COLORADO LIMB CONSULTANTS
1601 East 19th Avenue, Suite 3300
Denver, CO 80218
303-837-0072
303-837-0075 (fax)

Ross M. Wilkins, M.D. Cynthia M. Kelly, M.D. David B. Hahn, M.D.
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Dear Patient:

Thank you for scheduling your appointment with Colorado Limb Consultants. Our physicians look forward to meeting with you. Please arrive 15-20 minutes prior to your appointed time to complete the registration process.

You will find the paperwork necessary for our pre-registration process attached. Please complete these forms and bring them to your appointment. Any questions you have will be answered at that time. Please do not attempt to fax, mail or E-mail your completed forms as this may delay the check in process.

If your insurance company requires a referral to see a specialist, it is your responsibility to arrange for this in advance. If you're unable to obtain a referral, you will be asked to sign a waiver of liability form at the time of your appointment. If a co-pay is owed for the visit in our office, payment is expected at the time of service, unless other arrangements are made in advance. It is also important that you bring your insurance card to your appointment. Please keep in mind that as a new patient, your appointment may last up to two hours.

It is imperative that you bring the following information to your appointment:
- **X-rays, (films, cd's/discs)**
- **MRI/CT and reports (films, cd's/discs)**
- **Pathology slides, if applicable**
- **Operative Note – if prior surgery is applicable to your current problem & your appointment**

The absence of this information may result in the need to reschedule your appointment. This information will eliminate delays and also help your physician establish a treatment plan.

If you have questions regarding any of this information, you may phone our staff prior to your appointment or you may address your questions in person during the pre-registration process.

Thank you.

Revised 07/2014

COLORADO LIMB CONSULTANTS
PATIENT INFORMATION

Name (Last, First, Middle):_____ DOB:_____

Home Address:_____City, State Zip: _____

Home Phone Number:_____SS#:_____ Gender:_____

Marital Status:_____ E-mail Address (optional): _____

Cell Phone#:_____ Primary Care Provider:_____

Primary Employer Name: _____ Work Phone: _____

Address: _____ City, State Zip: _____

RESPONSIBLE/GUARANTOR INFORMATION (if different than above)

Name (Last, First, Middle):_____ SS#: _____

Home Address: _____ City, State Zip: _____

Home Phone Number: _____ Day Phone Number: _____

DOB: _____ Relationship to Patient: _____

PRIMARY INSURANCE INFORMATION

Name of Ins Company: _____ Member ID/Policy #: _____

Group #: _____ Ins Telephone #: _____

Ins Address: _____City, State Zip: _____

SECONDARY INSURANCE INFORMATION (if applicable)

Name of Ins Company: _____ Member ID/Policy #: _____

Group #: _____ Ins Telephone #: _____

Ins Address: _____ City, State Zip: _____

_____ _____

Signature of Patient/Guardian Date

Colorado Limb Consultants
Registration Form

HOW WERE YOU REFERRED TO OUR OFFICE?
(PLEASE CHECK ONE FROM THE FOLLOWING)

- ☐ **EMERGENCY ROOM**
- ☐ **PHYSICIAN**
- ☐ **HEALTH PLAN**
- ☐ **MEDIA**
- ☐ **PATIENT**
- ☐ **OTHER: _____**

WHO SENT YOU TO US, OR WHO TOLD YOU ABOUT OUR OFFICE:_____
_____

IF YOU SENT TO US **BY A PHYSICIAN**, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Referring Physician Name: _____

Phone:_____ Fax: _____

Address: _____

City, State, and Zip: _____

WHO IS YOUR PRIMARY CARE PHYSICIAN? (***The doctor that you see for check-ups and physicals)***

Primary Care Physician Name: _____

Phone: _____ Fax: _____

Address:_____

City, State, Zip: _____

IF YOU HAVE CONSULTED OTHER PHYSICIANS FOR THE PROBLEM YOU'RE PRESENTING TODAY, PLEASE PROVIDE:

Physician's Name:_____ Phone:_____

Address:_____

City, State, Zip:_____

IN CASE OF AN EMERGENCY, WHOM DO WE CONTACT?

Name_____ Phone:_____

Address: _____

City, State, and Zip: _____

Relationship: _____

If the patient is a minor or student, please provide the name of the responsible party:

Responsible Party Name:_____

Address:_____

Home Phone:_____ Work Phone:_____

Social Security Number: _____

Mother's Work Phone: _____

Father's Work Phone: _____

IS THE VISIT RELATED TO A WORK INJURY? YES ☐ NO ☐

IS THE VISIT RELATED TO AN AUTOMOBILE INJURY? YES ☐ NO ☐

If the above answer is YES, please complete the following:

Name of Auto or Work Comp. Insurance:_____

Name of Adjuster: _____

Adjuster's Phone: _____ Extension: _____

Claim Number: _____

Date of Injury: _____ Time: _____

Describe how the injury occurred: _____

_____

Colorado Limb Consultants
Orthopedic History

Name: _____ Age: _____ DOB:_____
SS#: _____ Today's Date:_____
Height: ____Weight:_____ Have you had any recent weight gain or loss: YES☐ NO ☐
If yes, how much_____

