

**COLORADO LIMB CONSULTANTS**  
**1601 East 19<sup>th</sup> Avenue, Suite 3300**  
**Denver, CO 80218**  
**303-837-0072**  
**303-837-0075 (fax)**

**Ross M. Wilkins, M.D.   Cynthia M. Kelly, M.D.   David B. Hahn, M.D.   Ronald R. Hugate, M.D.**

Dear Patient:

Thank you for scheduling your appointment with Colorado Limb Consultants. Our physicians look forward to meeting with you. Please arrive 15-20 minutes prior to your appointed time to complete the registration process.

You will find the paperwork necessary for our pre-registration process attached. Please complete these forms and bring them to your appointment. Any questions you have will be answered at that time. Please do not attempt to fax, mail or E-mail your completed forms as this may delay the check in process.

If your insurance company requires a referral to see a specialist, it is your responsibility to arrange for this in advance. If you're unable to obtain a referral, you will be asked to sign a waiver of liability form at the time of your appointment. If a co-pay is owed for the visit in our office, payment is expected at the time of service, unless other arrangements are made in advance. It is also important that you bring your insurance card to your appointment. Please keep in mind that as a new patient, your appointment may last up to two hours.

It is imperative that you bring the following information to your appointment:

- X-rays, (films, cd's/discs)
- MRI/CT reports (films, cd's/discs)
- Pathology slides, if applicable

This information will eliminate delays and also help your physician establish a treatment plan.

If you have questions regarding any of this information, you may phone our staff prior to your appointment or you may address your questions in person during the pre-registration process.

Thank you.

**COLORADO LIMB CONSULTANTS  
PATIENT INFORMATION**

Name (Last, First, Middle): \_\_\_\_\_ DOB: \_\_\_\_\_

Home Address: \_\_\_\_\_ City, State Zip: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ SS#: \_\_\_\_\_ Gender: \_\_\_\_\_

Marital Status: \_\_\_\_\_ E-mail Address (optional): \_\_\_\_\_

Cell Phone#: \_\_\_\_\_ Primary Care Provider: \_\_\_\_\_

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Primary Employer Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City, State Zip: \_\_\_\_\_

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**RESPONSIBLE/GUARANTOR INFORMATION (if different than above)**

Name (Last, First, Middle): \_\_\_\_\_ SS#: \_\_\_\_\_

Home Address: \_\_\_\_\_ City, State Zip: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Day Phone Number: \_\_\_\_\_

DOB: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

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**PRIMARY INSURANCE INFORMATION**

Name of Ins Company: \_\_\_\_\_ Member ID/Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_ Ins Telephone #: \_\_\_\_\_

Ins Address: \_\_\_\_\_ City, State Zip: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

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**SECONDARY INSURANCE INFORMATION (if applicable)**

Name of Ins Company: \_\_\_\_\_ Member ID/Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_ Ins Telephone #: \_\_\_\_\_

Ins Address: \_\_\_\_\_ City, State Zip: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

# Colorado Limb Consultants Registration Form

HOW WERE YOU REFERRED TO OUR OFFICE?

(PLEASE CHECK ONE FROM THE FOLLOWING)

EMERGENCY ROOM

PHYSICIAN

HEALTH PLAN

YELLOW PAGES

PATIENT

WORD OF MOUTH

MEDIA

OTHER: \_\_\_\_\_

WHO SENT YOU TO US, OR WHO TOLD YOU ABOUT OUR OFFICE: \_\_\_\_\_  
\_\_\_\_\_

IF YOU SENT TO US **BY A PHYSICIAN**, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Referring Physician Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, and Zip: \_\_\_\_\_

**WHO IS YOUR PRIMARY CARE PHYSICIAN? ( *The doctor that you see for check-ups and physicals* )**

Primary Care Physician Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

**IF YOU HAVE CONSULTED OTHER PHYSICIANS FOR THE PROBLEM YOU'RE PRESENTING TODAY, PLEASE PROVIDE:**

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

**IN CASE OF AN EMERGENCY, WHOM DO WE CONTACT?**

Name \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, and Zip: \_\_\_\_\_

Relationship: \_\_\_\_\_

**If the patient is a minor or student, please provide the name of the responsible party:**

Responsible Party Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Mother's Work Phone: \_\_\_\_\_

