Welcome to SurgOne

Colon and Rectal Clinic of Colorado

The offices of Dr. Graham Sellers and Dr. Craig Brown, and Dr. Warren Strutt

Your appointment is at the Aurora Office: 1400 S Potomac Street, Suite 120, Aurora, CO 80012

Our Website is: crccolorado.com

Please return your completed forms:

By mail: 1601 E. 19th Ave. Suite 6300, Denver, CO 80218

By Fax: 303- 839- 1216

Please fill out the enclosed forms completely and return to us as soon as possible, prior to your scheduled visit. Please fax or return by regular mail. If emailing or faxing the forms please bring the originals with you to the appointment.

For the best use of your appointment time we ask that you have your referring doctor send all pertinent information PRIOR to your appointment so our doctor can spend time with you rather then spend time reading about you while you are here.

Please also bring along your insurance cards to each appointment you have at our office. Without proof of insurance we will collect all fees for your appointment upfront and provide you with a receipt to submit to your insurance carrier for reimbursement. If you do not have insurance we will collect all fees upfront the day of your appointment. We accept cash, checks, MasterCard, Visa and Discover.

Insurance Referrals: Insurances that require referrals to specialists (including but not limited to Kaiser and Secure Horizons, and all AARP associated products) are your responsibility to obtain PRIOR to the office visit. Without these referrals in place your insurance company may deny or pay less of a benefit for your visit and increase your financial obligation. Check with your insurance carrier to understand your responsibilities with referrals.

Thank you for your time and we look forward to meeting you.

Graham J. Sellers MD

Craig L. Brown MD

Warren J. Strutt MD

Dr. Graham Sellers, Dr. Craig Brown, and Dr. Warren Strutt

Aurora Medical Center

1400 S. Potomac St, Suite 120 Aurora, CO 80012

From the South: From I-25 Northbound or Southbound take the exit to Highway I-225 North. Travel approximately 7 miles to the Mississippi Ave exit (Exit 7) Turn left (West) onto E. Mississippi Ave. Take the 1st left onto Potomac St. 1400 S Potomac St. is on your left, just past E. Arkansas Ave.

From the West: Take Colfax Ave (US-40) East to I-225 Southbound. Travel on I-225 approximately 3 miles to the Mississippi Ave West. Exit (Exit 7) toward Potomac St. South; Merge onto Mississippi Ave. Take the 1st left onto Potomac St. 1400 S. Potomac St. is on your left, just past E. Arkansas Ave.

From the North: Traveling Southbound on I-25 take the I-270 Exit (Exit 217B) on the left toward Aurora/Limon. In about ½ mile merge onto US-36 Eastbound, in about 9 miles merge onto I-225 via Exit 282 toward Aurora/Colorado Springs. Travel approximately 5 miles to Exit 7, Mississippi Avenue West. Merge onto Mississippi and take the first left onto S Potomac St. 1400 S. Potomac St. is on the left, just past Arkansas Ave.

From the East: Travel Westbound on I-70, merge onto US-40 East Colfax via Exit 288 on the left toward I-70 business. Merge onto I-225. Travel approximately 3 miles to the Mississippi Ave. West Exit, (Exit 7) toward Potomac St. South. Take the first left on S. Potomac St; 1400 S. Potomac is on the left, just past Arkansas Ave.

SurgOne, P.C.

I authorize this office to contact me via unsecure email: ___*Yes* ____*No*

PATIENT INFORMATION

Patient Email Address: _____

Requesting/Referring Physician_____ **Primary Care Physician**_____

Name (Legal): ***Last***:_____ ***First***:_____ ***M.I.***____ ***Mr. Mrs. Ms.*** Nickname:_____

Address:_____ ***City***:_____ ***State***:_____ ***Zip***:_____

Sex: M F ***Martial Status***: S M W D ***SS#***:_____ ***Date of Birth***: ____ ____ ____ ***Age***:____
MM DD YYYY

Race:_____ ***Ethnicity:*** _____ ***Preferred Language:*** _____

Phone: Home ( ) _____ ***Work*** ( ) _____ ***Cell/Pager*** ( ) _____

Patient's Employer:_____ ***Patient's Occupation***:_____

Employer's Address:_____ Employer's Phone #:_____

Spouse/Guardian Name:_____ ***Date of Birth***____ ____ ____ ***SS#***_____
MM DD YYYY

Address (If different from patient):_____ City:_____ State:____ Zip:_____

Spouse/Guardian Employer:_____ Employer's Address:_____

Spouse/Guardian Home Phone:_____ ***Work Phone***:_____ ***Cell/Pager***:_____

Person Responsible for Payment of Services (If different from Patient):_____

Emergency Contact: Relative/Friend, **not living with you**:

Contact:_____ Phone #:_____ Relationship to Patient:_____

Address:_____ City:_____ State:_____ Zip:_____

Long Term Contact: Relative/Friend, **not living with you** (Should we need to contact you in future years if you have moved from address given in patient info. above).