Present Problem

What are your current symptoms? _____
_____

What caused these symptoms? _____
_____

What date did the symptoms begin? ___/____/____
Have you had problems like this before? YES ☐ NO ☐ If yes, when? _____
When did you first seek medical assistance for this problem? ____/____/____
From Whom? _____ What type of healthcare professional? _____
How would you rate your pain from Zero to Ten:(Zero= No pain, Ten = Intolerable, as bad as possible)
Pain on a good day: _____ Pain on a bad day;_____

Previous Treatment for this Condition

Medication or injections for ***this*** problem:

Name of Medication	**Dose(i.e. mg)**	**Frequency (i.e. 2x/day, 3x/day)**	**Results**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Number of surgeries for ***this*** problem?

Date	**Surgery Type**	**Surgeon**
___/___/____	_____	_____
___/___/____	_____	_____
___/___/____	_____	_____

Other Treatment for this problem (circle all that apply):
Cast Splint Exercise Physical Therapy Other:_____

General Health – Review of Systems ☐ No Problems

Please check if you have ever had any of the following conditions: ☐ Hypertension/High Blood Pressure

☐ Abdominal Pain	☐ Blood Clots	☐ Fever/Chills	☐ Poor General Health
☐ AIDS/HIV	☐ Blurred Vision	☐ Headache	☐ Rash
☐ Alcohol/Drug Abuse	☐ Breathing Problems	☐ Heart Attack	☐ Shortness of Breath
☐ Allergic to Acrylic Nails	☐ Bruise Easily	☐ Heart Murmur	☐ Skin Reaction to Jewelry
☐ Angina/Chest Pain	☐ CANCER	☐ Hepatitis	☐ Skin Reaction to Metals
☐ Anxiety/Depression	☐ Diabetes	☐ Intolerance to Hot/Cold	☐ Thyroid Problems
☐ Asthma/Breathing Problems	☐ Digestive Problem	☐ Joint Pain	☐ Urinary Pain/Frequency
☐ Back Problems	☐ Dizziness	☐ Kidney Disease	☐ Weight Gain/Loss
☐ Bleeding Problems	☐ Fatigue	☐ Nasal Congestion	

Colorado Limb Consultants
Orthopedic History

Are you currently under another physician's care? YES ☐ NO ☐
If yes, for what reason? _____

Significant past and current medical problems: _____
_____

Please list previous surgeries not already listed:

Date	Surgery Type	Surgeon
____/____/_____	_____	_____
____/____/_____	_____	_____
____/____/_____	_____	_____

Please list all medications, vitamins or herbal supplements you are taking on a regular basis:

Name of Medication	Dose	Frequency	Reason for Medication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any allergies to medications or to the environment?
_____

FAMILY HISTORY

Please check any health problems diagnosed in your current family

Condition	Who?	Condition	Who?
Arthritis/Rheumatism	_____	Sciatic/Back Problems	_____
Hypertension	_____	Liver Problems	_____
Breathing Problems	_____	Kidney Disease	_____
Bleeding Problems	_____	Heart Problems	_____
Cancer	_____	Diabetes	_____
Angina	_____	Other	_____

SOCIAL HISTORY

Occupation:_____ Interests:_____
Which is your dominant hand? Left/Right Exercise/Sports History:_____
Tobacco use: ☐ Never used tobacco ☐ Currently use tobacco ☐ Smoke ☐Chew
☐I quit using tobacco _____ months/years ago
Alcohol use: : ☐ Never used alcohol ☐ Currently have _____ drinks per day

Is there anything else you feel that the doctor should know about your lifestyle or medical history?
_____
_____

Please be aware that if you are taking herbal medications or supplements, you will need to advise your physician. You may need to stop taking them for two weeks prior to any scheduled surgery.

COLORADO LIMB CONSULTANTS
CONSENT & INFORMATION DISCLOSURE

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient/Patient Representative Signature: _____

Date: _____ *Time:* _____

Consent to E-mail Usage for Appointment Reminders and Other Healthcare Communications:
Patients of Colorado Limb Consultants may be contacted via email to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health information. If at any time I provide an email address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email address from the Practice.

_____(Patient initials) I consent to receive email communication as stated above. All electronic communications sent to the E-mail address listed on page two of the patient information form will become a part of my permanent medical record at Colorado Limb Consultants. I understand that this request to receive emails will apply to all future appointment reminders, feedback and/or health information unless I request a change in writing. Revocation to receive email communications to be provided upon request.

Consent for Photographing or Other Recording for Security and/or Health Care Operations
_____(Patient initials) I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practices health care operations purposes (e.g. quality improvement activities). I understand that the practice retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representatives unless it is for the treatment, payment or healthcare operations purposes or otherwise permitted or required by law.

_____(Patient initials) I do not consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practices health care operations purposes, (e.g. quality improvement activities.

