PHYSICIAN TO BE SEEN: _____ Date: _____

NAME: Last_____First:_____MI: _____

Address:_____City/State:_____Zip: _____

Home Phone:_____Work Phone:_____Cell Phone: _____

Social Security Number:_____-_____-_____ Date of Birth:_____Age_____

Employer: _____

Family Physician:_____Referred to us by: _____

## IF PATIENT IS A MINOR - GUARANTOR INFORMATION

Guarantor's Full Name:_____

Guarantor's Address: _____

Guarantor's SSN:_____-_____-_____ Guarantor's Date of Birth: _____

## INSURANCE INFORMATION

Insured's Name:_____Insured's Date of Birth: _____

Patient's Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Primary Insurance Name:_____Policy #:_____Group #: _____

Secondary Insurance Name:_____Policy #:_____Group #: _____

If Workmen's Comp or Auto Claim, please provide the following: Claim# _____

Name and Address of Insurance Carrier: _____

Adjuster's Name_____Phone #_____ext. _____

## INJURY INFORMATION

Date of Injury: _____

Is This Injury Work Related? ☐ Yes ☐ No Auto Accident? ☐ Yes ☐ No Other Injury? ☐ Yes ☐ No

How Did Your Injury Occur?_____Where? _____

Which Body Part is Injured? _____ Right _____ Left _____

If Non-Injury, What Body Part? _____

**CONTINUED ON NEXT PAGE**

**Western Slope Orthopaedics has my permission to release my personal medical information to the following people:**

Name:_____ Relationship:_____ Phone #_____

Name:_____ Relationship:_____ Phone #_____

Name:_____ Relationship:_____ Phone #_____

**I DO NOT want my personal medical information released to the following individuals or organizations:**

Name or Business: _____

Name or Business: _____

Name or Business: _____

# INSURANCE ACKNOWLEDGEMENT/AUTHORIZATION

You are responsible for supplying your own personal insurance, or work comp/auto information to our office. If you do not give us your information, **you** will be responsible for all charges incurred and payment will be expected at the time of service.

I request that payment of authorized insurance benefits be made on my behalf to Western Slope Orthopaedics for any services rendered to me by C. Kelly Bynum, M.D., Thomas F. Dwyer, M.D., William E. Faragher, M.D., Timothy R. Judkins, M.D., Glenn E. Oren, M.D., Rhonda L. Parker, D.O., and Vineet Singh, M.D. I authorize any holder of medical information needed to determine these benefits payable for related services rendered. I understand that I am responsible for any amount of my charges **NOT** covered by my insurance. All information on this form is true to the best of my knowledge. I agree to the information stated above. A photocopy of this authorization shall be considered as valid as the original.

_____ _____

Signature of Patient/Guarantor Print Name of Patient/Guarantor

_____

Date

**CONTINUED ON NEXT PAGE**

# PRESCRIPTION POLICY

- Prescriptions may be refilled **MONDAY through FRIDAY ONLY**, **NO holiday or weekend refills.**
- We require a minimum of **48 HOURS** notice to process prescription renewal and/or pick-up requests.
- Patient is responsible for knowing when medication(s) will need to be refilled.
- Prescription pick-up: Monday-Friday during business hours **ONLY** (8am-5pm).
- Prescriptions will not be filled for unauthorized "walk-in" patients.

****Note: The Physicians & Physician Assistants may be inaccessible because of surgery & clinic schedules and therefore not available to authorize refills. Please plan ahead.****

- Non-controlled or non-narcotic prescriptions require a follow up appointment every 4 weeks.
- Controlled-substances/narcotic prescriptions require a follow up appointment every 2-4 weeks.
- New symptoms and/or events require a clinic appointment. Provider is unable to diagnose over the phone.
- We require a signed **"Controlled Substance Policy"** statement on hand if you are requesting or using narcotics or controlled medications.
- No early refills or prescription replacement if medications are overused/abused/misused. You must follow prescription directions.
- Medications are for the prescribed individual's use only. It is illegal to "share" your medicine.
- Patient must pick-up their controlled substance prescription(s) in person, unless pre-authorized by staff.

**THESE PROTOCOLS ARE PER RECOMMENDATIONS OF THE COLORADO BOARD OF MEDICAL EXAMINERS AND THE DRUG ENFORCEMENT AGENCY (DEA).**

**I understand and accept the protocol listed above. My failure to comply may result in the immediate termination of prescriptive medications.**

Patient Name: _____ Date _____/_____/_____

Signature: _____

Name of person authorized to pick up Rx (if not same): _____

**We strive to offer the best care and services for each of our patients in a timely manner. Because Physicians and Physician Assistants are often inaccessible due to surgery or inpatient needs, the above protocols are essential and necessary to manage a busy clinic efficiently. Thank you for your cooperation and understanding.**

**Sincerely,**
***The Physicians and Staff of Western Slope Orthopaedics***

# CONTROLLED SUBSTANCE POLICY

If you receive a prescription for a "controlled" (Schedule II through V) drug, your identifying prescription information will be entered into Colorado's Prescription Drug Monitoring Program (PDMP) database when this drug is dispensed to you. Your prescription information in the database is a protected health record and cannot be accessed by non-caregivers except as part of an authorized investigation. You have a right to access your information in the PDMP through the Colorado Board of Pharmacy. You may seek corrections to the information as you would with your other medical records.

Controlled Substances such as morphine, Percocet, methadone and codeine are some of the strongest known pain relievers. Studies suggest that they can be very helpful for some patients with pain. There are some patients who report being able to do more when they take narcotics, and others who do not. Most patients report considerable, but not complete pain relief.

