PEAK ORTHOPEDICS & SPINE

PATIENT INFORMATION

Patient Name _____
Last First M.I.

Address _____
Street Address

_____ Email _____
City State ZIP Code

Phone #_____ Work # _____ Cell # _____

Date of Birth _____/_____/_____ Age _____ SSN _____ - _____ - _____

Employer _____ Address _____

Primary Care Physician _____ Phone # _____

RESPONSIBLE PARTY (one who carries insurance)

Name _____ Relationship to Patient _____

Date of Birth _____/_____/_____ SSN _____ - _____ - _____

Address _____ City _____ State _____ Zip Code _____

Phone # _____ Work # _____ Employer _____

INSURANCE INFORMATION

Primary Ins. _____ ID# _____ Group # _____ Copay $ _____

Secondary Ins. _____ ID# _____ Group # _____ Copay $ _____

EMERGENCY CONTACT (relative or friend not living with you)

Name _____ Phone # _____

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO PHYSICIAN OR SUPPLIER FOR THESE SERVICES AND ALL FUTURE CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE AND IT IS MY RESPONSIBILTIY TO KNOW MY COPAYS, DEDUCTIBLES, OUT-OF-POCKET AMOUNTS, ETC. WHICH HAVE BEEN ESTABLISHED THROUGH MY INDIVIDUAL INSURANCE POLICY. I AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND ALL FUTURE CLAIMS.

Signature _____ Date _____

NEW PATIENT MEDICAL HISTORY FORM

Name_____ Date_____

How did you hear about us? (please check one or more)

◯ Primary Care Physician (list)_____

◯ Peak Website ◯ Insurance Website ◯ SportZu ◯ Yellow Pages

◯ Your Health Monthly magazine ◯ Family/Friend ◯ Other_____

Age_____ Height_____Weight_____ Occupation_____

◯Right-handed ◯ Left-handed ◯ Ambidextrous

What is the reason for your visit? ◯ Injury ◯ Pain ◯ Numbness ◯ Other_____

Where is the location of your symptoms? ◯ Right ◯ Left Area of the body_____

When did your problem begin?_____

How did the problem start?

◯ No specific injury ◯ Injury ◯ Sports ◯ Fall ◯ Work related ◯ Car Accident

Please explain:_____

Have you had similar symptoms in the past? ◯ Yes ◯ No

Are any other bones or joint painful or swollen? ◯ Yes ◯ No

What kind of pain do you feel? ◯ Sharp ◯ Throbbing ◯ Burning ◯ Dull ◯ Aching

How severe are the symptoms? ◯ Mild ◯ Moderate ◯ Severe

How often do symptoms occur? ◯ Intermittent ◯ Constant ◯ When sleeping at night

What makes the symptoms worse?

_____

Since symptoms started, they are: ◯ Unchanged ◯ Getting better ◯ Getting worse

The symptoms include: ◯ Pain ◯ Weakness ◯ Swelling ◯ Stiffness

◯ Numbness/Tingling ◯ Instability

Rate your pain 1 to 10; 10 being worst: 1 2 3 4 5 6 7 8 9 10

Have you had to use a cane/crutch/walker because of your pain?_____

Has your pain and limitation changed your activities of daily living? (please explain)_____

_____

Have you tried to lose weight to help this situation?_____

Are you ALLERGIC to any Metal? (please list)_____

Any history of INFECTIONS? (please list/date)_____

What are your interests and hobbies? _____

How far can you walk?_____

How many flights of stairs can you climb?_____

To the best of my knowledge, this information is accurate.

Patient Signature:_____ **Date:**_____

Which treatments have you tried?

◯Rest		Improvement? ◯Yes ◯No	
◯Physical Therapy	How Long? _____	Improvement? ◯Yes ◯No	Start Date: _____
◯Medications	List:_____	Improvement? ◯Yes ◯No	Start Date: _____
◯Injections	How many? _____	Improvement? ◯Yes ◯No	Start Date: _____
◯Splint		Improvement? ◯Yes ◯No	
◯Surgery	List:_____	Improvement? ◯Yes ◯No	
◯Assistive Devices	Type(i.e. Walker, Cane)_____	Improvement? ◯Yes ◯No	Start Date: _____
◯Other	List:_____	Improvement? ◯Yes ◯No	Start Date: _____

Medical History (your health issues)

◯Healthy
◯Cancer
◯Heart Disease
◯Diabetes
◯Asthma
◯High Blood Pressure
◯DVT (blood clot)
◯Acid Reflux
◯Kidney Disease
◯Liver Disease
◯Thyroid Disease
◯ Other:_____

Family History

(What runs in your family?)

