2015

WELCOME TO THE OFFICE OF
BOULDER BONE AND JOINT
(Please fill out completely, print and sign at the bottom)

PATIENT INFORMATION

Name_____ Today's Date: _____
Last First Middle

Permanent/Parent
Address_____
Street Apt. City State Zip

Date of Birth _____ Age____ Social Security# _____

Female ___ Male ___ Minor____Single____ Married____ Widowed____Other_____

Race (Circle one) White Black / African American Asian Hispanic

Home Phone _____ Secondary Phone _____

E-Mail Address _____

If under 21, parents name _____ Phone _____

Employer _____ Business Phone _____

Emergency Contact _____ Phone _____
(Not living with patient)

Primary Physician _____ Phone_____

MEDICAL INSURANCE INFORMATION (Please Fill Out Completely)

Primary Insurance Co._____

Policy Holder **- _____Self _____Spouse _____Parent ____Guardian**

Policy Holder Name:_____**DOB:**_____**Employer:**_____
(If different from patient)

Secondary Insurance Co._____

Policy Holder - _____**Self**_____**Spouse**_____**Parent**_____**Guardian**

Policy Holder Name (If different from patient)_____

Authorization: I certify to the accuracy of the above listed information. I hereby authorize the release of any medical information necessary to process my health insurance claims and request payment of benefits to the provider of services. I understand I am financially responsible to Boulder Bone and Joint for charges not covered or denied by my insurance company. Boulder Bone and Joint is not party to any legal agreements between divorced or separated parents. I further agree, in the event of my non-payment, to the collection agency cost and/or court costs and/or attorney fees and reasonable fees should this be required. A copy of this authorization may be treated as an original.

Insured/Patient's Signature _____ Date: _____

If minor (17 or younger), parent or legal guardian must sign
Parent or legal guardian_____ Relationship_____

Printed name of parent or legal guardian_____

ORTHOPEDIC PROFESSIONAL ASSOCIATION, P.C.

_____ _____

Name of Patient (please print) **Date of Birth**

I hereby acknowledge that I received Orthopedic Professional Association's Notice of Privacy Practices.

_____ _____

Signature of Patient or Patient Representative **Date**

_____ _____

Printed name if signed on behalf of the Patient **Relationship to Patient**

Documentation of Good Faith Efforts

To obtain patient's acknowledgment that they received provider's Notice of Privacy Practices

(For use when acknowledgment cannot be obtained from the patient.)

The patient presented to the office on _____ and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- ❑ Patient refused to sign.
- ❑ Patient was unable to sign or initial because:

  _____

  _____
- ❑ The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.
- ❑ Other reason (describe below):

  _____

  _____

_____ _____

Signature of Employee Completing Form Date

Coal Creek Medical Plaza
1032 South 88th St.
Louisville CO 80027
303-665-0286

Boulder Bone and Joint

Michael P. Wertz, M.D.
J. David Grauer, MD
James G. Reid, MD
E. Jordan Stoll, M.D.
Jeffrey Gagliano, M.D
Justin D. Green, M.D.
Jeremy James, P.A.
Daniel Keck, P.A.

BCH Foothills Campus
4820 Riverbend Rd.
Boulder, CO 80301
303-449-4545

Patient name_____ Age_____ Date _____

Employer/School_____ Position/Grade_____

Problem

Current Problem? _____

_____

_____

Date this problem started_____

Is this work related? _____

How did problem occur/start_____

_____

_____

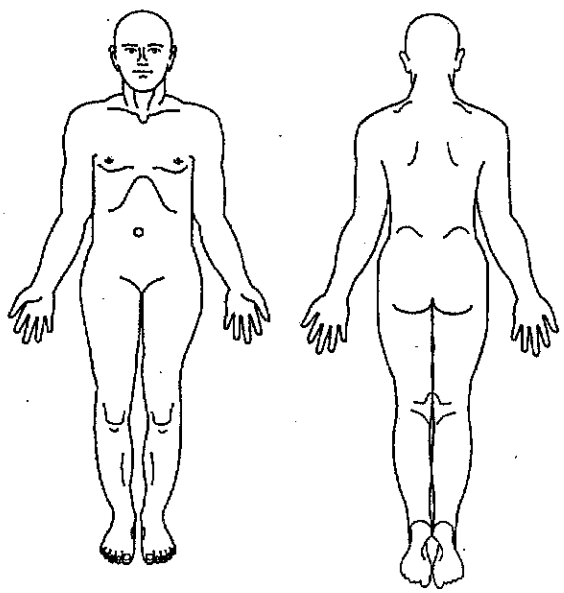
Treatments you have received for this problem _____

