**SURGICAL SPECIALISTS OF COLORADO, P.C.**

Krista Antenucci, DO Juhi Asad, DO  Bryan Baer, MD  Jennifer Bocker, MD  Elizabeth Brew, MD  Rachel Caiafa, MD  Ashley Davis, MD

Benjamin Foreman, DO  Fraser, MD  Robert Hammer, MD  Katayun Irani, MD  Rebecca Knight, MD  Robert Madayag, MD  Charles Mains, MD

Robert Marshall, MD  Vance Mitchell, MD  Patrick Offner, MD  Gregory Pinson, MD  Edward Pulido, MD  Franco Rea, MD  Christopher Roseberry, MD

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 Golden, Co 80401 Wheat Ridge, Co 80033 Aspen, Co 81611

 03-940-8200 303-940-8200 970-429-4267

 **PATIENT INFORMATION**

 Date of Birth

 Last Name First Name MI

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street Address City State Zip Code

 *Please indicate*  ( )  ( )

 *Preferred method* Home Phone Cell Phone

 *To reach you.*  ( )

 Work Phone Name of Employer

 Social Security Number - - Sex M  F 

 Patient Status Single  Married  Separated  Divorced  Widowed  Child 

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **\***If you receive a prescription for a "controlled" drug, your identifying prescription information will be entered into Colorado's

 electronic Prescription Drug Monitoring Database (PDMD) when the drug is **dispensed** to you and may be accessed for limited

 purposes by specific individuals.

 **INSURANCE POLICY HOLDER INFORMATION**:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last Name First Name MI Date of Birth

 Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone ( )

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Occupation Employer

 Is Patient a Student? Yes  No  If Yes, Name of School

 ***NEXT OF KIN*** In case of emergency, give the name of *nearest relative* or *close friend* not living with you.

 Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City State

 Home Phone ( ) Work Phone ( ) Relationship

 ***PRIMARY CARE PHYSICIAN***

 Name Phone ( )

 ***REFERRING PHYSICIAN***

Name Phone ( )

 ***INSURANCE INFORMATION*** Does the Patient have Health Insurance? YES  NO 

 Is this visit related to a work injury? YES  NO  If YES, Date of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( )

 Name of Insurance Contact Person Phone

 Claim # Claims Mailing Address

 Is this visit related to an automobile injury? YES  NO  If YES, Date of Accident:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( )

 Name of Insurance Contact Person Phone

 Claim # Claims Mailing Address

 **Primary Health Insurance Additional Health Insurance**

 Insurance Company Insurance Company

 \_

 Policy Holder Policy Holder

 Relationship to Patient: Self  Spouse  Child  Other  Relationship to Patient: Self  Spouse  Child  Other 

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ID/Policy # ID/Policy #

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Group # Group #

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Mailing Address Mailing Address

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City/State City/State

PLEASE READ AND SIGN THE FINANCIAL POLICY OF SURGICAL SPECIALISTS OF COLORADO, P.C. IT IS CUSTOMARY TO PAY

FOR SERVICES WHEN PROVIDED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. PLEASE CONTACT OUR BUSINESS

OFFICE TO ARRANGE PAYMENT OPTIONS OR TO DISCUSS ANY INSURANCE QUESTIONS AND/OR

FINANCIAL/PAYMENT QUESTIONS YOU MAY HAVE.

**I AGREE TO BE RESPONSIBLE FOR ALL PAYMENT OF SERVICES PROVIDED ON MY BEHALF OR MY DEPENDANTS.** IT IS ULTIMATELY

MY RESPONSIBILITY TO UNDERSTAND THE REQUIREMENTS AND PROVISIONS OF MY INSURANCE POLICY. IF

A REFERRAL IS REQUIRED PRIOR TO SEEING A SPECIALIST, I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO OBTAIN ONE.

THE UNDERSIGNED ASSIGNS ALL APPLICABLE INSURANCE BENEFITS/PAYMENTS TO THE PHYSICIAN/PROVIDER OF SERVICE.

IT IS FURTHER UNDERSTOOD THAT THE UNDERSIGNED IS FINANCIALLY RESPONSIBLE FOR PAYMENT OF ALL SERVICES THAT

ARE NOT COLLECTED AS A RESULT OF THIS ASSIGNMENT. THIS ALSO APPLIES TO NON-COVERED SERVICES PROVIDED

AND/OR THE ABSENCE OF INSURANCE COVERAGE AT THE TIME OF SERVICE. I AUTHORIZE SURGICAL SPECIALISTS OF COLORADO, P.C.

TO PROVIDE INFORMATION ABOUT MYSELF OR CHILD AND THE CARE GIVEN TO MY HEALTH INSURANCE COMPANY WHEN SUBMITTING

REQUESTS FOR PAYMENT OF SERVICES PROVIDED TO MYSELF OR MY MINOR CHILD.

 **\_\_\_\_\_ I AGREE TO ALLOW MY PHOTO TO BE TAKEN,** ONLY FOR THE PURPOSE OF INCLUSION IN THE SURGICAL SPECIALISTS

 OF COLORADO ELECTRONIC MEDICAL RECORD.

 **\_\_\_\_\_ I DECLINE TO HAVE MY PHOTO TAKEN**

 Patient/Parent of Minor or Authorized Person Date

 **PHONE CONSENT:**

 You agree, by providing us with your landline or cell phone number(s), you give express authorization to be contacted at those

 numbers, as well as authorize such contact by our agents and assigns. This express authorization also applies to any landline or

 cell phone number(s) you may acquire in the future.  Methods of contact may include using prerecorded/artificial voice messages

 and/or use of an automatic dialing device, as applicable.  Providing your phone number(s) is not a condition of receiving our services.

 I/We have read this disclosure and agree that we may be contacted as described above.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature Date