COLORADO SPRINGS SURGICAL ASSOCIATES P.C.

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	Recent Fever	Yes or No
Diabetes	Yes or No	Hemorrhoids	Yes or No
Reflux	Yes or No	Blood Clots	Yes or No
Cancer	Yes or No Type_____	Heart Disease	Yes or No
Weight Change	Yes or No	Kidney Disease	Yes or No
Fatigue	Yes or No		

Other: _____

Surgical History:

Date	Type of Surgery

Hospitalizations:

Date	Reason

Last Colonoscopy:_____ Last Influenza Immunization:_____

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 _____

FINANCIAL POLICY

Colorado Springs Surgical Associates, PC

(Print clearly & press firmly in black ink)

Today's Date_____

Patient Name_____
Last First MI

Date of Birth _____ SSN _____

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 the 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 claim is 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 _____

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

FMLA and Short Term Disability Forms

To assist you in filing your work-related forms (FMLA, work release, return to work, short-term disability, and attending physician statements), please consider the following:

We will attempt to complete all work-related forms in a timely manner. Due to the exceptional number of requests for such forms, it is the policy of this office that these forms are presented to the office a minimum of 5 business days prior to the expected procedure. ***The charge to complete forms is $20.00 per occurrence or procedure.*** All work-related forms must be accompanied by a ***signed medical records release*** giving us permission to give personal medical information to designated parties, including diagnosis if indicated. We will not be held responsible for delay in completion of work-related forms if forms are presented less than the specified time allowance. If your employer has not provided a medical records release form, you will be requested to sign one in our office prior to releasing work- related forms.

We reserve the right to utilize preprinted FMLA and short term disability (attending physician statement) forms whenever possible. We will <u>not</u> complete patient demographics on any work-related forms if employee (patient) information is missing or incomplete. We do not request work related forms from employers. Day one of a medical leave is given as the date of the initial procedure/illness/accident unless otherwise indicated. Please leave <u>only</u> those forms requiring a physician's comments and signature. We cannot be responsible for entire "packets" of employee benefit forms.

You will be informed when forms are completed. Forms may be picked up by patient at front office, forms may be mailed to patient or faxed with your authorization.

Please provide the following information with your forms request:

- Date of anticipated return to work date, type of work performed, i.e. physical labor, office work, driving, desk job, etc.

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

I, _____, understand that as 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 implementation, 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
Notice of Privacy Practices for Protected Health Information
Effective Date: April 14, 2003

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully!

The office is permitted by federal privacy laws to make uses and disclosure of your health information for purposes oftreatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of Uses of Your Health Information for Treatment Purposes are:

- The receptionist or nurse obtains medical records or x-rays pertinent to your condition from your referring physician and imaging center prior to the initial office consult.
- During the course of your treatment, the surgeon determines he will need to consult with another specialist in the area. He will share information with such specialist and obtain his/her input or request additional treatment alternatives.
- Qualification for special, elective procedures require independent evaluations by contracted professionals. Patient demographics and diagnoses are provided fothe purpose of scheduling appointments and diagnostic testing.
- Information regarding your diagnosis, demographics, and pending surgery is provided to hospital departments involved in preoperative preparation or operative scheduling.

Example of Use of Your Health Information for Payment Purposes:
We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) requests information from us regarding medical care given. We will provide information to them about you and the care given.

- Some insurance plans require "authorization" for specific procedures, diagnostic tests or for inpatient hospitalizations. Information regarding diagnoses, treatment, or surgery is conveyed for this process.

Example of Use of Your Information for Health Care Operations:

We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services. Example: Medical transcription.

Your Health Information Rights

The health and billing records we maintain are the physical property of this office. The information in the records, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request to our office- we are not required to grant the request, but we will comply with any request granted;
- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office;

- Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering the request to our office;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office. We may deny your request if you ask us to amend information that:
    - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
    - Is not part of the health information kept by or for the office;
    - Is not part of the information that you would be permitted to inspect and copy; or,
    - Is accurate and complete.

