1421 S Potomac Street, **Suite 220**, Aurora, CO 80012
Phone 303.337.5600 Fax 303.337.7734 www.surgicalconsultantsaurora.com

Patient Name: _____ **DOB:**_____
First Last

Thank you for choosing Surgical Consultants of Aurora for your medical needs.

On the day of your *New Patient Appointment*, you are expected to know and to have the following items available to complete your registration in order to be treated by our physician. The first visit is a consult or determination if surgery is needed; it is not your surgery date.

We are located next to the Medical Center of Aurora on South Potomac Street in Aurora.

Our physical address is 1421 S. Potomac St, Suite 220, Aurora CO 80012.

Parking is located in the open lot across from the building and in the parking garage. There is a shuttle provided by the hospital if the walk is further than planned or for days of inclement weather.

Arrive at the office at _____AM/PM for your scheduled appointment.

_____ New Patient paperwork (unless provided prior to appointment)

_____ Insurance Cards

_____ Photo ID (Drivers License, Passport, or other photo ID)

_____ Co-pay, percentage due, or self-pay total

_____ Referring physician information

_____ Primary Care Provider information

On other notes:

* Be prepared to complete additional paperwork if necessary.

* Be prepared to pay a deposit or your deductible towards scheduled surgery as our fees are separate from the fees from the hospital.

* If you are unable to keep your appointment or would like to reschedule we request a 24 hour notice.

Thank you for your cooperation.

Surgical Consultants of Aurora

***Additional Notes:

_____
_____
_____

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Preferred Provider (Check One):

[ ]Sallie B Clark MD [ ] James R Denton MD [ ]Michael C Fraterelli MD [ ]Robert T Rowland MD

Preferred Pharmacy Name & Phone Number: _____

Patient Information
Last Name: _____ First Name: _____ Middle Name: _____
Preferred Name: _____ Maiden Name: _____ Prefix: _____ Suffix: _____
Date of Birth: _____ Sex: _____ Social Security #: _____

Race: (circle one)
African American/Black
American Indian/Alaska Native
Asian
Caucasian/White
Declined
Hawaiian/Pacific Islander
Other

Ethnicity: (circle one)
Declined
Hispanic or Latino
Not Hispanic or Latino
Unknown

Primary Language: _____

Marital Status: _____ Drivers License Number & State: _____
Address: _____ Apt #: _____
Zip: _____ City: _____ State: _____ County: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Which number is primary (circle one): Home Work Cell
Email Address: _____ Contact Preference? Mail? Phone?

Patient Employer
Company: _____ Occupation: _____
Address: _____
Zip: _____ City: _____ State: _____ County: _____

Responsible Party (Insurance Policy Holder)
Your relationship to the insured: _____
Last Name: _____ First Name: _____ Middle Name: _____
Date of Birth: _____ Sex: _____ Social Security #: _____
Address: _____ Apt #: _____
Zip: _____ City: _____ State: _____ County: _____

Primary Care Doctor: _____ Phone:_____
Referring Doctor (if different)**:** _____ Phone:_____

Emergency Contact:
Name: _____ Phone Number: _____
Relationship to emergency contact you have listed:_____

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YOU MUST PROVIDE US WITH YOUR PHOTO ID AND ALL CURRENT INSURANCE CARDS.

Surgical Consultants of Aurora, P.C., 1421 S. Potomac St., Suite 110, Aurora, CO 80011

Acknowledgement of Privacy Practice

I acknowledge that I have seen and/or received a copy of the Notice of Privacy Practices for Surgical Consultants of Aurora, P.C. regarding the use and disclosure of my protected health information.

_____ Check if you would like a copy of Notice of Privacy Practices

Is it acceptable for a physician or staff member to leave a message from our office on your answering machine?
_____ Yes _____ No

Is there a family member permissible to leave test results or medical information with?

