



Date: _____

Name: Last _____ First: _____ MI: _____

Date of Birth: _____

Mailing Address _____

City _____ State _____ Zip: _____

Primary Phone# _____ Secondary Phone # _____

Social Security Number _____ - _____ - _____ Age _____

E-Mail _____

Race: _____ Ethnicity: _____ Preferred Language _____

Appointment Reminders: Text Message Phone Call E-mail

IF PATIENT IS A MINOR-GUARANTOR INFORMATION

Guarantor's Full Name _____

Guarantor's Address _____

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

INSURANCE INFORMATION

Policy Holders Name (if other than patient) _____

Relationship to Patient _____ Policy Holders DOB _____

******If this visit related to a Workman's Comp or Auto Claim, Please provide the following:**

Claim # _____ Insurance Carrier: _____

Adjuster's Name _____ Adjusters Phone # _____

Date of Injury _____ Employer: _____



Release of Protected Health Information

Western Slope Orthopaedics has my permission to release my personal information to the following people.

Name: _____ Relationship: _____ Phone# _____

Name: _____ Relationship: _____ Phone# _____

Name: _____ Relationship: _____ Phone# _____

Signature _____

Printed Name _____

Date _____



Patient Financial Responsibility/ Insurance Acknowledgement & Authorization

Thank you for choosing **Western Slope Orthopaedics** as your healthcare provider. We are honored by your choice and committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

- The patient is ultimately responsible for the payment of his/her treatment and care.
- The patient is responsible for charges associated with Insurance co-pays or non-covered charges such as deductible or coinsurance amounts.
- Self-pay patients are eligible for a cash discount of 30% up to 30 days after the date of service seen.
- The patient is responsible for any costs associated with collections of patient balances.
- Patient statements are mailed monthly. The patient is responsible for making a payment, or for arranging a payment plan, within 30 days of the date that appears on his/her patient statement.
- The patient is aware that failure to pay for his/her treatment and care will result in collection actions being taken to collect the debt (i.e. being sent to a collection agency)

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., Timothy R. Judkins, M.D., Ryan K. Albrecht, M.D, Joshua Bagley, M.D, Jared Sanderford, 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.

By my signature below, I hereby authorize the assignment of financial benefits directly to Western Slope Orthopaedics. I understand that I am financially responsible for charges not covered by this assignment.

Signature of Patient or Guardian: _____ **Date:** _____

Name of patient: _____



Important notice regarding the privacy of your health information

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 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 _____