    If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office. An accounting will not include uses and disclosures of information, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosure made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition, or your death.
- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office, except to the extent information or action has already been taken.

If you want to exercise any of the above rights, please contact Kelley Carr at 2222 N. Nevada Ave., Suite 5017, Colorado Springs, CO 80907, phone: 719-635-2501, during regular business hours. Requests must be in writing. She will inform you of the steps that need to be taken to exercise your rights.

Our Responsibilities

The Office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable request regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by callinand requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information you may contact Kelley Carr, Privacy Officer, at 635-2501.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Kelley Carr.

You may also file a complaint by mailing it ore-mailing it to the Secretary of Health and Human Services, whose street address and e-mail address is: Office for Civil Rights- U.S. Department of Health and Human Services – 200 Independence Avenue S.W. – Room 509F, HHH Building – Washington, D.C. 20201.

• We cannot, and will not require you to waive the right to file a complaint with the Secretary of Health and
Human Services (HHS) as a condition of receiving treatment from the office.

• We cannot, and will not, retaliate against you for filing a complaint with the Secretary ofHealth and Human Services.

Other Disclosures and Uses

Communication with Family

• Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Notification

• Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Research

• We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Disaster Relief

• We may use and disclose your protected health information to assist in disaster relief efforts.

Organ Procurement Organization

• Consistent with applicable law, we may disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Food and Drug Administration (FDA)

• We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation

• If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

• As authorized by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

Abuse & Neglect

• We may disclose your protected health information to public authorities as allowed by law to report . abuse or neglect.

Correctional Institutions

• If you are an inmate of a correctional institution, we may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of other individuals.

Employers

• We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of that information to your employer.

Law Enforcement

• We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecution, or to the extent an individual is in the custody of law enforcement.

Health Oversight

• Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

• We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

Serious Threat

• To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Governmental Functions

• We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Coroners, Medical Examiners, and Funeral Directors

• We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary for them to carry out their duties.

Other Uses

• Other uses and disclosures, besides those identified in this Notice, will be made only as otherwise required by law or with your written authorization and you may revoke the authorization as previously provided in this Notice under "Your Health Information Rights."

Website

• This Notice is posted on our website at www.coloradosurgical.com.

Venous Health History Form

Name: _____ DOB: _____

Sex: M F Age: _____

Doctor Name: _____

Directions: Please answer the following questions. Provide your best estimate for dates of occurrence.

Past Medical History

1. Have you ever had vein stripping surgery? Yes No
   If yes, when and which leg(s)? _____

2. Have you ever had vein injections? Yes No
   If yes, when, which leg(s) and location on the leg (calf, thigh, foot, etc.) ?

   _____

3. Have you ever had a blood clot in your leg? Yes No
   If yes, which leg(s) and when? _____

4. Have you ever had phlebitis? Yes No
   If yes, which leg and when? _____

Family History

Does anyone in your family have (or have a history of) varicose veins, spider veins, leg ulcers, or swollen legs?

Father..... Yes No
Mother..... Yes No
Brother(s)..... Yes No
Sister(s)..... Yes No
Other..... Yes No

1. Do you experience any of the following?
    a. Aching/pain in your legs..... Yes No
    b. Heaviness in legs..... Yes No
    c. Tiredness/fatigue..... Yes No
    d. Itching/burning..... Yes No
    e. Swollen ankles..... Yes No
    f. Leg cramps..... Yes No
    g. Restless legs..... Yes No
    h. Throbbing..... Yes No
    Other:_____

Do you experience these problems in one, or both legs? One Both

2. Have your veins gotten worse in recent months? Yes No

3. Do you elevate your legs to relieve discomfort? Yes No

4. Do you wear support hose prescribed by your doctor? Yes No

If yes, what type of how long have you worn them?

_____

5. Do you wear light support hose (e.g. sheer energy)? Yes No

6. Do they provide relief? Yes No

7. Do you have any problem walking? Yes No

8. Do you stand much at work? Yes No
    At home? Yes No

9. Have you ever had any test(s) done on your veins? Yes No

10. Were you diagnosed with saphenous vein reflux