575 Rivergate Lane, Ste 105

Durango, CO. 81301

970-259-3020

Date:______________________

Patient Information

Last Name First Name Middle Initial

Address City State Zip Code

Mailing address if different City State Zip Code

Preferred contact number Home Phone Cell Phone

E-mail Address Marital Status

Social Security Number: _____ - _____ - _______ Date of Birth: _____ / _____ / _______ Sex: ❑ Male ❑ Female

Preferred language: ______________ Race: ____________ Religion: _______________ Primary Care Doctor________________

Insurance

What is the name of your insurance provider: ❑ Medicare ❑ Medicaid ❑ BC/BS ❑ Other

Other (Please Specify): ____ Effective Date: _____ / _____ / _______

/

Name of policy holder: Last Name First Name Middle Initial Relationship to Patient

Address of policy holder if not the same as Patient's

City State Zip Code

Phone: (_______) _______ - __________

Social Security Number of Policy Holder: ______ - ______ - _________

Insurance Identification Number: ______________________________ Group Identification Number: ______________________________

Secondary/Supplemental Insurance

Carrier ____ Phone ( ) ______________________________

Address ______________________________________ City______________________ State__________ Zip ______________

Insured's Name ______________________________________ Relationship to patient ______________________________

Subscribers date of birth ______________________ ID# ______________________________ Group# ______________________

Employer ______________________________________ Employers Phone ( ) ______________________________

I hereby authorize the ______________________________ insurance company to pay by check made out and mailed directly to: Animas Orthopedic Associates. I authorize Animas Orthopedic Associates to release any medical information requested by my insurance company to process a claim.

X **Signed** ____________________ Please sign

Emergency Contact

Last Name | First Name | Middle Initial

Address

City | State | Zip Code

Home Phone | Work Phone | Cell Phone

E-mail Address | Relationship

Employment

Status: ☐ Retired ☐ Full-Time ☐ Part-Time ☐ Unemployed Other: ____________________

Name of Employer (Company Name) | Occupation

Phone Number: (____) _____ - _________.

Address

City | State | Zip Code

Advance Directives

Date Reviewed: ____________ ☐ None ☐ DNR ☐ Living Will ☐ Durable Power of Attorney ☐ HC Proxy

Race:________________ Religion:__________________ Primary Language:__________________

Do you have a preferred pharmacy?

____

Address: ____ Phone Number: ________________________________

Who can we share your medical information with (example—family or doctor's office)?

____ ____

____ ____

Are there any exclusions?

____

New Problem Questionnaire

Please Check a box as appropriate

Name:____ Age: _______Date:____________

1) Sex: ☐ Male or ☐ Female Height _______________ Weight ________________

2) Are you ☐ Right or ☐ Left Handed?

3) What brings you in today?____

____

____

4) What is your main problem?

☐ Pain ☐ Unstable or Dislocating Joint
☐ Numbness ☐ Swelling
☐ Weakness ☐ Stiffness
☐ Other (explain):____

5) How did your problem start? (give details as needed)

☐ Job Injury ☐ Sports Injury
☐ Motor Vehicle Accident ☐ Gradual or Slow Onset
☐ Other (explain):____

6) How long have you had this problem, approximately?______________________________

7) Is your pain: ☐ Aching ☐ Burning ☐ Dull ☐ Piercing ☐ Sharp ☐ Throbbing

8) Is your problem:

☐ Improving ☐ Worsening ☐ Staying the Same

9) Does your pain or problem awaken you from sleep? ☐ Yes ☐ No

10) Is your pain or problem intermittent? ☐ Yes ☐ No or Constant? ☐ Yes ☐ No

11) What worsens your problem? (give details as needed)

☐ Exercise ☐ Repetitive Motions ☐ Nothing
☐ Sitting ☐ Overhead Activities ☐ Rest
☐ Standing ☐ Going up and down stairs ☐ Walking
☐ Other (explain):____

12) What helps your problem? ☐ Brace ☐ Elevation ☐ Heat ☐ Ice ☐ Injection
☐ Massage ☐ Pain meds ☐ NSAIDs ☐ Physical therapy ☐ Rest ☐ Stretching ☐ Nothing
Other (explain):______________________

13) Are routine activities or walking limited because of your problem? ☐ Yes ☐ No

14) Do you use any assistive devices? ☐ Cane ☐ Walker ☐ Wheelchair ☐ Other:_____________

15) What tests have you had?

