Colorado Orthopedic
Rehabilitation Specialists, LLC

**11325 N. Colorado Blvd.**
**Thornton, CO 80233**
**303.457.2022**
**Fax: 303.457.2320**
**www.ColoradoOrthoRehab.com**

# PATIENT INFORMATION

Welcome to Colorado Orthopedic Rehabilitation Specialists, L.L.C., a clinic specializing in the treatment of individuals with orthopedic problems. We are pleased to treat individuals with insurance coverage, workman's compensation, and those choosing to pay out of pocket. Each individual will be examined to determine an appropriate treatment plan. We strive to help you achieve your goals. If you ever have any questions, please address them with your therapist.

**Patient Rights:**

1. No person shall be excluded from participating, or be denied benefits of, or be subjected to discrimination in the provision of any care or services on the basis of race, color, religious creed, gender, national origin, citizenship, age, marital status, sexual orientation, ancestry, disability or any other prohibited basis under Federal, State and local law.
2. Patients have the right to be treated promptly with dignity and respect.
3. All patient information and records, including source of payment will be treated confidentially.
4. Patients have the right to get current information on their care and progress.
5. Patients have the right to ask for and receive a full explanation of their bill.
6. Patients have the right to use of an interpreter to be provided by their insurance carrier. Please notify the front desk of this before your first visit.
7. Patients may refuse treatment. Patients are responsible for their actions if they refuse treatment or do not follow their therapist's recommendations.

**Patient Responsibilities:**

1. Each patient is responsible to follow the treatment plan.
2. Each patient is responsible to keep appointments and to notify the clinic 24 hours in advance if unable to do so.
3. Each patient is responsible to notify the staff when the patient does not clearly understand something.
4. Each patient is responsible to give the clinic all applicable insurance and financial information.
5. Each patient is expected to be considerate of the staff, other patients, and clinic property.
6. Each patient is expected to provide complete medical history in order to allow for appropriate treatment and outcome.
7. If changes or concerns occur during the course of treatment, the patient must notify the therapist.

I have received a copy of the patient information form and understand it.

Patient Signature: _____ Date: _____

Patient or Guardian Signature: _____ Date: _____

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# PATIENT CONSENT

**Permission for Treatment:**
I give Colorado Orthopedic Rehabilitation Specialists, L.L.C. permission to provide necessary testing and treatment according to my diagnosis. I agree that no guarantee or promise has been made as to the results of the services I receive.

Initial _____

**Assignment of Benefits:**
I authorize direct payment to Colorado Orthopedic Rehabilitation Specialists, L.L.C of any insurance or health plan benefits payable for the service(s) I receive.

Initial _____

**Guarantee of Payment:**
I agree to pay Colorado Orthopedic Rehabilitation Specialists, L.L.C. for all charges NOT covered by my insurance or health plan. Co-payments are due at time of service. In the event collection action is undertaken, all costs that go with collection, including lawyer fees, will be the responsibility of the patient and/or guardian. Payment plans may be established at the discretion of the owner with appropriate arrangements. THERE WILL BE NO COURTESY DISCOUNTS GIVEN ON ANY AMOUNT THAT YOUR INSURANCE POLICY APPLIES TO YOUR COPAY OR DEDUCTIBLE. If you fail to pay your first bill provided, there will be an additional $10 assessed to each subsequent bill.

Initial _____

**Permission for Release of Records and Medical Information:**
I give permission for Colorado Orthopedic Rehabilitation Specialists, L.L.C to give medical information and/or copies of any medical records to insurance companies, worker's compensation carriers, medical or utilization review organizations, health maintenance organizations (HMO), etc., for the purpose of processing all or any portion of charges made relating to the care I receive at Colorado Orthopedic Rehabilitation Specialist, L.L.C. At times, we may need to request reports from your referring physician, in order to provide the most effective care, such as surgery notes or progress notes. Please note that this is an authorization for release of records which apply directly to your treatment. There is a charge for medical records in accordance to the Colorado fee schedule to cover costs of retrieving and printing.

Initial _____

**Appointments, No Show, and Cancellation Policy:**
We strive to maintain promptness in our appointments and we expect the same from you. Please arrive on time for your appointments. We pride ourselves in quality of care and shortened appointments may not allow us to fully address your needs. We will not be able to see you if you are more than 15 minutes late for an appointment. We require at least 24 hour notice for cancellation of appointments. Please give us a call as soon as you know that you will not be able to make an appointment or if you are running late. Sometimes we are able to reschedule appointments even last minute. If you have a late cancellation, no-show, or are more than 15 minutes late, you will be assessed a $60 fee. This fee is not covered by your insurance and must be paid before any further treatment will be provided. If there are three no-show appointments, your referring physician will be notified, your case will be discharged from our care, and your future appointments will be cancelled.

Initial _____

**Childcare:**
Childcare is not offered at this clinic. You may bring your children with you to your appointments, but they must be kept under control at all times to prevent injury. They are not allowed to climb on or use equipment. We would rather that you come in for appointments than cancel due to lack of childcare.

Initial _____

Patient Signature: _____Date:_____

Parent/Guardian Signature: _____Date:_____

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(Under age 18)

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with a copy of the Practice's Notice of Privacy Practices.

_____

Print Name

_____ _____

Patient (or Patient Representative*) Signature Date

_____

For Practice Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

*If Patient Representative is signing, legal documentation must be included designating authority to sign or receive information. This form must be maintained for 6 years.

