Orthopedic
Rehabilitation Specialists, LLC

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

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 the time of service. What if this account is sent to collections, we agree that in addition to any amount left owing to Colorado Orthopedic Rehabilitation Specialists, LLC, we will be responsible for interest at the rate of 18% annually on any past due balance, calculated from the date of service, plus court costs and reasonable attorneys' fees, with or without a suit, incurred in collecting any past due balance, and a collection fee equal to 40% of the past due balance. THERE WILL BE NO COURTESY DISCOUNTS GIVEN ON ANY AMOUNT THAT YOUR INSURANCE POLICY APPLIES TO YOUR COPAY OR DEDUCTIBLE. 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 the release of records that apply directly to your treatment. There is a charge for medical records in accordance with 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 on 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 the 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 an $80 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 canceled.

Initial _____

What if this account is sent to collections, we agree that in addition to any amount left owing to (Colorado Orthopedic Rehabilitation Specialists, LLC), we will be responsible for interest at the rate of 18% annually on any past due balance, calculated from the date of service, plus court costs and reasonable attorneys' fees, with or without a suit, incurred in collecting any past due balance, and a collection fee equal to 40% of the past due balance.

Initial _____

Patient Signature: _____ Date: _____

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PATIENT INFORMATION

Welcome to Colorado Orthopedic Rehabilitation Specialists, L.L.C., We are a clinic specializing in the treatment of individuals with orthopedic problems. We are pleased to treat individuals with insurance coverage, workman's compensation, auto insurance, 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 the 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.

If changes or concerns occur during the course of treatment, the patient must notify the therapist.

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.

7.

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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Parent/Guardian Signature: _____ Date: _____
(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.

Colorado *Orthopedic*
Rehabilitation Specialists, LLC

Cancellation Policy/No Show Policy

1. ***Cancellation/No Show Policy for therapy appointment***

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance, you will be charged a sixty dollar ($60) fee; this will not be covered by your insurance company.

2. Scheduled appointments

We understand that delays can happen, however we must try to keep the other patients and therapists on time. The therapist want to give you the most time possible as well.

If a patient is 15 minutes past their scheduled time, we will have to reschedule the appointment.

Payment Policy

We kindly ask for all payments to be made at time of service.

This includes: Deductible, co-insurance, or copay amounts.

Collections Policy

We make every effort to keep payments from going to collections. But in the event that my account is assigned to a collection agency, my account will be charged interest at the rate of 18% annually on all past due balances from the original due date, plus court costs and reasonable attorney's fees, with or without suit, incurred in collecting any past due balance, and a collection fee of up to 50% of the principal balance.

_____ _____ __/__/__

Signature Printed Name