☐ X-rays ☐ Nerve Test (EMG or NCV)
☐ CT Scan or MRI ☐ Ultrasound ☐ Other:_________________

17) What medicines are you taking for this problem?______________________________________

18) Are you on or applying to any of the following programs because of your problem?

☐ Disability ☐ Worker's Compensation

19) What is your occupation?____

20) What is your present work status?

☐ Not Working Date last worked:_____________________________

☐ Light Duty For how long?________________________

☐ Regular Duty, no restrictions

21) If you are working, does your job require the following?

☐ Lifting How Many Pounds:________	☐ Extended Walking
☐ Frequent Bending & Lifting	☐ Continuous Standing
☐ Frequent Squatting or Kneeling	☐ Sitting
☐ Climbing	☐ Repetitive Motions

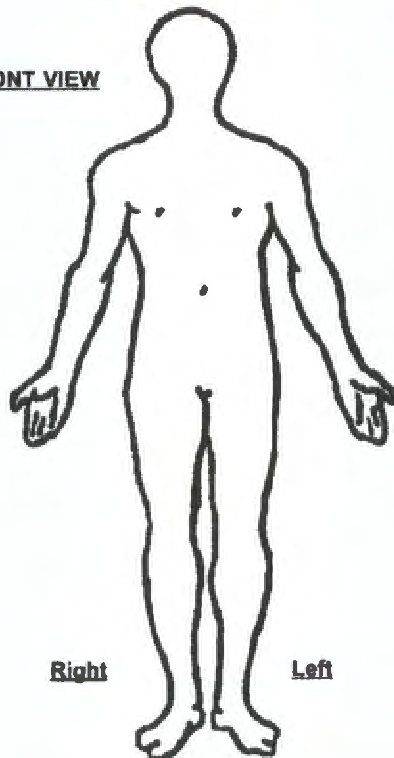
22) Any other acute problems in your life right now or anything else regarding your problem that you wish us to know?____

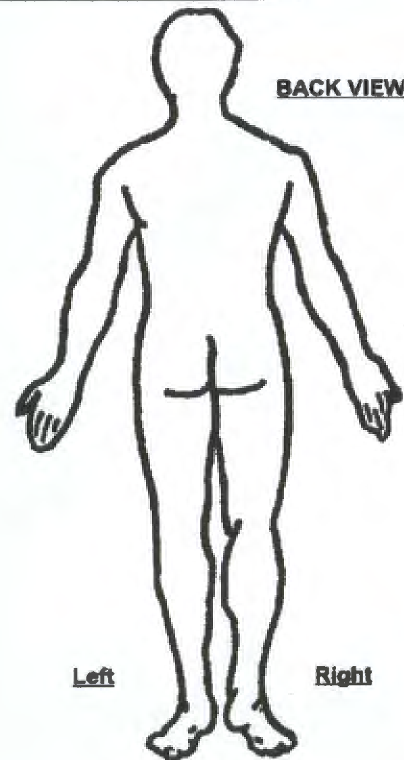
23) Please make a mark on the scale regarding the severity of your problem.

24) Mark the area(s) on your body where you feel the sensations described below, using the appropriate symbol. Include all pertinent areas and radiating pain.