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# REGISTRATION FORM

(Please Print)

Today's date:

## PATIENT INFORMATION

| Last name | First | Middle |
|---|---|---|
| | | |

| Social Security no.: | Home phone no.: | Cell phone no.: | Birth date: | Age: | Sex: |
|---|---|---|---|---|---|
| | ( ) | ( ) | / / | | ❑ M ❑ F |

| Street address: | City, State: | ZIP Code: |
|---|---|---|
| | | |

| Occupation: | Employer: | Employer phone no.: |
|---|---|---|
| | | ( ) |

Chose clinic because/Referred to clinic by (please check one box): ❑ Physician ❑ Insurance Plan ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Website ❑ Other _____

PCP or Referring Physician:

## INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

❑ Insurance ❑Self Pay

| Person responsible for bill: | Birth date: | Address (if different): | Home phone no.: (if different) |
|---|---|---|---|
| | / / | | ( ) |

| Occupation: (if different) | Employer: (if different) | Employer address: (if different) | Employer phone no.: (if different) |
|---|---|---|---|
| | | | ( ) |

Primary insurance

| Subscriber's name: | Subscriber's S.S. no.: | Birth date: | ID no.: | Group no.: |
|---|---|---|---|---|
| | | / / | | |

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

| Name of secondary insurance (if applicable): | Subscriber's name: | Group no.: | ID no.: |
|---|---|---|---|
| | | | |

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

## IN CASE OF EMERGENCY

| Name of friend or relative: | Relationship to patient: | Home phone no.: | Cell phone no.: |
|---|---|---|---|
| | | ( ) | ( ) |

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

*Patient/Guardian signature* *Date*

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# MEDICAL INFORMATION

(Please Print)

Name:

## CURRENT MEDICAL STATUS

Reason for visit:

Date of onset::

/ /

What do you think caused your symptoms?

My Symptoms are currently:

❑ Getting better ❑ Getting worse ❑ Staying about the same

I should not do physical activities that might make my pain worse:

❑ Agree ❑ Disagree ❑ Unsure

Treatments received for this problem:

Special tests performed (x-ray, MRI, labs):

Have you ever had this problem before?

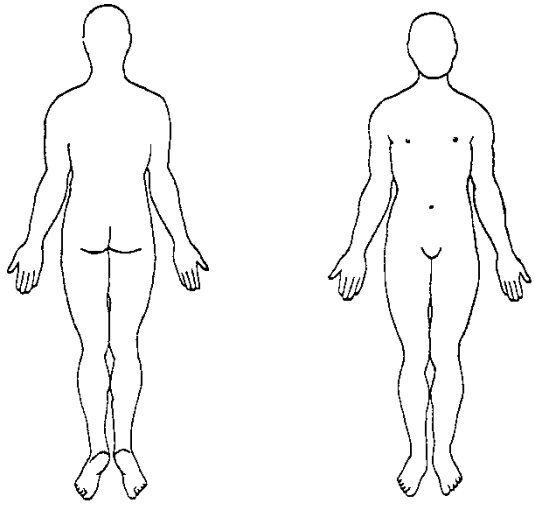
❑ Yes ❑ No

How are you currently able to sleep at night due to your symptoms?

❑ No problem ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

Please mark the areas where you feel pain on the chart to the right with the following symbols to describe your pain:

↓ **Shooting/sharp pain**
**O** **Dull/aching pain**
**|||** **Numbness**
**=** **Tingling**



Pain level in last 24 hours: 0=No pain, 10=Worst possible pain

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Worst | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Current | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Best | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Aggravating Factors

1. _____
2. _____
3. _____

Easing Factors

1. _____
2. _____
3. _____

Goals for therapy:

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Name:

## MEDICAL HISTORY

In the last 3 months have you noticed any of the following?

☐Abdominal pain
☐Appetite changes
☐Black tarry stools
☐Bowel/Bladder changes
☐Chest pain
☐Constipation
☐Cough
☐Diarrhea
☐Difficulty swallowing
☐Difficulty with balance
☐Dizziness
☐Fainting
☐Falls
☐Fatigue
☐Fever, chills, sweats
☐Frequent heartburn
☐Headaches
☐Hearing changes
☐Nausea or vomiting
☐Numbness or tingling
☐Pain that wakes you up at night
☐Pain with urinating
☐Ringing in ears
☐Sensation change
☐Shortness of breath
☐Swelling in legs or feet
☐Taste/smell changes
☐Vision changes
☐Weakness
☐Weight loss/gain >10lbs
☐Other health changes
_____

Have you EVER been diagnosed with any of the following conditions?

☐Alcoholism
☐Anemia
☐Anxiety
☐Arterial disease
☐Asthma
☐Blood clot
☐Cancer
☐Chest pain/Angina
☐Circulation problems
☐Dementia or memory issues
☐Depression
☐Epilepsy
☐Headaches
☐Heart problems
☐Hepatitis
☐High blood pressure
☐High cholesterol
☐HIV/Aids
☐Infection
☐Kidney problems
☐Liver problems
☐Lung problems
☐Lupus
☐Migraines
☐Multiple sclerosis
☐Neuropathy
☐Osteoarthritis
☐Osteopenia
☐Osteoporosis
☐Parkinson's
☐Psychological issues
☐Recreational drug use
☐Rheumatoid arthritis
☐Stroke
☐Thyroid condition
☐Traumatic brain injury
☐Tuberculosis
☐Ulcers
☐Other _____

**Diabetes:** Do you have diabetes? ❑ Yes ❑ No

☐ Type I
☐ Type II
☐Peripheral Arterial disease
☐Neuropathy
☐Sensation loss
☐Wounds or foot ulcers

**For Women**: Are you pregnant or think you may be pregnant? ❑ Yes ❑ No

**Falls**: Have you fallen in the last year? ❑ Yes ❑ No
If yes, how many times? _____ Did it result in any injury? ❑ Yes ❑ No

Please list accidents, injuries, hospitalizations, and surgeries with dates:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Current medications (with dosage) and supplements (or provide printed list):

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Allergies:

In what types of activities do you participate?