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
Fred Seale, MD • Eben Strobos, MD • Rebecca Vogel, MD • Bruce Waring, MD • Rebecca Wiebe, MD • Christopher Zaw-Mon, MD

400 Indiana St, Suite 200
Golden, Co 80401
03-940-8200

3455 Lutheran Pkwy, Suite 290
Wheat Ridge, Co 80033
303-940-8200

0401 Castle Creek Road, Suite 2400
Aspen, Co 81611
970-429-4267

PATIENT INFORMATION

_____ Date of Birth _____
Last Name First Name MI

_____ _____
Street Address City State Zip Code

Please indicate Preferred method To reach you.

☐ (____)_____ ☐ (____)_____
Home Phone Cell Phone

☐ (____)_____ _____
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

_____

Insurance Company

_____

Policy Holder

Relationship to Patient: Self ○ Spouse ◉ Child ○ Other ○

_____

ID/Policy #

_____

Group #

_____

Mailing Address

_____

City/State

Additional Health Insurance

_____

Insurance Company

_____

Policy Holder

Relationship to Patient: Self ○ Spouse ○ Child ◉ Other ○

_____

ID/Policy #

_____

Group #

_____

Mailing Address

_____

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