○ *Ache* / *Sharp Pain* Δ *Burning or Tingling* # *Numbness*

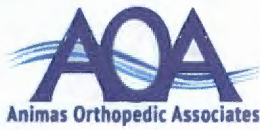
To complete the picture, draw in your face and place an "X" where the pain is worst now





X________________________________ ____________ X____________________

Signature of Patient, Parent, or Guardian Date Reviewed by MD



General Medical History Worksheet

Check boxes and fill in information as appropriate

Name: ______________________ Date of Birth: ____________ Date: ____________

Who are your primary doctor(s) to whom reports should be sent? ______________________

Past Medical History

☐ Diabetes/High Blood Sugar	☐ High Blood Pressure	☐ Heart Attack/Heart Disease	☐ Lung Disease/Emphysema (explain): ____________
☐ Arthritis	☐ Sleep Apnea	☐ Gout	☐ Prior Fractures/Broken Bones (explain): ____________
☐ Varicose Veins	☐ Thyroid Disease	☐ Psychiatric Problems	☐ Inflammatory Arthritis (Rheumatoid, Lupus, Psoriatic, Spondylitis)
☐ Fibromyalgia	☐ Stroke/T.I.A.	☐ High Cholesterol	☐ Bowel and GI Problems (explain): ____________
☐ Urinary Tract Infections	☐ Anemia/Hemophilia	☐ Blood Clot/Deep Vein Thrombosis	☐ Serious Infections (explain): ____________
☐ HIV/AIDS	☐ Breast Disease	☐ Poor Circulation or Vascular Disease	☐ Sexually Transmitted Disease (explain): ____________
☐ Prostate Disease	☐ Multiple Sclerosis	☐ Eating Disorder/Poor Nutrition	☐ Skin Disease (explain): ____________
☐ Kidney Disease	☐ Anesthesia Problems	☐ Gastric Ulcers	☐ Hepatitis ("Jaundice")/Liver Disease

Cancer History (type and current status): ______________________

Other Medical Problems: ______________________

Prior Hospitalizations and Surgical History ☐ No Past Medical History

Type of Surgery/Reason for Hospitalization	Date	Surgeon/Physican
1.		
2.		
3.		
4.		
5.		

Current Medications (include herbal supplements and attach sheet if necessary) ☐ Taking No Medication

Name of Medication	Dose/Strength	Schedule Taken
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Allergies to Medication or Materials ☐ None Known

Allergen	Reaction
1.	
2.	

Social Background

Marital Status: ☐ Married ☐ Domestic Partnership ☐ Single ☐ Divorced ☐ Widowed

Age(s) of children: ________________ Can someone care for you at home? ☐ No ☐ Yes who? __________

Do you drink caffeinated beverages? ☐ No ☐ Yes If so, how much per day? __________________________

Do you have a history of illicit drug use? ☐ No ☐ Yes If so, explain: __________________________

Do you use tobacco? ☐ No ☐ Yes If so, how much/ packs per day? ________ How many years? __________

Previously used tobacco? ☐ No ☐ Yes If so, did you quit ☐ 1 year ago ☐ > 5 years ago ☐ > 10 years ago

Do you drink alcohol? ☐ No ☐ Occasionally ☐ Daily How much? __________________________

Family Medical History

Relation	Age	State of Health	Age of Death	Medical Problems or Cause of Death
Mother				
Father				
Sibling ☐Bro ☐Sis				
Sibling ☐Bro ☐Sis				
Sibling ☐Bro ☐Sis				
Grandfather (maternal)				
Grandmother (maternal)				
Grandfather (paternal)				
Grandmother (paternal)				

Review of Systems: Are you currently having or have you had problems with:

Condition	Check a Box	Please Describe all "Yes" Responses
Fever or Shaking Chills	☐ No ☐ Yes	
Weight Loss (not Diet related)	☐ No ☐ Yes	
Chest Pain	☐ No ☐ Yes	
Lung or Breathing Problems	☐ No ☐ Yes	
Irregular Heart Beat	☐ No ☐ Yes	
Problems Urinating	☐ No ☐ Yes	
Loss of Strength or Numb/Tingling	☐ No ☐ Yes	
Bowel or Stool Problems	☐ No ☐ Yes	
Headaches	☐ No ☐ Yes	
Vision Problems	☐ No ☐ Yes	
Skin Issues	☐ No ☐ Yes	
Pregnancy or Menstrual Problems	☐ No ☐ Yes	
Lumps or Masses (incl. Breast)	☐ No ☐ Yes	
Fainting/Seizures/Blackout	☐ No ☐ Yes	
Bleeding or Blood Clots	☐ No ☐ Yes	
Psychiatric Issues	☐ No ☐ Yes	
Problems with Anesthesia	☐ No ☐ Yes	
Ears, Nose or Throat	☐ No ☐ Yes	

X ________________________________ ____________ X ____________________

Signature of Patient, Parent, or Guardian — Date — Reviewed by MD

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT.

This Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA). This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any written and oral health information about you, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

I. Uses and Disclosures of Protected Health Information The facility may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless the *facility* has obtained your authorization or the HIPAA privacy regulations or state law otherwise permits the use or disclosure. Disclosures of your protected health information for the purposes described in this Privacy Notice may be made in writing, orally, or by facsimile.

A. Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your protected health information to a pharmacy to fill a prescription or to a laboratory to order a blood test. We may also disclose protected health information to physicians who may be treating you or consulting with the facility with respect to your care. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of the other provider. **B. Payment**. Your protected health information will be used, as needed, to obtain payment for the services that we provide. This may include certain communications to your health insurance company to get approval for the visit or procedure that we have scheduled. For example, we may need to disclose information to your health insurance company to get prior approval for surgery. We may also disclose protected health information to your health insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. In order to get payment for the services we provide to you, we may also need to disclose your protected health information to your health insurance company to demonstrate the medical necessity of the services or, as required by your insurance company, for utilization review. We may also disclose patient information to another provider involved in your care for the other provider's payment activities. This may include disclosure of demographic information to anesthesia care providers for payment of their services. **C. Operations**. We may use or disclose your protected health information, as necessary, for our own health care operations to facilitate the function of the facility and to provide quality care to all patients. Health care operations include such activities as: quality assessment and improvement activities, employee review activities, training programs including those in which students, trainees, or practitioners in health care learn under supervision, accreditation, certification, licensing or credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs, and business management and general administrative activities.

In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

D. Other Uses and Disclosures.As part of treatment, payment and health care operations, we may also use or disclose your protected health information for the following purposes: to remind you of your appointment date, to follow-up with you regarding care provided by the facility, to inform you of potential treatment alternatives or options, to inform you of health-related benefits or services that may be of interest to you. This contact may mean leaving a message on an answering machine or voice-mail. If you do not wish for use to leave a message on an answering machine or individual other than yourself who answers the phone, please inform the office of this restriction. During your treatment we may use or disclose information in teaching residents, students, vendors or other health care providers. We may discuss your x-rays, surgery and results at the viewing boxes located in office hallways or in waiting rooms. If you object to these uses you need to notify the privacy officer.

Uses and Disclosures Beyond Treatment, Payment, and Health Care Operations Permitted Without Authorization or Opportunity to Object Federal privacy rules allow us to use or disclose your protected health information without your permission or authorization for a number of reasons including the following:

A. When Legally Required. We will disclose your protected health information when we are required to do so by any federal, state or local law. **B. When There Are Risks to Public Health**. We may disclose your protected health information for the following public activities and purposes:To prevent, control, or report disease, injury or disability as permitted by law.To report vital events such as birth or death as permitted or required by law.To conduct public health surveillance, investigations and interventions as permitted or required by law.To collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs or replacements to the FDA and to conduct post marketing surveillance. To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.To report to an employer information about an individual who is a member of the workforce as legally permitted or required. **C. To Report Suspended Abuse, Neglect Or Domestic Violence**. We may notify government authorities if we believe that a patient is the victim of abuse, neglect or

