2222 N. Nevada, Suite 5017
Colorado Springs, CO 80907
Phone: (719) 635-2501
Fax: (719) 632-1062

Patient Registration

**Please read, print clearly and fill out completely*

Today's Date: _____

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

SSN: _____ Sex (circle): M F T Marital Status: Single Married Widowed Divorced

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ Employment Status: FT PT Unemployed Retired

Race: Native American Black Asian Hawaiian or Pacific Islander White Hispanic Other

Ethnicity: (circle) Hispanic/Latin Non-Hispanic/Latin Decline Preferred Language: _____

If patient is a minor, name of Custodial Parent: _____ Custodial Primary Phone: _____

Secondary Phone: _____ Custodial Parents SSN: _____

Primary Physician: _____ Referring Physician: _____

If no referring physician, please circle one: Self referral Hospital referral

Name of person/persons we may speak to regarding your medical care other than yourself:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Insurance Information

Primary Insurance: _____ Subscriber Name: _____

Subscriber's Date of Birth: _____ Subscriber's SSN: _____

Subscriber ID: _____ Relationship to patient: Self Spouse Parent Other

Secondary Insurance: _____ Subscriber Name: _____

Subscriber's Date of Birth: _____ Subscriber's SSN: _____

Subscriber ID: _____ Relationship to patient: Self Spouse Parent Other

Emergency Contact

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Preferred Pharmacy: _____ Location: _____

Rx History Consent: I hereby authorize CSSA to obtain my previous prescription/medication history through external sources. ____ (initials)

The above information is complete and correct. I hereby authorize release of information necessary to file a claim with my insurance company. I assign benefits otherwise payable to me to Colorado Springs Surgical Associates. I understand that I am financially responsible for charges for medical services rendered regardless of insurance coverage. I also understand that I am responsible for any office visit copayment due at time of service and/or deductibles, additional fees for form processing, returned checks, copying of medical records, and missed appointments that may apply. If this account is assigned to an attorney for collection and/or suit, a copy of the signature is valid as the original.

Signature of Patient or Legal Representative: _____ **Relationship**: _____

HEALTH SUMMARY

Name_____**D.O.B**._____**Age:** _____**Date** _____

CURRENT MEDICATIONS: include non-prescription, vitamin/ mineral supplements, & herbs

MEDICATION	DOSAGE	FREQUENCY

Medication allergies/Intolerance: _____ None: _____

Medical History

Hypertension Yes or No
Diabetes Yes or No
Reflux Yes or No
Cancer Yes or No Type_____
Weight Change Yes or No
Heart Disease Yes or No

Fatigue Yes or No
Recent Fever Yes or No
Hemorrhoids Yes or No
Blood Clots Yes or No
Kidney Disease Yes or No

Other: _____

Surgical History:

Date	Type of Surgery

Hospitalizations:

Date	Reason

Last Colonoscopy:_____ Last Influenza Immunization:_____ Last Pneumonia Vaccination: _____

Family History: *Please indicate medical conditions occurring within immediate family. If deceased, please indicate cause of death.*

Mother _____
Father _____
Siblings _____
Children _____

Social History (please circle if applicable):

Cigarette / Vape None Current Smoker How long?: _____ Former Smoker How long? _____

Tobacco Use (chew, pipe, cigar) None Current Use How long? _____ Former Use How long? _____

Drug Use None Current Use Former Use

Marijuana None Current Use Former Use

Alcohol Use Yes or No How often? (circle) Occasional Weekly Daily

Caffeine Use Yes or No

REVIEW OF SYSTEMS

Name_____**D.O.B**._____**Date** _____

Review of Systems: (please circle if you are experiencing)

Constitutional:	Chills Fatigue Fever Weight gain Weight loss
Ophthalmologic:	Blurred vision Itching and redness Eye Pain
ENT:	Hoarseness Difficulty Swallowing Sore throat Swollen glands
Respiratory:	Cough Shortness of breath at rest Shortness of breath with exertion Sputum production Wheezing
Cardiovascular:	Chest pain at rest Chest pain with exertion Orthopnea Palpitations Swelling in hands/feet
Gastrointestinal:	Abdominal pain Blood in stool Change in bowel habits Constipation Decreased appetite Diarrhea Heartburn Nausea Rectal bleeding Vomiting
Genitourinary:	Blood in urine Frequent urination Painful urination
Musculoskeletal:	Back problems Painful joints Swollen joints Weakness
Peripheral Vascular:	Absent pulses in feet Blanching of skin Blood clots in legs Cold extremities Decreased sensation in extremities Pain/cramping in legs after exertion Painful extremities Ulceration of feet
Skin:	Rash Skin lesion(s) Skin oozing
Neurologic:	Gait abnormality Headache Seizures Tingling/Numbness

For Update Only: Annual review of health summary

☐ I have marked current changes including medications

☐ No changes in health summary, including medications

Revised 01/18

Patient signature _____ Date _____

COLORADO SPRINGS SURGICAL ASSOCIATES P.C.

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I, _____, understand that as a part of my health care, Colorado Springs Surgical Associates, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

A basis for planning my care and treatment,
A means of communication among the many health professionals who contribute to my care,
A source of information for applying my diagnosis and surgical information to my bill,
A means by which a third-party payer can verify that services billed were actually provided, and
A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

The right to review the notice prior to signing this consent,
The right to object to the use of my health information for directory purposes, and
The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Colorado Springs Surgical Associates is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Colorado Springs Surgical Associates reserves the right to change their notice and practices and prior to implimentation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Colorado Springs Surgical Associates change their notice, they will send a copy of any revised notice to the address I've provided.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

_____ _____

Patient Signature (or legal representative) Date

COLORADO SPRINGS SURGICAL ASSOCIATES P.C.