**My signature below indicates that I have read this Controlled Substance Policy and acknowledge and agree to the following statements:**

I understand that taking narcotics might impede my ability to concentrate and think clearly, though this side effect usually decreases in time. Side effects may also include constipation, dizziness, itching, nausea, and difficulty urinating. If I already have these problems, I have told my doctor. I understand that the narcotics prescribed to me are intended to control, but not necessarily eliminate my pain.

I understand that taking narcotics regularly for a long period of time usually causes physical dependence. This means that if I stop taking the medications suddenly, I could experience withdrawal symptoms, such as tearing, runny nose, difficulty sleeping, agitation, rapid heart rate, abdominal pain, and severe discomfort. I also understand that taking narcotics over a long period of time might put me at risk for developing an addiction. This means that I could become preoccupied with taking narcotics or other drugs to the point that other important aspects of my life, such as family, friends, work, and health, could suffer.

WOMEN: Taking regular doses of narcotics during pregnancy can be harmful to developing babies. I am definitely not pregnant now, and I will make sure as best I can that I will not become pregnant while I am taking narcotics. If there is a possibility of pregnancy, please consult with your primary care physician.

**Further, I agree that:**

1. I will take my medication exactly as prescribed by my doctor. I will not take medications in excess of my doctor's instructions.
2. I will avoid alcohol on days that I take narcotics. I will avoid all illicit drugs.
3. I will not drive, operate heavy machinery, or serve in any capacity related to public safety while taking narcotic medications.
4. I will submit a urine specimen or perform a breath alcohol test (BAT) whenever my doctor requests to test for narcotics and other drugs to help monitor me for addiction.
5. I will allow my doctor to contact other associated healthcare providers to discuss my uses of medications.
6. I agree to not get any other narcotics from any other physician.
7. I agree to utilize only one pharmacy for all of my narcotic prescriptions.
8. If my doctor recommends, I will see a specialist for the purpose of determining whether I am developing an addiction.

Signature _____ Print Name _____

Date _____

# Appointment Cancellation / No Show Policy

Western Slope Orthopaedics encourages patients to give us at least 24 hours advance notice of cancellation of any appointment. Likewise, we ask patients to arrive punctually for their scheduled appointment to avoid any unnecessary delays or inconveniencing of other patients.

If you fail to appear for or cancel an appointment without at least 24 hours advance notification to this office, a $50.00 fee will be applied to your account.

This charge is not covered by any insurance plan; therefore you will be personally responsible for this fee before further appointments are allowed.In addition, no further appointments will be made without a refundable deposit of $50.00 for a routine office visit and $150.00 for a new patient and/or new problem visit. This deposit is fully refundable if you call to cancel the appointment with 24 hours advance notice.

After three (3) missed appointments (failure to show or call 24 hours in advance), you may be discharged from care as a direct result of being “non-compliant to treatment.”

***My signature below indicates that I understand and will abide by this policy.***

_____ _____

Signature Print Name

_____

Date

# IMPORTANT NOTICE REGARDING THE PRIVACY OF YOUR HEALTH INFORMATION
# WESTERN SLOPE ORTHOPAEDICS

Effective April 14, 2003, revised regulations restrict the use and disclosure of your private health information (PHI) by our practice and other organizations. It has been, and continues to be, the policy of our practice to protect the privacy of our patients' health information and to comply with any regulations regarding the use and disclosure of patient health information. The following summarizes the new law and under what circumstances your PHI may be disclosed.

**Permitted Disclosures**
Our practice is permitted to use and disclose your PHI for treatment, payment and health care operation purposes. These uses include sharing your PHI with other health care providers for confirmation of a diagnosis, using your PHI to accurately bill services we provide to you, providing your PHI to your insurance company for reimbursement, to remind you of appointments and as part of our quality improvement program.

We are also permitted to disclose your PHI in compliance with guidelines outlined by law and when required to do so by various government agencies. We may also disclose your PHI to family members, relatives or a close personal friend when the information we disclose is relevant to the individual's involvement with your care or is required to assist in your health care (e.g., pick up prescriptions or other documents, note follow-up care instructions, etc.). We will disclose your PHI when we refer you to other physicians or providers of health care. Finally, we reserve the right to change a privacy practice described in this notice as may be permitted or required by law and to make such change effective for all protected health information.

**Restricted Disclosures**
You have the right to request restrictions on certain uses and disclosures of your PHI and to request portions of your PHI be amended. However, our practice is not obligated to agree to requested restrictions or to amend your PHI in the manner you request. You also have the right to inspect and receive a copy of your PHI, but must pay a reasonable charge for the labor and costs associated with copying your PHI. Finally, you have a right to receive an accounting of disclosures of your health information.

**Authorization for Other Uses**
Our practice will make other uses and disclosure of your protected health information ONLY after obtaining your written authorization. If you authorize a use not contained in this notice, you may revoke your authorization at any time by notifying us in writing that you wish to revoke your authorization.

**Concerns**
If you believe your privacy rights have been violated, you may contact Kathy Simpson at 910 South Fourth Street, Montrose, CO 81401-4226, 970-249-6641 or the Secretary for the Department of Health and Human Services. No individual will be retaliated against for filing a complaint.

**Acknowledgement**
I acknowledge that I have received this summary and a copy of the Notice of Privacy Practices regarding the use and disclosure of my private health information.

_____ _____

Signature Print Name

_____

Date