Father's Work Phone: \_\_\_\_\_

IS THE VISIT RELATED TO A WORK INJURY? YES  NO

IS THE VISIT RELATED TO AN AUTOMOBILE INJURY? YES  NO

*If the above answer is YES, please complete the following:*

Name of Auto or Work Comp. Insurance: \_\_\_\_\_

Name of Adjuster: \_\_\_\_\_

Adjuster's Phone: \_\_\_\_\_ Extension: \_\_\_\_\_

Claim Number: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Time: \_\_\_\_\_

Describe how the injury occurred: \_\_\_\_\_

\_\_\_\_\_

## Colorado Limb Consultants Orthopedic History

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_  
 SS#: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Have you had any recent weight gain or loss: YES  NO   
 If yes, how much \_\_\_\_\_

### Present Problem

What are your current symptoms? \_\_\_\_\_  
 \_\_\_\_\_

What caused these symptoms? \_\_\_\_\_  
 \_\_\_\_\_

What date did the symptoms begin? \_\_\_/\_\_\_/\_\_\_

Have you had problems like this before? YES  NO  If yes, when? \_\_\_\_\_

When did you first seek medical assistance for this problem? \_\_\_/\_\_\_/\_\_\_

From Whom? \_\_\_\_\_ What type of healthcare professional? \_\_\_\_\_

How would you rate your pain from Zero to Ten: (Zero= No pain, Ten = Intolerable, as bad as possible)

Pain on a good day: \_\_\_\_\_ Pain on a bad day: \_\_\_\_\_

### Previous Treatment for this Condition

Medication or injections for *this* problem:

Name of Medication	Dose (i.e. mg)	Frequency (i.e. 2x/day, 3x/day)	Results
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Number of surgeries for *this* problem?

Date	Surgery Type	Surgeon
___/___/___	_____	_____
___/___/___	_____	_____
___/___/___	_____	_____

Other Treatment for this problem (circle all that apply):

Cast    Splint    Exercise    Physical Therapy    Other: \_\_\_\_\_

### **General Health – Past Medical History and Review of Symptoms**

Please check if you have ever had any of the following conditions:

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Alcohol/Drug Abuse   | <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Heart Murmur                     | <input type="checkbox"/> Psychological Problems |
| <input type="checkbox"/> AIDS/HIV             | <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Hepatitis                        | <input type="checkbox"/> Reproductive Problems  |
| <input type="checkbox"/> Angina               | <input type="checkbox"/> Cancer             | <input type="checkbox"/> Hypertension/High Blood Pressure |   |
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Kidney Disease                   | <input type="checkbox"/> Thyroid                |
| <input type="checkbox"/> Back Problems        | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Liver Problems                   | <input type="checkbox"/> Urinary Tract          |
| <input type="checkbox"/> Bleeding Problems    | <input type="checkbox"/> Fever/Chills       | <input type="checkbox"/> Poor General Health              | <input type="checkbox"/> Other                  |
| <input type="checkbox"/> Blood Clots          | <input type="checkbox"/> Heart Attack       | <input type="checkbox"/> Problems w/Anesthesia            |   |

Are you currently under another physician's care? YES  NO

If yes, for what reason? \_\_\_\_\_

Significant past and current medical problems: \_\_\_\_\_

Please list previous surgeries not already listed:

Date	Surgery Type	Surgeon
____/____/____	_____	_____
____/____/____	_____	_____
____/____/____	_____	_____

Please list all medications, vitamins or herbal supplements you are taking on a regular basis:

Name of Medication	Dose	Frequency	Reason for Medication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any allergies to medications or to the environment?