FINANCIAL POLICY

Today's Date: _____

Patient Name _____
Last First MI

Date of Birth: _____ Social Security Number: _____

We are committed to providing you with the best possible medical care. If you have medical insurance, we would like to help you receive the maximum allowable benefits. In order to achieve this goal, we will need your assistance and understanding of our financial policies. Please carefully review this information and sign/initial where indicated. *Current insurance cards must be presented to the office at each visit. Any changes to personal information must be given to the office immediately.*

ASSIGNMENT: I request that payment of authorized insurance, Medicare, and Medicaid benefits be made payable to Colorado Springs Surgical Associates, PC on my behalf for services furnished to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. In the event that my account is turned over to a collection agency, I agree to pay all reasonable costs of collection and understand that I may no longer be a patient at this office.

_____(Initial) I have read and agree to the above statement.

CO-PAY/COINSURANCE/DEDUCTIBLE: I understand that my primary insurance will be billed; billing secondary insurance is a courtesy only and I am ultimately responsible for assigned co-payments, coinsurance and deductible amounts by primary and/or secondary insurance. Tertiary insurance billing remains my responsibility.

_____(Initial) I have read and agree to the above statement.

RELEASE OF INFORMATION: I authorize the holder of medical information about me to release any and all information to Centers for Medicare and Medicaid Services, its agents, my insurance carrier(s), or other entities as needed to determine these benefits or the benefits for my dependents or myself. If I have health insurance coverage under an HMO, I authorize Colorado Springs Surgical Associates, PC to release information concerning my diagnosis and treatment to my primary care or referring physician after each visit.

_____(Initial) I have read and agree to the above statement.

REQUESTS FOR INFORMATION: Should I receive any requests from my insurance company in regards to my services at this office, I must respond to that correspondence immediately, in order to have the claim processed and paid.

_____(Initial) I have read and agree to the above statement.

SELF-PAY PATIENTS: Self-pay and previous balance amounts are due and payable in full on or before the time of service.

_____(Initial) I have read and agree to the above statement.

PATIENTS WITH INSURANCE: Patients will be sent statements after we hear from your insurance carrier. Statements will then be sent showing patient responsibility. Payment is due in full within 30 days unless prior arrangements have been made.

_____(Initial) I have read and agree to the above statement.

WORKERS' COMPENSATION: I will provide approval/authorization by the Workers' Compensation carrier at the initial visit. If the claims deferred, the private medical insurance will be billed. I understand if the claim is denied, I will be responsible for payment in full. If the claim is in litigation, a verification of this from an attorney and/or the Workers' Compensation carrier will be provided to this office.

_____(Initial) I have read and agree to the above statement.

RETURNED CHECKS/NO SHOW POLICY: I understand, and agree to pay a returned check charge of $35.00 for each check that is returned for any reason. I agree to pay the amount of the check, plus the service charge within 30 days of receipt of notification. I understand and agree to pay a $50.00 charge for appointments that I do not honor or do not cancel within 48 hours prior to the scheduled appointment.

_____(Initial) I have read and agree to the above statement.

PRIVACY POLICY: I have been made aware of the privacy policy of Colorado Springs Surgical Associates, PC and have received (or reviewed or been given the option to receive and review) a copy of the Notice of Privacy Practices.

I have read and agree to the above information and I, the undersigned/patient, am ultimately responsible for the fees. By signing below, I consent to be contacted by regular mail, by email or by telephone (including a cell phone number) regarding any matter related to the above referenced account by the creditor, its successors or assigns. This consent includes any updated or additional contact information that I may provide and includes contact that employs auto-dialer technology and/or prerecorded messages.

Print Name: _____

Signature: _____ Date: _____

BARIATRIC SURGERY PATIENT INTAKE QUESTIONNAIRE

In order to maximize your experience, please take a moment to complete this questionnaire. All information will be kept confidential.

Please Print

First Name: _____ MI: ____ Last Name: _____

DOB: _____

Years obese: _____ Approximate weight last year: _____

Family History:

Parents overweight _____ Siblings overweight _____

Weight Loss Program History

Please indicate which *unsupervised* diets you have tried in the past:

☐ Atkins	☐ Calorie Counting	☐ South Beach Diet
☐ Health Spa	☐ Herbal Life	☐ High Protein
☐ Low Carbohydrate	☐ Mediterranean Diet	☐ Paleo Diet

Other: _____

Please indicate which *supervised* diets you have tried in the past:

- ☐ Diet Center: _____
- ☐ Jenny Craig
- ☐ Optifast/Medifast
- ☐ Physician Weight Loss Center
- ☐ Weight Watchers
- ☐ LA Weight Loss
- ☐ Nutri-System
- ☐ MRC

Please indicate which weight loss medications you have tried in the past:

☐ Fen-Phen ☐ Phentermine ☐ Redux

Current Habits

How many carbonated beverages do you drink a day? _____

How many meals a day do you eat? _____

Do you snack? If yes, describe: _____ How often: _____

Do you eat in the middle of the night? _____

How many times a week do you eat out in a restaurant? _____

How many times a week do you bring home take-out food? _____

How many glasses of water do you drink a day? _____

How many cups of coffee do you drink a day? _____

Do you drink alcoholic beverages? _____