available. If you have any questions, please do not hesitate to contact us.
If you have any questions, please do not hesitate to call our billing office at (303) 861-2663.
I certify that I have read and fully understand the above statements.

___________ Patient/ Representative Initials

10. CONSENT TO TELEPHONE CALLS FOR FINANCIAL COMMUNICATIONS

I agree that, in order for Rocky Mountain Pediatric Orthopedics, 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 Rocky Mountain Pediatric Orthopedics or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or Rocky Mountain Pediatric Orthopedics 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.

___________ Patient/ Representative Initials

11. PHOTOCOPY

A photocopy of this consent shall be considered as valid as the original.

___________ Patient/ Representative Initials

Patient/ Representative Signature: ____Date:_____________________

If you are not the Patient, please identify your Relationship to the Patient.

Spouse Guarantor

Parent Healthcare Power of Attorney

Legal Guardian Other (please specify)___________________

Rocky Mountain Pediatric OrthoONE

Patient Medical History

Today's Date: ________________________ **Primary Care Physician: ____**

Referring Provider: ____

Patient's Legal First Name: __________________________MI: ___ Last Name:______________________________________

DOB: ______________ Gender: _____________ Age: _________

Grade in School: _________ Birth Weight: _________ Dominant Hand: _________ Height: _________ Weight: _________

School Name: ______________________________________ School District: ___________________________________

Reason for today's visit (Chief Complaint): ____

How did it occur: ____

Is this a: ❑Recent Injury(with in last month) ❑Old Injury ❑On-going problem/pain ❑Second Opinion

Which Side: ❑Right ❑Left ❑Bilateral (both) BODY PART(s):____

Date of Injury/Pain Began: ____

Did you have: ❑X-RAYS ❑CT SCAN ❑MRI ❑Labs ❑None ❑Other____________ Do you have them with you? ❑Yes ❑No

Did you visit an Emergency Department/ Urgent Care? ❑Yes ❑No Facility Name: _________________Date: _________

FRONT	BACK	Describe your pain/symptoms:	What is your pain level today?
RIGHT LEFT	LEFT RIGHT	☐ Shooting ☐ Tingling ☐ Numb ☐ Stabbing ☐ Dull ☐ Stinging ☐ Burning ☐ Aching ☐ Sharp	No Pain — Moderate Pain — Worst Pain 0 1 2 3 4 5 6 7 8 9 10

What makes the pain better? ___________________________	What makes the pain worse? _________________________

Received treatment for this Injury/Problem?	☐ Yes	☐ No	If Yes, please choose the following options:
☐ Medication-List below in Current Medication	☐ Compression (Ace Wrap)	☐ Elevation	☐ Physical Therapy
☐ Splinted/ Temp Cast	☐ Ice	☐ Crutches	☐ Other: ______________________________

Medical Information

Current Medication:	**Dose & Frequency:**	☐ **Check if None**
Medical Problems: ______________________________		☐ **Check if None**
Allergies & Reactions: ______________________________		☐ **Check if None**
Surgeries and Dates: ______________________________		☐ **Check if None**
Hospitalization and Dates: ______________________________ ***Please see the back/next of the page for additional space.		☐ **Check if None**

Patient's Name:		DOB:
Medication:	Dose:	Frequency:
Surgeries and Dates		
Hospitalization and Dates		

Family History

Parent's/Guardian's Name: _______________________	Occupation: ______________________________________
Parent's/Guardian's Name: _______________________	Occupation: ______________________________________

Please indicate the PATIENT'S family member that has the below family history(FOR THE PATIENT):

1. **Orthopedic Problems** – Mom, Dad, Brother, Sister	2. **Scoliosis** – Mom, Dad, Brother, Sister
3. **Hip Dysplasia** – Mom, Dad, Brother, Sister	4. Diabetes – Mom, Dad, Brother, Sister
5. Hypertension – Mom, Dad, Brother, Sister	6. Breast Cancer – Mom, Dad, Brother, Sister
7. Coronary Artery Disease – Mom, Dad, Brother, Sister	8. Lung Cancer – Mom, Dad, Brother, Sister
9. Colon Cancer – Mom, Dad, Brother, Sister	10. Heart Attack – Mom, Dad, Brother, Sister
11. High Cholesterol – Mom, Dad, Brother Sister	12. Asthma – Mom, Dad, Brother, Sister
13. Other: _________________________________Mom, Dad, Brother, Sister	☐ **Check if ALL Family History is None**

Mom: Alive / Deceased	Dad: Alive / Deceased	Sister(s): Alive / Deceased	Brother(s): Alive / Deceased

Social History

Who lives with you: ____

Tobacco/Nicotine Use: ☐ Never ☐ Current ☐ Former
(13 and Older)

Sports/Hobbies: ____

Do you exercise? ☐ Yes ☐ No _________ Days per week you exercise. _________ Hours per day you exercise.

Name of Sports Organization/Team: ____

Immunizations

Influenza-Flu Shot (All Ages) ☐ Yes/Month and Year:___________________ ☐ No ☐ Refused

Immunizations up to date? ☐ Yes ☐ No

Review of Systems (Past & Present)

☐ ***Check if all are Negative***

Psychiatric:
☐ Depression
☐ Emotional Difficulties

Respiratory:
☐ Coughing
☐ Asthma
☐ Shortness of Breath
☐ Wheezing

Hematologic:
☐ Bleeding Problems
☐ Bruise Easily
☐ Anemia
☐ Clotting Problems

Gastrointestinal:
☐ Stomach Pain
☐ Heart Burn

Genitourinary:
☐ Blood in Urine
☐ Urinary Difficulties

Dermatologic:
☐ Rash
☐ Eczema
☐ Keloids/Hypertrophic Scarring

Cardiovascular:
☐ Chest Pain
☐ Palpitations
☐ Murmur

Eyes, ears, nose, throat:
☐ Vision/Hearing problems
☐ Nose Bleeds
☐ Sinus Problems

Constitutional symptoms:
☐ Fatigue
☐ Fever
☐ Weight Loss
☐ Night Sweats

Musculoskeletal:
☐ Joint/Muscles Aches

Neurologic:
☐ Balance Problems
☐ Seizure
☐ Other: _________________
____

Endocrine:
☐ Low/High Blood Sugar
☐ Low/High Thyroid Functioning

☐ **Cancer:**_______________________________________ ☐ **Other:**____

Patient Name: ____ **DOB:** _______________

Parent/Responsible Party Signature: ________________________________ **Date:** _______________