domestic violence. We will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure. **D. To Conduct Health Oversight Activities**. We may disclose your protected health information to a health oversight agency for activities including audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections; licenser or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law. We will not disclose your health information under this authority if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.**E. In Connection With Judicial And Administrative Proceedings**. We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. In certain circumstances, we may disclose your protected health information in response to a subpoena to the extent authorized by state law if we receive satisfactory assurances that you have been notified of the request or that an effort was made to secure a protective order.**F. For Law Enforcement Purposes**. We may disclose your protected health information to a law enforcement official for law enforcement purposes as follows:As required by law for reporting of certain types of wounds or other physical injuries.Pursuant to court order, court-ordered warrant, subpoena, summons or similar process.For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.Under certain limited circumstances, when you are the victim of a crime.To a law enforcement official if the facility has a suspicion that your health condition was the result of criminal conduct.In an emergency to report a crime.**G. To Coroners, Funeral Directors, and for Organ Donation**. We may disclose protected health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaverous organ, eye or tissue donation purposes.**H. For Research Purposes**. We may use or disclose your protected health information for research when the use or disclosure for research has been approved by an institutional review board that has reviewed the research proposal and research protocols to address the privacy of your protected health information.**I. In the Event of a Serious Threat to Health or Safety**. We may, consistent with applicable law and ethical standards of conduct, use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.**J. For Specified Government Functions**. In certain circumstances, federal regulations authorize the facility to use or disclose your protected health information to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.**K. For Worker's Compensation**. The facility may release your health information to comply with worker's compensation laws or similar programs.**Uses and Disclosures Permitted without Authorization but with Opportunity to Object**

We may disclose your protected health information to your family member or a close personal friend if it is directly relevant to the person's involvement in your care or payment related to your care. We can also disclose your information in connection with trying to locate or notify family members or others involved in your care concerning your location, condition or death. You may object to these disclosures. If you do not object to these disclosures or we can infer from the circumstances that you do not object or we determine, in the exercise of our professional judgment, that it is in your best interests for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your protected health information as described.

IV. Uses and Disclosures which you Authorize

Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.

V. Your Rights You have the following rights regarding your health information:

A. The right to inspect and copy your protected health information. You may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the facility uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to a law that prohibits access to protected health information. Depending on the circumstances, you may have the right to have a decision to deny access reviewed.

We may deny your request to inspect or copy your protected health information if, in our professional judgment, we determine that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referenced within the information. You have the right to request a review of this decision.

To inspect and copy your medical information, you must submit a written request to the Privacy Officer whose contact information is listed on the last page of this Privacy Notice. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request.

Please contact our Privacy Officer if you have questions about access to your medical record.

B. The right to request a restriction on uses and disclosures of your protected health information. You may ask us not to use or disclose certain parts of your protected health information for the purposes of treatment, payment or health care operations. You may also request that we not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this Privacy Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply.

The facility is not required to agree to a restriction that you may request. We will notify you if we deny your request to a restriction. If the facility does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Under certain circumstances, we may terminate our agreement to a restriction. You may request a restriction by contacting the Privacy Officer at «PrivacyOfficerNumber».

C. The right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not require you to provide an explanation for your request. Requests must be made in writing to our Privacy Officer.

D. The right to request amendments to your protected health information. You may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Requests for amendment must be in writing and must be directed to our Privacy Officer. In this written request, you must also provide a reason to support the requested amendments.

E. The right to receive an accounting. You have the right to request an accounting of certain disclosures of your protected health information made by the facility. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Privacy Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures for a facility directory, to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer. The request should specify the time period sought for the accounting. We are not required to provide an accounting for disclosures that take place prior to April 14, 2003. Accounting requests may not be made for periods of time in excess of six years. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

F. The right to obtain a paper copy of this notice. Upon request, we will provide a separate paper copy of this notice even if you have already received a copy of the notice or have agreed to accept this notice electronically.

VI. Our Duties The facility is required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our duties and privacy practices. We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all future protected health information that we maintain. If the facility changes its Notice, we will provide a copy of the revised Notice upon your first visit after the change is effective.

VII. Complaints You have the right to express complaints to the facility and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the facility by contacting the facility's Privacy Officer verbally or in writing, using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint. VIII. Contact PersonThe facility's contact person for all issues regarding patient privacy and your rights under the federal privacy standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. If you feel that your privacy rights have been violated by this facility you may submit a complaint to our Privacy Officer by sending it to:

Animas Orthopedic Associates 575 Rivergate Lane Suite 105 Durango, CO 81301 Attn: Privacy Officer (970) 259-3020 or (866) 737-4739 This Notice is effective September 15, 2008Animas Orthopedic Associates all rights reserved.