Name: _____ Relationship: _____

_____ _____
Patient's Name (Please Print) Signature

_____
Date

****

Documentation of Good Faith Efforts

Patient presented to the office on _____ and was provided with a copy of the Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of receipt of the Notice. However, such acknowledgement was not obtained because:

- ❑ Patient refused to sign.
- ❑ Patient was unable to sign or initial because: _____

  _____
- ❑ The patient had a medical emergency. Acknowledgment will be made at the next available opportunity.
- ❑ Other reason: _____

_____ _____
SCA Staff (Employee) Signature Date

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Patient Name: _____ **DOB:**_____
First Last

Financial Policies & Agreement

(Effective 9/1/05, updated 9/2018)

Thank you for choosing Surgical Consultants of Aurora for your surgical care.
Read, review, and sign this financial statement for a better understanding of the financial aspects of your care.

BASIC PRINCIPLES

1. Our practice is a business concern. Our business is to render professional services to our patients. In order for our business to continue to operate, certain financial expenses must be met. Among these are salaries for employees, rent, insurance, supplies, equipment, repairs and maintenance.
2. Our expenses can only be met if we receive compensation for our services.
3. *Each patient is responsible for the cost of our services*. Insurance plans are available to assist with this responsibility. If you have insurance, we will submit the appropriate claims to your insurance. You will be responsible for balances assigned to you by your insurance plan and claims denied by your insurance plan. **These fees are for the surgeon and are separate from any other fees incurred such as hospital, labs, surgical assistants, etc…**
4. Physicians are NOT responsible for coverage decisions made by insurance plans or employers who sponsor such plans. Most insurance plans involve discounted contracts with physicians. We agree to accept these discounted payments from the insurance plan in exchange for appearing on the plan's list of preferred providers. The discount depends on the plan itself and the specific service rendered.

FINANCIAL POLICIES

1. **Current insurance information is absolutely vital. It is your responsibility to provide your current insurance ID card.**
2. Patients without insurance are expected to pay all charges at the time services are rendered or prior to surgery performed.
3. We accept cash, debit and credit cards, checks, and money orders. (accepted: Visa, MasterCard, Discover, and American Express)
4. Office visit copayments must be paid at the time of the appointment. We will review your card and online eligibility in order to collect the correct amount. If the copay amount is higher than expected we will bill you for the difference.
5. If you will be having surgery, we will contact your insurance company to determine an estimate of the deductible or coinsurance that is due and **may choose to collect this amount prior to surgery**. You will be given a receipt and may present to the hospital at the time of preadmission. If our estimate of services was incorrect, you will be billed for the difference or refunded overpayment after the claim is processed and we receive an Explanation of Benefits (EOB)
6. As a courtesy, we will send a claim to your insurance plan after services have been rendered. (Office Visits and Surgery) Your insurance will process the claim and then send an Explanation of Benefits (EOB) to you and to us. If there is a payment from your insurance company to us, it is attached to our EOB or transmitted electronically. The payment process usually takes less than 45 days. Once we receive the EOB, our billing department enters the appropriate data into your account. We will send a bill to you based on what your insurance plan has stated is "patient responsibility".
7. You are responsible for paying your account balance within thirty (30) days of our first statement to you.
8. Checks returned to us due to "insufficient funds" or "closed account" will be handled as follows. We will assess a $20.00 charge to your account. We will attempt to contact you by phone or by mail. Future payments must be by either cash or money order.
9. DELINQUENT ACCOUNTS. Any account more than thirty (30) days old is deemed delinquent. We then begin a series of steps to collect the amount due. A bill will be mailed to you two times. If we **do not** receive a response, your account will be sent to a collection agency. If the collection agency deems it necessary, we will authorize legal action on their part**.** **Please contact us if you have questions about your account at 303-337-5600 ext 104 or 303-534-0391.**

I understand this statement of policies and this Agreement. I agree to be bound by the terms and conditions above.

_____ _____
Signature of Patient (or Responsible Party) Date

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Health Questionnaire

(If a system review doesn't apply, check the "None" provided in that section. Do not leave a section blank.)