_____

_____

Seen in ER?(if yes name)_____ X-Rays/MRI Taken?(where)_____
Auto Accident?_____ Pending litigation?_____
Who referred you to our office_____

Mark Injury Location



Name_____Date_____

Surgical History (any surgery, not just orthopedic surgery)

Problem + Date or Age	*Treatments + Doctor*	Successful (Y/N)

Medical History Height_____Weight_____

Are you pregnant?_____

List any current or past medical problems (dates and Doctors)

_____

_____

_____

_____

_____

Current Medications (Prescription, Over the Counter, Herbal health products,vitamins, or dietary supplements)

	Name	Dose	Frequency		Name	Dose	Frequency
1.				6.			
2.				7.			
3.				8.			
4.				9.			
5.				10.			

All Medications written and called in from this office will be done so during normal business hrs (8am-5pm) Mon-Fri. Please contact the pharmacy first when requesting a new prescription or prescription refill. Please give our office 24 hours to refill your prescription.

Allergies to MEDICATIONS (list medication and reaction)

_____

_____

_____

How often do you smoke (packs per day) _____Are you a former smoker_____
How often do you drink alcohol (glasses per week) _____
How often do you use recreational drugs (per week) _____

Family Physician _____

Thank you for filling out this form

Boulder Bone and Joint

Michael P. Wertz, M.D.
Sports Medicine
Hand Surgery
Orthopedic Surgery

J. David Grauer, M.D.
Sports Medicine
Orthopedic Surgery

James G. Reid, M.D.
Orthopedic Surgery
Upper Extremity/Hand Surgery
Reconstructive Surgery

E. Jordan Stoll, M.D.
Sports Medicine
Orthopedic Surgery

Jeffrey R. Gagliano, M.D.
Orthopedic Surgery
Fellowship trained in
Sports Medicine,
Shoudler and Knee

Justin D. Green, M.D.
Physical Medicine
Rehabilitation

REFERRALS

If your insurance company requires a referral for you to see a specialist you must obtain that from your primary care physician prior to your appointment. It is your responsibility to find out if a referral is required. Our office staff will not be checking for this information.

The referral must be logged in the insurance companies system in order to be effective. Just because you have a handwritten or faxed referral from your primary care physician does not mean the insurance company has it in their system.

If you do not take the necessary steps to ensure the referral is on file with your insurance company, any visits that are denied will be your responsibility.

Thank you,
Boulder Bone and Joint

_____
Patient's Printed Name

☐ I have checked with my insurance company and they DO NOT require a referral

_____
Patient's Signature

_____
Date

1032 South 88th Street • Louisville, CO 80027 • (303) 665-0286 • Fax: (303) 866-5112
4820 Riverbend Road • Boulder, CO 80301 • (303) 449-4545 • Fax: (303) 449-2812
www.orthopro.com

No - Show / Billing policy

This is to inform you that Orthopedic Professional Association has a no-show policy. If you do not keep your regular scheduled physician / therapy appointment, you will be charged $40.00 for the missed appointment.
YOU WILL BE RESPONSIBLE FOR THIS CHARGE, as insurance companies do not pay for no-shows.

Orthopedic Professional Association will send out statements for any outstanding balances due. Any balance that exceeds the first billing cycle will have a $5.00 fee added on monthly until the balance is paid in full.

I have read all of the above and understand/agree to all provisions therein regarding responsibility for payments.

Patient's Name:_____ Date:_____
Patient's Signature:_____
Parent or Legal Guardian's Signature _____