



PATIENT'S FULL NAME _____ DATE OF BIRTH _____ AGE _____ SOCIAL SECURITY # _____

LOCAL MAILING ADDRESS/STREET ADDRESS _____ CITY / STATE _____ ZIP CODE _____ LOCAL / CELL PHONE NO. _____

PERMANENT MAILING ADDRESS / STREET ADDRESS _____ CITY / STATE _____ ZIP CODE _____ PERMANENT PHONE NO. _____

EMPLOYERS NAME & ADDRESS _____ CITY / STATE _____ ZIP CODE _____ EMPLOYER'S PHONE NO. _____

SPOUSE'S NAME _____ SPOUSE'S EMPLOYER (NAME, ADDRESS & PHONE NO.) _____ SPOUSE'S SOCIAL SECURITY NO. _____

NEAREST RELATIVE NOT LIVING WITH YOU (NAME, ADDRESS & PHONE NO.) _____

COMPLETE SECTION BELOW IF PATIENT IS A MINOR

RESPONSIBLE PARTY (NAME, ADDRESS & PHONE NO.) _____ DATE OF BIRTH _____ SOCIAL SECURITY # _____ PHONE NO. _____

RESPONSIBLE PARTY'S EMPLOYER (NAME, ADDRESS & PHONE NO.) _____

INSURANCE INFORMATION

NAME & ADDRESS OF COMPANY _____ JOB RELATED? _____

I.D. NUMBER _____ GROUP NO. _____ SUBSCRIBER'S SOCIAL SECURITY # _____

SUBSCRIBER'S NAME, ADDRESS & PHONE NO. _____

SUBSCRIBER'S DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

REFERRING PHYSICIAN INFORMATION

HOW DID YOU FIND OUT ABOUT OUR PRACTICE, i.e. newspaper, radio, internet, etc.? _____

REFERRING PHYSICIAN: _____

FAMILY PHYSICIAN: _____

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I, THE UNDERSIGNED, AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO ALPINE ORTHOPAEDICS AND SPORTS MEDICINE, P.C. FOR ANY SERVICES FURNISHED TO ME BY THE PHYSICIANS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY CONTRACT. I ALSO AUTHORIZE YOU TO RELEASE TO MY INSURANCE COMPANY INFORMATION CONCERNING HEALTH CARE, ADVICE, TREATMENT OR SUPPLIES PROVIDED TO ME. THIS INFORMATION WILL BE USED FOR THE PURPOSE OF EVALUATION AND ADMINISTERING CLAIMS OF BENEFITS.

SIGNED _____ DATE _____

MEDICARE LIFETIME SIGNATURE ON FILE

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO ALPINE ORTHOPAEDICS & SPORTS MEDICINE, P.C., FOR ANY SERVICES FURNISHED ME BY THE PHYSICIANS. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO BE RELEASED TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR BENEFITS PAYABLE FOR RELATED SERVICES.

SIGNED _____ DATE _____



DISCLOSURE AUTHORIZATION

Date: _____

Patient Name: _____

Names of family and/or friends we MAY discuss your treatment/health information with:

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

For privacy reasons, please list telephone numbers where we MAY leave messages:

Patient/Legal Representative Signature: _____ Date: _____

If Legal Representative what is your relationship to Patient: _____



New Patient Medical Information

****This is important information your doctor needs to know. Please provide as much information as possible****

Patient Name: _____ **Date of Birth:** _____

Age: _____ **Weight:** _____ **Height:** _____ **Sex:** _____

Your current physical health is: Good Fair Poor

Are you current under the care of a physician? Y N

If yes, please explain: _____

Do you smoke or use tobacco in any other form: Y N

If yes, please explain: _____

Do you use alcohol? ? Y N

If yes, please explain: _____

Have you had any previous fractures or sprains: ? Y N

If yes, please explain: _____

Have you had any surgeries? ? Y N

If yes, what kind: _____

Have you ever had a reaction to anesthesia? ? Y N

If yes, please explain: _____

Are you taking any medication? ? Y N

If yes, please list each one: _____

Are you allergic to any medication? ? Y N

If yes, please list each one: _____

Do you have any allergies, (including any food allergies)? ? Y N

If yes, please list each one: _____

Do you have a history of:

- | | | |
|---|---|-------------------------------|
| Y N Abnormal bleeding | Y N Epilepsy | Y N Low Blood Pressure |
| Y N Alcohol / Drug Abuse | Y N Heart Attack / Heart Murmur / Heart Surgery | Y N Fevers / Weight Loss |
| Y N Anemia | Y N Venereal Disease | Y N Mitral Valve Prolapse |
| Y N Arthritis / Stiff or Painful Joints | Y N Fainting Spells | Y N Pacemaker |
| Y N Artificial Bones / Joints / Valves | Y N Frequent Headaches | Y N Psychiatric Problems |
| Y N Asthma | Y N Glaucoma | Y N Rheumatic / Scarlet Fever |
| Y N Blood Transfusion | Y N Hay Fever | Y N Seizures |
| Y N Cancer / Chemotherapy / Radiation | Y N Hemophilia / Blood Disorder | Y N Shingles |
| Y N Clotting Disorder | Y N Hepatitis | Y N Sickle Cell Disease |
| Y N Colitis | Y N Herpes / Fever Blisters | Y N Sinus Problems |
| Y N Congenital Heart Disease | Y N High Blood Pressure | Y N Stroke |
| Y N Diabetes | Y N HIV+ / AIDS | Y N Thyroid problems |
| Y N Difficulty Breathing | Y N Hospitalized for any reason | Y N Tuberculosis (TB) |
| Y N DVT | Y N Kidney problems | Y N Ulcers |
| Y N Emphysema | Y N Liver Disease | Y N Latex Allergy |

Family Physician Name, Address & Phone: _____

Family History: Has any family member had any of the following disorders? If so, which relative?

Arthritis: Y N Type, if known: _____ Relative _____

Heart Disease: Y N Relative: _____

Muscle Disease: Y N Relative: _____

Diabetes: Y N Relative: _____

High Blood Pressure: Y N Relative: _____

Cancer: Y N Relative: _____

Are your parents living? Mother: Y N Age and cause of death: _____

Father: Y N Age and cause of death: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any change in my medical status. I hereby authorize the Doctor/Physician Assistant to provide medically necessary services, including x-rays, fracture treatment, casting, or procedures in the office, which are determined to be in the best interest of the patient.

Signature of Patient / Legal Guardian: _____ Relationship: _____ Date: _____



SPORTS PERFORMANCE &
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Gunnison, CO 81230
Fax: (970) 641-0282

FINANCIAL POLICY

INSURANCE : We are more than willing to bill your insurance company for you. As a matter of fact, with the CPT and ICD-9 coding required by insurance companies, it is easier for both of us and faster if we perform this service for you. If we **are** contracted with your insurance company we wait 45 days for insurance company payment. Upon receipt of insurance payment, or at 45 days, the patient or responsible party will be billed for the balance. If there is an overpayment, refund will be made to the patient or responsible party.

If we **are not** contracted with your insurance company, payment is expected at the time services are rendered. In order for you to be reimbursed, we will file a claim for you with your insurance company and have the payment sent directly to you. If your insurance company sends payment to us a refund will be made to the patient or responsible party.

PAST DUE ACCOUNTS: The patient or responsible party is responsible for contacting the insurance company if payment is not received within 45 days.

We do accept monthly payments but require that the payments be 10% of the total bill per month so as not to carry the account over one (1) year. There is a 1.8% (21.5% APR) finance charge on the balance due. If we do not receive a payment from you for two consecutive billings, we will turn your account over to a collection agency.

I certify that I have read and understand the above and agree that I am financially responsible for all charges whether or not paid by insurance. I agree that I am also financially responsible for **all collection fees** required to secure this obligation. I further understand that finance charges will be added to all accounts with unpaid balances over 45 days at the rate of 1.8% per month.

Signature / Date

IMPORTANT

Before you schedule your surgery, MRI, bone scan, epidural steroid injections or braces (soft goods) **YOU** need to check with your insurance company or workers compensation carrier. We are willing to **pre-authorize** this with your insurance company, but we encourage you to find out what your **benefits** are.

YOU will be responsible for any costs that your insurance does not pay. Many insurance companies will not pay for any part of the procedure/goods if they are not pre-authorized beforehand.

If you have any questions, please contact the office staff at 641-6788.

Signature / Date