ANIMAS ORTHOPEDIC ASSOCIATES
AND
SPORTS MEDICINE

575 Rivergate Lane, Suite 105 ~ Durango, CO 81301
(970)259-3020 Fax: (970) 259-9766

Field T. Blevins, MD ~ Gareth Hammond, MD
Brinceton M Phipps, MD ~ Brian Butzen, MD

CONSENT OF DISCLOSURE

For the usage and/or disclosure of protected health information

I hereby give consent to Animas Orthopedic Associates and Sports Medicine (AOA) to use and disclose my protected health information (PHI) for the purpose of treatment, payment and health care operations (TPO).

AOA's Notice of Privacy Practices provides more detailed information about the usage and disclosure of my protected health information. I have the right to review the Notice before I sign this consent. AOA reserves the right to amend the Notice of Privacy Practices. I may obtain a copy of the current policy by contacting AOA at (970) 259-3020.

I have the right to request restriction on the usage and disclosure of my protected health information for the purposes of treatment, payment or health care operations. AOA is not required to grant my request, however, if it does, it is bound by the agreement.

I understand, with respect to payment for treatment received, that although I may be covered by insurance, I am personally responsible for all charges, unless the charges are covered under workers' compensation insurance.

I may cancel this consent in writing except to the extent that AOA has already made disclosures in reliance upon my prior consent.

If I do not sign this consent, Animas Orthopedic Associates and Sports Medicine may decline to provide treatment to me.

Signature of Patient/ Legal Guardian: ______________________________

Date: ______________________________

Print Patient's Name: ______________________________

Print Name of Legal Guardian: ______________________________

MEDICAL INSURANCE COVERAGE

For our patients who have medical insurance, we will be happy to submit your claims for services rendered. **Your co-payment is due at the time of service.** As we deal with literally hundreds of insurance companies, we can not have full knowledge of each carrier's particular benefits, or each patient's term of coverage.

Please bring the most current copy of your insurance card and a picture ID.

Although we are contracted providers for some insurance companies, there are many with who we are not contracted. In that instance, **payment in full is due at the time of service.** We will submit your insurance claims for you; however, it is the patients' responsibility to follow up with their insurance company should any payment issues arise.

If you are covered under a group policy provided by an employer, the personnel department can provide you with a comprehensive explanation of your benefits and coverage. Almost all insurance companies have a toll free number that can be accessed for any questions regarding your coverage. Whether it is medical, dental, automobile, or life insurance, it is the policyholders' responsibility to know the limits and terms of their coverage; **ultimately, the policyholder is responsible for all fees incurred.**

Insurance companies determine their reimbursement figures based on physician charges over a broad geographical area. As we all know, living in La Plata County is more expensive than living in Cortez or Grand Junction. Therefore, is some cases, our fees are higher than insurance maximums. In many instances, they are actually lower than the average. In cases where there are differences, we will not make any adjustments or write off balances. Payment at the time of service simplifies this process.

Insurance Terms

Co-Payment: This is usually a flat fee due when a patient sees a physician.

Co-Insurance: This is a percentage due by the patient for services rendered. Some plans pay 90%, the patient pays 10%. Others pay 80% or 70%, and the patient pays 20% or 30%.

Deductible: This is the amount due by a patient before insurance covers a charge. It is not always across the board, however. It may apply to an office visit, but not other charges incurred during that visit, i.e. x-ray, injection, etc.

Allowable Charge: The amount a practice has agreed to charge, per its contact with the insurance company.

Your co-payment is due at the time of service. However, it may not be the only thing you will ultimately owe. After insurance has processed your claim, you may receive a billing statement from us showing that you owe additional money because some charges were applied to your co-insurance, deductible, a non-covered service or a service that was not a benefit.

If you do not have any insurance coverage, payment in full is due at the time of service.