HCA Physician Services

Colorado Limb Consultants' Patient HIPAA Acknowledgement & Consent Form

Patient Name _____ Date of Birth _____
Today's Date _____

Notice of Privacy Practices Acknowledgement

_____ (patient initials) I acknowledge that I have been presented with the option to receive Colorado Limb Consultants' Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in Colorado Limb Consultants' Notice of Privacy Practices.

Release of Information

_____ (patient initials) I permit the practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment or healthcare operations.

Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate patient care for case management purposes. Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.

If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.

Authorization to Release and Receive Private Health Information

I give permission for my Protected Health Information to be disclosed for purposes of coordination of care with the healthcare providers listed below.

Physician Name/Address_____
Physician Name/Address_____

Consent for family and/or friends to have access to my Protected Health Information to be provided upon request.

Patient/Patient Representative Signature: _____

Date: _____ *Time:* _____

COLORADO LIMB CONSULTANTS
WAIVER FOR SURGICAL PROCEDURES

Please be advised of the following information:

Every attempt will be made by this office to pre-certify or obtain authorization for your surgery, if required by your insurance company. We will also go through the steps required to determine if your surgery is a benefit of your policy. However, this is not a guarantee of payment. Benefits are determined at the time of claim submission. If your insurance company does deny payment, you will be responsible for payment of any services rendered.

Policy coverage information such as benefits, exclusions, co-pays, co-insurance, etc, can be obtained by calling the member service number on your insurance card. If your insurance is an HMO or requires referrals/authorizations, you are ultimately responsible for obtaining referrals/authorizations from your primary care physician, if and when they are needed.

SURGICAL ASSISTANT

The physicians may require a surgical assistant to perform your surgery safely. In some cases, two surgical assistants will be required. The surgical assistant aides the physician in performing procedures which are more complicated and therefore lessen the amount of time that you are in the operating room under a general anesthesia. Every effort will be made by the office to obtain authorization with your insurance company for the use of surgical assistant(s).

If your insurance policy does not have benefits which reimburse for a surgical assistant, you will be responsible for payment of the surgical assistant's fee. However, since benefits are not determined until the claim is submitted, all patients will be required to sign this waiver even if a surgical assistant has been pre-authorized. In most cases, the PA's at Colorado Limb Consultants are available to assist with your surgery. Every effort will be made to collect payment from your insurance company for these services. In the event the SA charge is denied, a first level appeal will be submitted, when applicable. If your insurance company denies the appeal, you will be responsible for this service.
The most you would be expected to pay for the SA fee is $175.

In some cases, the use of independent surgical assistants is required. When this occurs, the independent surgical assistants will submit their claim to your insurance company for payment. SA fees are typically 20% of the primary surgeon's fee. In the event your insurance company denies the charge, the staff at Colorado Limb Consultants will assist the SA billing company with any appeal efforts. However, you are ultimately responsible for any amounts they deem reasonable. As such, you will receive a statement/bill directly from the surgical assistant and are obligated to make payment arrangements directly with them.

I agree to accept full responsibility for fees not paid by my insurance company

_____ _____
Patient Signature Date

_____ _____
Signature of legal guardian Date

THE LIMB PRESERVATION FOUNDATION

Funding Hope, Help and Possibilities

1601 East 19th Avenue
Suite 3200
Denver, CO 80218
www.limbpreservation.org
303-429-0688

Dear Patient:

The physicians at **Colorado Limb Consultants** work closely with **The Limb Preservation Foundation**, a nonprofit organization founded in 1986 by Dr. Ross Wilkins and the late Dr. Tom Arganese. The mission of The Limb Preservation Foundation is to support the prevention and treatment of limb threatening conditions. The goal of The Foundation is to enhance the quality of life for those individuals facing limb-threatening conditions due to trauma, tumor or infection through research, patient assistance and educational programs.

As a patient of Colorado Limb Consultants we would like to give you the opportunity to learn more about the important work of The Foundation by receiving quarterly newsletters and other communications regarding progress in research, treatment and educational programs.

Drs. Arganese and Wilkins shared a belief that all people with complex extremity problems should have access to the best medical care, regardless of their ability to pay. Following their vision, a unique model was created bringing together world-class physicians and researchers, passionate healthcare professionals and patients to advance research, support care and enhance lives.

Since inception, The Foundation has funded over a million dollars through its Patient Assistance Program to individuals across the Rocky Mountain Region. These programs provide patients with the ***hope*** and ***help*** they need in times of financial uncertainty.

The Limb Preservation Foundation funds life-changing research that is accelerating improvements in treatments and outcomes for patients with limb threatening conditions. Research funded by The Foundation has increased the survival rate of both adult and pediatric bone cancer patients from 60% to 92%.

Please understand that your personal contact information (home address and/or email address) will not be released to The Limb Preservation Foundation without your consent below. The Foundation will not share your information with any other entity.

We hope this gives you an opportunity to learn more about the important work of The Limb Preservation Foundation.

☐ By checking this box, patient /guardian **agrees to receive** communications from The Limb Preservation Foundation.

☐ By checking this box, you have elected **not to receive** communications from The Limb Preservation Foundation.

_____ _____

Patient / Guardian Signature Date