Name: DOB:
Chart: Age:
Date: Gender:

Patient Information

Patient Name Social Security Number ____________ Address ____________ City, State & Zip Code	Home Telephone # ____________ Work telephone # ____________ Cell Telephone # ____________ Email Address (Please Print) Preferred Method of Contact: ☐ Text ☐ Phone Call Date of Birth ____________ Age ____________ Emergency Contact Name & Phone Number: Relationship to Patient:
For Medicare Patients Only Do you currently reside in a Skilled Nursing Facility? ☐ Yes ☐ No	Employer Name & Address ____________
Employment / Student Status: ☐ Full time employed ☐ Full time student ☐ Part time employed ☐ Part time student ☐ Unemployed ☐ Retired	Occupation: Married ☐ Single ☐ Other ☐
Referring Physician: Family Physician: Name of Preferred Pharmacy: Pharmacy Address or location: Ethnicity of Patient: ☐ Hispanic Origin ☐ Unknown ☐ Non-Hispanic Origin ☐ Declined to answer	Race of Patient: ☐ American Indian/ Alaskan Native ☐ Asian ☐ Black/ African American ☐ Native Hawaiian/ Other Pacific Islander ☐ White ☐ Unknown ☐ Declined to answer Primary Language of Patient: ☐ English ☐ Spanish ☐ Other: ____________

In compliance with the American Recovery and Reinvestment Act of 2009 (ARRA) to demonstrate Meaningful Use, we are required to capture demographic data including your preferred language, race and ethnicity.

Financially Responsible Person (if different from above):

Full Name: ____________ Address: ____________ City, State & Zip code: ____________ Date of Birth: Employer:	Social Security Number: ____________ Home telephone #: ____________ Cell telephone #: ____________ Work telephone #: ____________ Relationship to Patient (Circle one) Self Spouse Child Parent Other

Date reviewed ____________ Initials ____________

Name: DOB:
Chart: Age:
Date: Gender:

Insurance Company Information

Primary Insurance Company Name		Secondary Insurance Company Name	
Address, City, State & Zip Code		Address, City, State & Zip Code	
Policy Holder	Date of Birth	Policy Holder	Date of Birth
Policy Holder Employer	Policy Holder SSN	Policy Holder Employer	Policy Holder SSN
Policy Number	Group Number	Policy Number	Group Number
Relationship to Patient (Circle One) Self Spouse Child Parent Other		Relationship to Patient (Circle One) Self Spouse Child Parent Other	

Appointment Information:

Patient Name: ______________________________________ Account #: ___________________________________

Name of Physician to see today: ____

Name of Physician who referred you here today: ____

Body area being seen for today: ____

Problem? ☐ Yes ☐ No Date problem began: ____
Injury? ☐ Yes ☐ No Date of Injury: _____________________________
Work Injury? ☐ Yes ☐ No Date of Injury: _____________________________
Auto Accident? ☐ Yes ☐ No Date of Accident: _______________ State of Accident: _________________________

By signing below, I authorize the release of myself and/or my child's medical records to my insurance company for the processing of medical claims. I further authorize my insurance company to issue payment for services rendered. In addition, I understand that: 1) The contract with my insurance is between me and my insurance carrier. 2) Co-Pay and/or co-insurance is due at the time of service. 3) A medical claim shall be filed to my insurance as a courtesy and if the balance is not paid within 45 days, I may be billed for any outstanding balance. 4) Any balance remaining after my insurance pays is my responsibility and will be remitted immediately upon receipt of a billing statement. 5) I must present a copy of my insurance card at each visit as well as any changes to my mailing address and telephone number(s).

ASSIGNMENT OF BENEFITS

I hereby assign to COLORADO CENTER OF ORTHOPAEDIC EXCELLENCE any insurance or other third-part benefits available for health care services provided to me for these services and any future claims. I understand that COLORADO CENTER OF ORTHOPAEDIC EXCELLENCE has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to the COLORADO CENTER OF ORTHOPAEDIC EXCELLENCE, I agree to forward to COLORADO CENTER OF ORTHOPAEDIC EXCELLENCE, all health insurance and other third-party payments that I receive for services rendered to me immediately upon request. I authorize the release of any medical information necessary to process all claims.

NO-SHOW AND CANCELLATION POLICY

In the event an appointment is missed or cancelled with less than 24 hours' notice or no notice, a **$25.00** charge will be bill to the patient. This fee will not be covered by your insurance company.

STATEMENT OF FINANCIAL RESPONSIBILITY

I acknowledge that I am responsible for all charges and wish to receive medical services provided by COLORADO CENTER OF ORTHOPAEDIC EXCELLENCE, including any non-covered services or amounts not paid by insurance. This also applied if coverage is provided by any third-party payors. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment for all services provided.

Signature: ____ Date: ______________________________________

Printed Name: ____

Relationship to Patient (if other than patient): ____

Date reviewed __________ Initials _________