



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



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**

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 within 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 charges 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 Orthopedics

Orthopedics, Spine, Concussion, Sports Medicine

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: _____

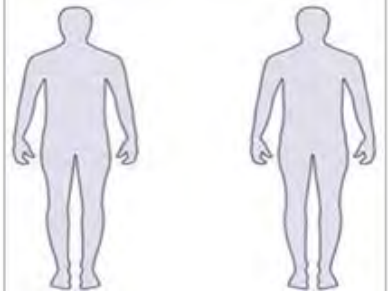
Is this a: Recent Injury(with in last month) Old Injury On-going problem/pain Second Opinion

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		
					

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: _____ Check if None

***Please see the back/next of the page for additional space.

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:** _____