Contact:_____ Phone#:_____ Relationship to Patient:_____

Address:_____ City:_____ State:_____ Zip:_____

INSURANCE INFORMATION

Legible Copy of Ins. Card **Copy of Driver's License**

PRIMARY Insurance:_____ ***Subscriber ID#***:_____

Group#_____ ***Mailing Address (for claims)***:_____

Policy Holder Name_____ ***Relationship***: Self / Spouse / Child / Other_____

Policy Holder **DOB:**_____ ***Phone #:*** ( )_____ ***Employer carrying insurance***:_____

Deductible:_____ Copay:_____ **If Accident**: WorkComp or Auto: Date of Injury _____ Claim No._____

SECONDARY Insurance:_____ ***Subscriber ID#***:_____

Group#_____ ***Mailing Address (for claims)***:_____

Policy Holder Name_____ ***Relationship***: Self / Spouse / Child / Other_____

DOB:_____ ***Phone #:*** ( )_____ ***Employer carrying insurance***:_____

Deductible:_____ Copay:_____ **If Accident**: WorkComp or Auto: Date of Injury _____ Claim No._____

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES. I WILL FURNISH THIS OFFICE WITH ALL INFORMATION NECESSARY TO BILL MY INSURANCE. ANY BALANCE AFTER INSURANCE HAS PAID OR DENIED IS DUE BY ME. I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY, I WILL ALSO BE RESPONSIBLE FOR THE REASONABLE COST OF COLLECTION,, TO INCLUDE ATTORNEY FEES. I UNDERSTAND THAT MY INSURANCE BENEFITS AND REFERRAL REQUIREMENTS ARE MY RESPONSIBILITY AND THAT ALL COPAYMENTS ARE DUE AT THE TIME OF SERVICE.

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO PHYSICIAN FOR THESE SERVICES AND ALL FUTURE CLAIMS AND I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND ALL FUTURE CLAIMS.

X_____(Signed) Date:_____

SurgOne, P.C.

Graham J. Sellers, MD Craig, L. Brown, MD Warren J. Strutt, MD

Medical History/Review Of Systems

Today's Date: _____

Patient Name: _____ Age: _____ Weight: _____ Height: _____

Requesting/Referring Physician _____ Primary Physician _____

Reason for Visit (Chief Complaint): _____

List all Significant **Medical Problems**	Please list all **Medications** and their doses: ASPIRIN YES OR NO Dose
1	
2	2 Dose
3	3 Dose
4	4 Dose
5	5 Dose
6	6 Dose
7	7 Dose
8	8 Dose

List **ALL PAST SURGERIES** you have had and the approximate date

1

2

3

4 _____

ALLERGIES: (please list) Are you allergic to any medications, tapes, latex, etc.

_____

ENDOSCOPIC HISTORY

List years of all previous colonoscopies _____ **Findings?** _____

List years of all previous upper endoscopies _____ **Findings?** _____

SOCIAL HISTORY

Do you smoke? _____ (If so how much per day?) _____ If you have smoked, when did you quit? _____

Do you drink alcohol? _____ If so, how many drinks per day? _____

List any non-prescribed drugs or supplements used: _____

Are you on any type of special diet? Please describe _____

FAMILY HISTORY Please indicate if any family member (including Grandparents, Parents, Siblings) had/does have the following:

Reaction to Anesthesia _____ Breast Cancer _____

Bleeding or clotting problems _____ Ovarian Cancer _____

Heart Attacks _____ Colon Cancer _____

Diabetes _____ Rectal Cancer _____

Blood Pressure Problems _____ Any other Cancers _____

Anything else your physician should know about your health or your family's health?