Our policy has always been to help our patients utilize their insurance coverage. Under no circumstances will we allow insurance companies to compromise or dictate the level of quality medical care provided to our patients or the fees required to support that level of care.

We value each and every patient who comes to us for medical care. It is important to us that you take an active part in your medical care as well as the financial responsibilities associated with that care. If you have any questions before or after seeing our physicians as a patient, please do not hesitate to speak with a member of our office staff.

FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted this financial policy. We are dedicated to providing the best possible care and service to you and regard your complete understanding and acceptance of your financial responsibilities as an essential element of your care and treatment
Unless other arrangements have been made in advance by either you or our insurance carrier, **full payment is due at the time of service, including any Medicare deductibles or co-payments.** For your convenience we accept cash, check, VISA and MasterCard.

We have made prior arrangements with some insurance companies to accept assignment of benefits. We will bill those plans with whom we have an agreement and will require you to pay only the authorized co-payment, co-insurance, and/or deductible at the time of service.

If you have an insurance company with whom we do NOT have a contract, we will file your insurance claim for you on an unassigned basis. This means your insurance company may send the payment directly to you. If payment is sent to us, and you have previously

paid the full amount of the charge, we will reimburse you the amount of the insurance payment. **The charges for your care and treatment are due at the time of service.** In the event your insurance carrier determines a service to be "not covered," "not a benefit," or a "non-covered" service, you will be responsible for the complete charge. Pre-authorization is **not** a guarantee of payment. It is ultimately your responsibility to contact you insurance company regarding your individual policy coverage.

We will bill your insurance carrier for all office physician services and/or physician services provided to you at the Animas Surgical Hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office for any unpaid charges. There may also e additional charges, such as laboratory, X-ray, pathology, anesthesiology, and/or a facility fee, which must be paid to the rendering facility or physician.

Animas Orthopedic and Associates requires 24 hours notice of cancellation for an appointment. There will be a $25 fee billed to the patient for any late cancellations or no shows.

In the current atmosphere of identity theft, we realize that some patients are concerned about providing their social security number to anyone. We appreciate your concerns about this issue; therefore, we take every possible precaution against this or any personal information getting into the wrong hands. However, if you would prefer to not provide this information to us, we must ask for payment in cash or credit card before you see they physician. We DO require a copy of your most current insurance card, and a picture ID, for your protection.

If a balance on any account remains unpaid after 45 days, that account may be sent to a collection agency. The patient/responsible party will then be responsible for the amount due plus all costs of collection, including but not limited to:

*All collection expenses charged by the collection agency
*Court costs
*Attorney's fees
*Any discounts previously applied to the account may be reversed

If your account is sent to a collection agency, you will be seen by this practice on an emergency basis only. Prepayment by cash or credit card will be required for any incurred charges.

Minor Patients
For all services rendered to minor patients (under 18 years of age), we will look to the adult accompanying the patient for payment. Custody agreements are not a consideration of this practice.

Financial Interest Statement
Dr. Field T. Blevins, Dr. Brinceton M. Phipps, and Dr. Gareth Hammond have a financial interest in the Animas Surgical Hospital LLC, which is a private, for-profit organization. As such, there is a financial incentive to order tests and perform surgeries and procedures at this hospital.

Statement of Responsibility, Assignment of Medical Benefits & Authorization for Release of Information
It is the policy of this office to have patients pay for services in the office on the day they are rendered.

I agree that if I or my minor children are covered by insurance, and if my carrier does not pay in full for services any one of us receives through Animas Orthopedic Associates and Sports Medicine, that I am personally responsible for payment of this balance within 15 days of billing.

In the event my balance becomes delinquent and further collection efforts are necessary, I agree to pay all costs and reasonable attorneys' fees incurred by Animas Orthopedic Associates and Sports Medicine, in said collection efforts.

My signature below represents my understanding and acceptance of this policy. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I hereby authorize the release by Animas Orthopedic Associates and Sports Medicine, any medical information necessary to process any claim or appeal on my behalf, or to another physician or facility for continuation of my medical care.

Signature of Patient/Legal Guardian____ **Date**____________________

Patient's Printed Name____