◯Heart Disease
◯High Blood Pressure
◯Diabetes
◯Cancer
◯Arthritis

Surgical History

(Please list surgeries)

_____date_____
_____date_____
_____date_____
_____date_____
_____date_____
_____date_____

Medications (List current medications) **Start Date:**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Allergies to medications

◯ None
◯ Penicillin
◯ Sulfa
◯ Aspirin
◯ Codeine
◯ Other_____

Social History

Smoking:
If yes, _____packs/day
Alcohol:
◯ None ◯ Occasional
◯ Frequent
Marital status:
◯ Single ◯ Married
◯ Divorced ◯ Widowed

Do you currently experience any of the following? (Check all that apply)

General
◯ weight loss
◯ fevers
◯ fatigue

Cardiovascular
◯ chest pain
◯ heart murmur
◯ irregular beat

Gastrointestinal
◯ heartburn
◯ stomach ulcer
◯ hepatitis

Musculskeletal
◯ arthritis
◯ osteoporosis
◯ prior fracture

Neurological
◯ balance problems
◯ dizziness
◯ headaches
◯ seizures ◯ weakness

Eyes
◯ need glasses
◯ wear contacts
◯ glaucoma

Ear/Nose/Throat
◯ hearing loss
◯ sinus infection

Respiratory
◯ shortness of breath
◯ sleep apnea

Urinary
◯ painful
◯ frequent
◯ infection

Other
_____
_____
_____

Skin
◯ rash
◯ blisters

Hematologic
◯ bleeding issues
◯ blood clots

Immunologic
◯ tuberculosis
◯ frequent infections

Psychiatric
◯ depression
◯ anxiety

Endocrine
◯ thyoid issues
◯ diabetes

Patient Signature:_____ **Date:**_____

PEAK ORTHOPEDICS & SPINE POLICIES AND PROCEDURES

Welcome to Peak Orthopedics & Spine! Our Physicians and staff are looking forward to providing you with exceptional care. It is important to us that you understand our policies so that we may operate efficiently and effectively.

1. Please arrive for your appointment 10 minutes prior to your scheduled time. To access our new patient paperwork, please visit our website at www.peakorthopedics.com , click on office forms and the physician you are seeing, print out and fill out the forms and bring them with you when you come. If you are unable to do this, you will need to arrive early for your appointment and complete the paperwork.
2. Please make sure you bring a photo ID and proof of insurance with you to your appointment. **If you do not have this information, your appointment will be rescheduled.** Please also bring any tests/studies/films/notes/reports you have had done pertinent to the issue we are treating. We will need this information prior to seeing you.
3. If your physician orders any special test (i.e. MRI, CT scan etc.), you will need to make a follow up visit to go over the results of your test. You can either make that follow up appointment when you leave the office or call and schedule an appointment when your test is complete. The Doctor usually will not go over results on the phone, so please make sure you schedule your follow up.
4. You may be under a global follow up period (generally 90 days) after surgery or a fracture. Depending on the agreement between you and your insurance, you may not be charged an office visit co-pay. You may be responsible for any x-rays, casting, equipment fittings etc. that may occur during this period.
5. If you are unable to make your scheduled appointment, please notify us as soon as possible. If we are not notified prior to your scheduled appointment time, you will be charged $50 for a missed appointment.

FINANCIAL POLICY

1. It is the responsibility of the patient to know your coverage benefits and co-pay amounts. Peak Orthopedics & Spine is a specialist and you will pay a specialist co-pay. Please call your insurance company to obtain this information prior to your visit if you are unsure of your co-pay amount.
2. All co-pays and outstanding balances are to be paid at the time of your office visit.
3. If you are uninsured, the cost for an office visit is $250.00 and must be paid at the time of visit. After the first visit, any follow up visits are $50 and up depending on x-rays, casting, braces etc... and payment is due at the time of service.
4. Peak Orthopedics & Spine does not do third party billing. We will bill your health insurance only. If you are seeing us because of an auto accident, we will not bill auto insurance. We will bill your health insurance and you submit a claim to your auto insurance. If you are an uninsured patient and seeing us as a result of an accident, you will be charged accordingly and you may obtain all copies of your bills to submit to auto insurance for possible reimbursement.
5. We do not see patients on a lien basis. You will be considered self-pay and may obtain copies of your bills to submit for possible reimbursement to the party in which the claim is against.
6. If you are seeing us on a Workmen's Compensation claim, you will need to provide the following information at your visit: The Workmen's Comp carrier, the billing address, adjusters name and phone number and a claim number. This information can be obtained from your employer and you will need to have this information with you at the time of your visit. If you do not have this information, you will need to reschedule your appointment.
7. All amounts due for surgical services must be paid prior to surgery.
8. A surgical assistant may be medically necessary as decided by your physician. Please understand this assistant is necessary to provide efficiency in the operating room and is not always covered by your insurance company.

I, _____, have read and agreed to the above policies and procedures.

_____ _____

Patient Signature Date

Peak Orthopedics & Spine, PLLC
Notice of Privacy Practices for Protected Health Information

9777 S. Yosemite Street, Suite 220
Lone Tree, CO 80124
Phone: 303-699-7325
Fax: 303-699-5486
www.peakorthopedics.com

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date 9/23/2013

This Notice of Privacy Practices applies to the following organizations.

Peak Orthopedics & Spine, PLLC
Emergency Orthopedic Services, PLLC

Lisa Aspromonte, Administrator
lisa@peakorthopedics.com
303-699-7325

Acknowledgement of Privacy Notice

I acknowledge the receipt of the notice of Privacy Practices for Peak Orthopedics & Spine, PLLC.

Patient Signature _____

Patient Printed Name _____

Date _____