Name:_____ Date of Birth:_____ Todays Date:_____

Pharmacy name & Phone number:_____

Personal Medical History

Please check all that apply:

History of Diverticulitis__
Multiple Sclerosis__
Heart Attack__
Supplemental Oxygen__
Heart Disease__
Congestive Heart Failure__
Excessive Bleeding Disorder__
Herpes/Genital__
AIDS/HIV__
Glaucoma/Cataracts__

History of UTI__
Kidney Disease__
Thyroid Abnormalities__
Asthma__
Pulmonary Embolism__
Problems with Surgical Anesthesia__
Emphysema__
COPD__
Sleep Apnea__
Historoy of Colitis__
History of Warts (HPV)

High Blood Pressure__
History of Blood Clots__
Malignant Hyperthermia__
History of Ulcerative Colitis__
Pancreatitis__
Diabetes__
Difficult Airway Intubation__
History of Artery Stent__
DVT__
Stomach Ulcers__
History of Crohns Disease__

Review of Symptoms

Constitutional:
Fevers__
Chills__
Weight Loss__
Night Sweats__
Fatigue__

Cardiac:
Heart Murmur__
Palpations/Heart Racing__
Chest Pain__
Fainting__

Neurologic:
Numbness__
Memory Loss__
Loss of Strength__
Convulsions__
Headache __

Respiratory:
Shortness of Breathe__
Bloody Cough__
Wheezing__

Musculoskeletal/Skin:
Back/Neck/Joint Problems__

GI:
Abdominal Pain__
Naseau/Vomiting__
Constipation__
Diarrhea__
Jaundice__
Change in Bowel Habits__
Rectal Bleeding or Pain__

Ears/Nose/Throat:
Ringing in Ears__
Vertigo (Diziness)__
Hoarsness-Chronic__

Genitourinary:
Pain Urinating__
Burning__
Blood in Urine__
Increased Nightime Frequency__

Endocrine:
Tired/Sluggish__
Loss of Hair__
Easy Bleeding__
Easy Bruising__
Temp. Intolerance__

Skin:
Chronic Itching__
Skin Rash__

Eyes:
Double Vision__

Psychological/ Emotional:
Depression__
Anxiety__
Mood Swings__

Cancer:

Type: _____ _____ _____
When: _____ _____ _____
Treatment: _____ _____ _____

SurgOne, P.C.

Protected Health Information and Communication Consent

Your physician and/or the staff may at times need to contact you and/or discuss your care with those persons whom you give us consent to do so. By completing the information below, we will be better able to serve you.

In an effort to protect your privacy and follow new federal guidelines, we have developed a policy regarding leaving medical care messages and/or discussing your care with others:

- We will ***NOT*** leave messages on voice mail or answering machines ***UNLESS WE HAVE WRITTEN PERMISSION TO DO SO.***
- We will ***NOT*** discuss your care with others ***UNLESS WE HAVE WRITTEN PERMISSION TO DO SO.***

PATIENT NAME: _____ Birth Date:_____

		May we leave a message?		May we discuss your care?	
HOME PHONE:	_____	Yes	No	Yes	No
WORK PHONE:	_____	Yes	No	Yes	No
CELL PHONE:	_____	Yes	No	Yes	No
EMAIL ADDRESS:	_____	scheduling purposes only email is an unsecure email			

Please carefully consider with whom we may leave messages and/or whom you wish to have access to your medical/billing information:

Spouse or Partner	Yes	No	If yes, name:_____
Son or Daughter	Yes	No	If yes, name:_____
Mother or Father	Yes	No	If yes, name:_____
Friend/Neighbor	Yes	No	If yes, name:_____
Other	Yes	No	If yes, name:_____

Notes:_____

Voice mail or answering machine messages may include the following information:

Specific information regarding my surgery/treatment	Yes	No
Scheduling for Lab/Test/Surgery	Yes	No
Results for Lab/Test/Surgery	Yes	No

Email will only include scheduling information no medical information will be sent

Medical information can be sent through our secure portal email

I fully understand that this consent will remain valid until revoked in writing by me.

SIGNATURE:_____ **DATE:**_____

SURGONE, P.C. FINANCIAL POLICY

Thank you for choosing SurgOne, P.C. for your healthcare. In order to achieve our goal of providing and maintaining a good physician-patient relationship, we believe it is important to have solid financial policies in place. We also believe that these policies will allow us to provide our patients with high quality, cost-effective care. We ask that you carefully read and sign the following SurgOne, P.C. Financial Policy prior to your treatment.