**FAMILY HISTORY**

Please check any health problems diagnosed in your current family

<u>Condition</u>	<u>Who?</u>	<u>Condition</u>	<u>Who?</u>
Arthritis/Rheumatism	_____	Sciatic/Back Problems	_____
Hypertension	_____	Liver Problems	_____
Breathing Problems	_____	Kidney Disease	_____
Bleeding Problems	_____	Heart Problems	_____
Cancer	_____	Diabetes	_____
Angina	_____	Other	_____

**SOCIAL HISTORY**

Occupation: \_\_\_\_\_ Interests: \_\_\_\_\_

Which is your dominant hand? Left/Right \_\_\_\_\_ Exercise/Sports History: \_\_\_\_\_

Tobacco use:  Never used tobacco  Currently use tobacco  Smoke  Chew  I quit using tobacco \_\_\_\_\_ months/years ago

Alcohol use: :  Never used alcohol  Currently have \_\_\_\_\_ drinks per day

Is there anything else you feel that the doctor should know about your lifestyle or medical history?

\_\_\_\_\_  
\_\_\_\_\_

Please be aware that if you are taking herbal medications or supplements, you will need to advise your physician. You may need to stop taking them for two weeks prior to any scheduled surgery.

**COLORADO LIMB CONSULTANTS**  
**INFORMATION DISCLOSURE**

**Assignments of benefits:** I hereby assign Colorado Limb Consultants all payment(s) for the surgical and medical services rendered to my dependent or myself. I understand that I am responsible for the amount not covered by my insurance company.

Initial\_\_\_\_\_.

**Consent to Treatment:** I hereby grant Ross Wilkins, M.D, Cynthia Kelly M.D., David Hahn, M.D., Ronald Hugate, M.D. and the Physician Assistants the authority to treat and examine me or my dependent, order testing, treatment and any other medical treatment necessary for my care.

Initial\_\_\_\_\_.

**E-mail Communications:** I hereby grant Ross Wilkins, M.D., Cynthia Kelly M.D., David Hahn, M.D., Ronald Hugate, M.D. and the Physician Assistants the authority to send me E-mail communications, when applicable. As you may know, internet communication is not 100% confidential. As such, this type of communication is your discretion. In the cases of extremely important or sensitive information, verbal contact would be a priority. Also understand that all electronic communications will become a part of your permanent record at Colorado Limb Consultants.

Initial\_\_\_\_\_.

**Insurance Authorization:** I hereby authorize Colorado Limb Consultants to furnish my insurance carrier with information concerning my illness and treatment .

Initial\_\_\_\_\_.

**Payment of Office Visits:** Payment will be rendered in full at the time of service. For your convenience, our office accepts cash, checks, MasterCard, Visa, Discover and American Express. A \$25.00 service charge will be charged on all returned checks.

Initial\_\_\_\_\_.

**Provider:** We must emphasize that as medical care providers our relationship is with you and not your insurance company. Your insurance company is a contract between you, your employer and the insurance company. We are not a party to that contract. (This does not pertain to carriers such as HMO/PPO contracts).

Initial\_\_\_\_\_.

**Waiver Form:** If you arrive for an appointment and you do not have the appropriate referral/authorization form from your insurance company (HMO, POS etc), you will be expected to sign a waiver form prior to seeing the physician. This waiver stipulates that you could be financially responsible for the visit costs if our attempts to obtain the referral/authorization form fails.

Initial\_\_\_\_\_.

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient Representative

\_\_\_\_\_  
Date

If the patient is unable to sign please state the reason: \_\_\_\_\_

**COLORADO LIMB CONSULTANTS**  
**WAIVER FOR SURGICAL PROCEDURES**

Please be advised of the following information:

Every attempt will be made by this office to pre-certify or obtain authorization for your surgery, if required by your insurance company. We will also go through the steps required to determine if your surgery is a benefit of your policy. However, this is not a guarantee of payment. Benefits are determined at the time of claim submission. If your insurance company does deny payment, you will be responsible for payment of any services rendered.

Policy coverage information such as benefits, exclusions, co-pays, co-insurance, etc, can be obtained by calling the member service number on your insurance card. If your insurance is an HMO or requires referrals/authorizations, you are ultimately responsible for obtaining referrals/authorizations from your primary care physician, if and when they are needed.

**SURGICAL ASSISTANT**

The physicians may require a surgical assistant to perform your surgery safely. In some cases, two surgical assistants will be required. The surgical assistant aides the physician in performing procedures which are more complicated and therefore lessen the amount of time that you are in the operating room under a general anesthesia. Every effort will be made by the office to obtain authorization with your insurance company for the use of surgical assistant(s).

