Rocky Mountain Pediatric Orthopedics

Orthopedics, Spine, Concussion, Sports Medicine

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: _____

Rocky Mountain Pediatric Orthopedics | Rocky Mountain Scoliosis & Spine | Rocky Mountain Hospital for Children | Rocky Mountain Youth Center for Concussion | Rocky Mountain Youth Sports Medicine Institute

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Rocky Mountain Scoliosis & Spine
Rocky Mountain Youth Sports Medicine & Center for Concussion
PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Patient Name**:** _____

Date of Birth: _____

_____ (Patient initials) **Notice of Privacy Practices.** I 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 uses 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 by the Provider and/or 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.

_____ (Patient initials) **Release of Information.** I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- 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 or 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 are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- 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 accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as 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.

Disclosures to Friends and/or Family Members
DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?"

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

	Name	Relationship	Contact Number
1:			
2:			
3:			

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

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:
Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.
If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

_____ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).
The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is_____.
The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____.
The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Revocation
I hereby revoke my request for future communications via email and/or text.
__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.
__ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.
NOTE: This revocation only applies to communications from this Practice.
Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____ Time: _____

Consent for Photographing or Other Recording for Security and/or Health Care Operations
____ (Patient Initials) I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., 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 recordings 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.

____ (Patient Initials) I do not consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities).

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.
____ (Patient initials) I wish to designate the following family member / friend to pick up an order on my behalf:
Name: _____ Date: _____
Name: _____ Date: _____
____ (Patient initials) I do not want to designate anyone to pick-up my prescription order.

Patient Signature _____ Date: _____

Patient Name (Printed): _____ DOB: _____

Rocky Mountain Pediatric Orthopedics
Rocky Mountain Scoliosis & Spine
Rocky Mountain Youth Sports Medicine & Center for Concussion

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**

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Rocky Mountain Scoliosis & Spine
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FINANCIAL POLICY

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.

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)

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.

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.

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.

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.

INSURANCE

All services performed by our providers will be submitted as a **courtesy** to your insurance. Insurance plans vary considerably. It is your responsibility as the parent/guardian/patient to provide accurate and timely insurance information.

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.

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 Name: _____ DOB: _____

Patient/Responsible Party Signature: _____Date:_____

Name: _____ DOB:_____

Rocky Mountain Youth Sports Medicine Institute
14000 E. Arapahoe Road Suite #300
Centennial, CO 80112
Phone: 720-979-0840
Fax 303-690-5948

Research Information

Patients under 18 years

Introduction

If you are a parent or legal guardian of a child who may take part in this research, permission from you is required. When we say "you" in this consent form, we mean you or your child; "we" means the doctors and other staff.

Your physician is a member of the Rocky Mountain Youth Sports Medicine Institute, a team of specialized healthcare providers composed in part by Drs. Pengel, Polousky and McAvoy. Our group of physicians believe that clinical research is an important part of medicine. Our studies are reported at medical meetings around the world and/or published in medical journals.

Your Role

You play an important role in how clinical research is done. You may be asked to complete questionnaires during your office visits. In addition, we will be collecting specific information from your chart for our database.

Information Storage and Confidentiality

Your answers to the evaluations are entered and scored in a password-protected database program. Whenever your medical information is accessed and used for publication or presentation, your identity is kept confidential and your name is de- identified with a unique code. The HCA-HealthOne Institutional Review Board will have the right to inspect your research records, as will the physicians at P/SL who participate in your care and the research coordinator. Every effort will be taken to protect your identity and your personal information.

Financial Responsibility

There are no costs to you for participating in a study.

Contact Information

If you have questions about your role in the research conducted here, contact Courtney Newbold, Research Coordinator (720) 754-4714 or you may present questions during your appointment.

Research

The data collected through your participation will possibly be used for presentations or publications to the medical community, although all information will be de-identified and thus not traceable back to you. Papers that are published using information from this office will be available for you to read in the waiting room as well as by request. If information will be collected during a visit or surgical procedure, we will give you an additional informed consent form and information on patient protected health information.

Alternatives

You have the option of not participating in any study. If you would like to opt out, please let your physician or a member of the staff know. You will continue to receive care at this facility with no penalties but your information will not be used for any studies.

By signing below, you acknowledge that you have read the above information and understand that we may use your survey answers for research without further consent. For other studies that require more information, you will be given a separate informed consent document.

If you have questions or would like more information, please call 720-754-4714 to speak with Courtney Newbold, our Research Coordinator.

Thank you for your help.

_____

Patient Name

_____ _____

Patient Signature Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Signature Date