

Rocky Mountain Pediatric Orthopedics

Orthopedics, Spine, Concussion, Sports Medicine

Concussion

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 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

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

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.

IMPACT TESTING

If we treat you or your dependent for a post-concussion your insurance company requires that we bill our services using a coding system called CPT (current procedural Terminology.) The services that we have completed for you are found in the behavioral health benefits section of the CPT book.

Most Insurance companies cover this code however, some Insurance companies consider impact / Neuro psych testing a mental health benefit, so this may or may not be covered depending on your policy.

Please note that 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 regarding the Impact / Neuro psych testing fees, please feel free to contact our billing office at (303)854-3692.

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