If your insurance policy does not have benefits which reimburse for a surgical assistant, you will be responsible for payment of the surgical assistant's fee. However, since benefits are not determined until the claim is submitted, all patients will be required to sign this waiver even if a surgical assistant has been pre-authorized. In most cases, the PA's at Colorado Limb Consultants are available to assist with your surgery. Every effort will be made to collect payment from your insurance company for these services. In the event the SA charge is denied, a first level appeal will be submitted, when applicable. If your insurance company denies the appeal, you will be responsible for this service. The most you would be expected to pay for the SA fee is \$175.

In some cases, the use of independent surgical assistants is required. When this occurs, the independent surgical assistant will submit their claim to your insurance company for payment. Surgical Assistant (SA) fees are typically 20% of the primary surgeon's fee. In the event your insurance company denies the charge, the staff at Colorado Limb Consultants will assist the SA billing group with any appeal efforts. However, you are ultimately responsible for any amounts they deem reasonable. As such, you will receive a statement/bill directly from the surgical assistant and are obligated to make payment arrangements directly with them.

I agree to accept full responsibility for fees not paid by my insurance company

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of legal guardian

\_\_\_\_\_  
Date

HCA Physician Services  
Colorado Limb Consultants

**Patient Consent Form**

(Please Read and Sign)

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I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that **Colorado Limb Consultants** may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that **Colorado Limb Consultants** will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

**MEDICARE PATIENTS:** I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to **Colorado Limb Consultants**.

I acknowledge that I have been given **Colorado Limb Consultants** Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official, Kara Burke.

Patient Initial: \_\_\_\_\_

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

\_\_\_\_\_  
Patient (or Responsible Party) Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Printed Name & DOB



**Denver Clinic for Extremities at Risk**  
**1601 East 19<sup>th</sup> Avenue, Suite 3250**  
**Denver, CO 80218**  
**Phone: 1-800-262-LIMB**  
**Fax: 303-839-6399**

## **Research Information**

### **Introduction**

Your physician is a member of the Denver Clinic for Extremities at Risk (DCER), a team of specialized healthcare providers composed in part of Drs. Wilkins, Kelly, Hahn and Hugate. DCER believes that clinical research is an important part of medicine. Our studies are reported at medical meetings around the world and/or published in medical journals.

### **Your Role**

You play an important role in how clinical research is done. You will be asked to complete questionnaires during your office visits, including the Health Status Questionnaire (HSQ), a nationally recognized tool which asks about your overall health and how well you take care of yourself. Other evaluations specific to the hip, the knee or the ankle may also be included in your packet. In addition, for certain research studies, you may be asked to fill out other questionnaires.

### **Information Storage and Confidentiality**

Your answers to the evaluations are entered and scored in a password-protected database program. Whenever your medical information is accessed and used for publication or presentation, your identity is kept confidential and your name is de-identified with a unique code. The HealthOne Alliance Institutional Review Board will have the right to inspect your research records, as will the physicians at P/SL who participate in your care and the research coordinator. Every effort will be taken to protect your identity and your personal information.

### **Financial Responsibility**

There are no costs to you for participating in a study.

### **Contact Information**

If you have questions about your role in the research conducted here, contact Katherine Pavlovsky, DCER Research Coordinator (303) 832-5462 or you may present questions during your appointment.

### **Research**

The data collected through your participation will possibly be used for presentations or publications to the medical community, although all information will be de-identified and thus not traceable back to you. Papers that are published using information from this office will be available for you to read in the waiting room as well as by request. If information will be collected during a visit or surgical procedure, we will give you an additional informed consent form and information on patient protected health information.

### **Alternatives**

You have the option of not participating in any study. If you would like to opt out, please let your physician or a member of the staff know. You will continue to receive care at this facility with no penalties but your information will not be used for any studies.

By signing below, you acknowledge that you have read the above information and understand that we may use your survey answers for research without further consent. For other studies that require more information, you will be given a separate informed consent document.

If you have questions or would like more information, please call 303-832-LIMB to speak with Katherine Pavlovsky, our Research Coordinator.

Thank you for your help.

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Patient Name/Signature

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Date