Purpose of visit: _____ Age: _____
Primary care doctor: _____Referring doctor: _____

Past Medical History

EENT

_____ Difficulty swallowing
_____ Hoarseness
_____ Pressure in throat
_____ None
_____ Other _____
_____

Endocrine

_____ Diabetes
_____ Thyroid disease
_____ Weight gain/loss, unusual
_____ None
_____ Other _____
_____

Cardiovascular

_____ Heart disease
_____ Heart surgery
_____ High blood pressure
_____ None
_____ Other _____
_____

Respiratory

_____ COPD
_____ Emphysema
_____ Problems with anesthesia
_____ Shortness of breath
_____ Sleep apnea
_____ None
_____ Other _____
_____

Gastrointestinal

_____ Abdominal pain
_____ Change in bowel habits
_____ Heartburn
_____ Loss of appetite
_____ Reflux/GERD
_____ None
_____ Other _____
_____

Neurologic

_____ Head injury
_____ Seizures
_____ Stroke
_____ None
_____ Other _____
_____

Hematologic/Lymphatic

_____ Abnormal bleeding
_____ Blood clot
_____ None
_____ Other _____
_____

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Breast

_____ Breast cancer
_____ Breast fed children
_____ Breast lump or mass
_____ Breast pain or tenderness
_____ Breast surgery
_____ Breast swelling
_____ Mammogram/ultrasound
_____
(List date & place of last exam)

_____ Nipple discharge
_____ Relatives with breast cancer
_____ Relatives with colon cancer
_____ Relatives with ovarian cancer
_____ Current or previous hormone replacement or
_____ birth control pills
_____ None
_____ Other _____
_____

This section applies to women only, if male resume at **General** *section.*

Pregnancies

_____ I have never been pregnant
_____ Total number of pregnancies
_____ Total number of miscarriages
_____ Total number of live births

Menstrual History

_____ Age at first period
_____ Date of last menstrual cycle
_____ Still have regular periods?
_____ Age at onset of menopause

Menopause status? ___Premenopause ___Perimenopause ___Postmenopause

General

_____ Cancer
_____ Hepatitis
_____ Tuberculosis (TB)
_____ None
_____ Other _____
_____

Past Surgical History

(Please enter approximate date of surgery.)

_____ Abdominal surgery
_____ Adhesions
_____ Appendectomy
_____ Colon surgery
_____ Gallbladder removed
_____ Hernia repair
_____ Hysterectomy (uterus removed)
_____ Laparotomy
_____ Ovary removed
_____ Thyroid
_____ Tonsillectomy
_____ None
_____ Other_____
_____

Medications

List all medications you are currently taking, including vitamins and herbal supplements. You may attach a separate list if needed.

_____ _____ _____
_____ _____ _____

Do you take Coumadin? Yes No Do you take aspirin? Yes No

Allergies & Adverse Reactions

Let us know if you cannot take a medication or use an item on this list for any reason.

Explain the reaction you had to the drug or product.

_____ Adhesive tape
_____ Antibiotics
_____ Latex
_____ Penicillin
_____ Percocet
_____ Sulfa antibiotics
_____ Vicodin
_____ None
_____ Other _____

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Family History Has any member of **your family** had any of the following?

Diagnosis	**Yes**	**Mothers** (Side of Family)	**Fathers** (Side of Family)	**Age of Onset**
Abnormal bleeding/clotting				
Cancer				
Diabetes				
Heart disease				
Hypertension				
Stroke				
None				
Other				

Notes or Comments:_____

Social History

Tobacco

_____ I have never smoked
_____ I smoke currently. How long? _____ How much? _____
_____ I use to smoke. How long? _____ How much _____

HIV/AIDS Infection Risk

_____ At risk for HIV/AIDS
_____ Have you been tested for HIV/AIDS?
_____ No known infection risk
_____ Other

Substance Use

_____ I have never used any of the following substances.
_____ I currently use or have a history of use of the following substances.

Substance	**Yes**	**How often?**	**Age Started**	**Amount Used**	**Age Stopped**	**Notes**
Alcohol						
Caffeine						
Cocaine						
Heroin						
Marijuana						
Other						

Health Directives If you are over 18 years of age, do you have the following?

_____ Advance Directive
_____ Living Will
_____ Personal Directive
_____ None
_____ Other _____
_____

Transfusion Directive

_____ I will accept a blood transfusion if necessary during surgery.
_____ I will not accept a blood transfusion.