- Upon arrival, please sign in at the front desk and present your current health insurance card as well as your driver's license or another acceptable form of ID. You may be asked to present both of these items at each visit for proper identification.
- If you do not have health insurance coverage, choose to bill your own insurance, or if our physicians do not participate in your health insurance plan, payment IN FULL is due at the time of service. Acceptable forms of payment are cash, check, VISA and MasterCard.
- You are responsible to make complete insurance information available to SurgOne, P.C. for accurate filing of claims. Complete insurance information includes current benefit cards (primary and secondary), proper identification, and referrals from other providers if applicable.
- You are responsible for checking with your insurance plan regarding any co-payment, deductible or co-insurance that you may owe at the time of service.
- Co-payments are a contractual obligation with your insurance company. You are required to pay your co-payment, and we are required to collect your co-payment at the time of each visit. Co-payments are collected prior to service.
- If the insurance information that you provide at the time of your visit is incorrect, you will be responsible for payment of your visit and to submit the charges to the correct plan.
- For indemnity-type health insurance plans, insurance payments received by SurgOne, P.C. will be applied to your account and you agree to pay the balance.
- If you have a HMO or PPO health insurance plan and our SurgOne, P.C. physicians participate in your plan, we will accept payment from the carrier for services covered by your benefit plan.
- If you have a surgical procedure that requires the use of a surgical assistant, SurgOne, P.C. may not bill for those services. You may receive a separate statement from the surgical assistant. These services may or may not be covered by your health insurance plan.
- If you undergo a surgical procedure, in addition to a bill from your surgeon, you may also receive bills from the hospital or surgical center where the procedure is performed, regarding anesthesia, pathology/lab, radiology and various consultants.

- Not all services provided by our office are covered by every health insurance plan. Any service determined NOT to be covered by your plan will be your responsibility.
- SurgOne, P.C. is committed to providing the best treatment for our patients; however, you are responsible for any unpaid balance regardless of your insurance company's arbitrary determination of usual and customary rates.
- For scheduled appointments, prior balances must be paid prior to the visit.
- We require 24-hour notice for canceling any appointments.
- A $20 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
- A $35 fee is required for the completion of patient forms regarding disability insurance, life insurance and FMLA.
- **It is your responsibility to know your healthcare benefits and coverage limitations.**

We will be happy to address any questions you may have after reading our Financial Policy. Please let our staff know if you would like a copy of this policy.

I have read and understand SurgOne, P.C.'s Financial Policy and agree to comply and accept the responsibility for any payment that becomes due as outlined in the above policy. I agree to pay for all services rendered not covered by my insurance and to notify this office should there be any change to my health insurance coverage.

Notice of Privacy Practices Acknowledgment
I acknowledge that I am in receipt of Privacy Practices for SurgOne PC
(Copy available in office)

_____
Printed name

_____ _____
Signature Date

_____ _____
Legal Guardian Printed Name Relationship to patient

_____ _____
Legal Guardian Signature Date

09/2015

SURGONE, P.C.

Payment Policy

Thank you for choosing SurgOne, P.C. We are committed to providing you with the best patient care possible. In order to best serve you and to avoid confusion, please review our payment policy and let us know if you have any questions.

Patients with Insurance Benefits: If you have insurance coverage that you would like to use for your visit, please review the following policies for in-network and out-of-network health plans.

- **In-Network Health Plans:** SurgOne, P.C. currently participates with most major insurance plans, including Blue Cross Blue Shield, Cigna, and United Healthcare (to see a complete list, please ask our staff). If you are covered by one of these plans, or by another insurer for which SurgOne, P.C. is "in-network", SurgOne, P.C. will submit an insurance claim on your behalf. You will be required to pay any applicable coinsurance and copayment at the time of service.
    - If the procedure is being performed in a SurgOne office, payment will be expected at the time of service for any copay and/or coinsurance.
    - If the procedure is being performed outside of a SurgOne office, we require that you provide a credit card authorization in advance. On the day of your procedure your credit card will be billed for your portion (i.e. copay and/or coinsurance) of the procedure, based upon information provided by your insurer. If you would like an estimated cost of the procedure, please ask the office staff.

- In addition, to the payment above, you will be responsible for any remaining balances that may be on your account after your insurer processes the claim. We will attempt to collect the full amount allowable from your insurance plan. However, in the event that there are additional amounts for which you are responsible (i.e. deductible), we will charge you for any remaining balance after your initial payment up to a maximum charge of $500.00. Any additional remaining balance above $500.00 will be billed to you by U.S. Mail.

- **Out-of-Network Health Plans:** If you are covered by a health plan for which SurgOne, P.C. is "out-of-network" or if SurgOne, P.C. is not a "participating provider", we require that you pay for your charges at the time of service. We will give you a claim form that you can submit to your insurance company to instruct them to send reimbursements directly to you.

Self-Pay Patients: If you do not have health insurance coverage or if you do not want us to file an insurance claim on your behalf, or if you do not authorize us to store your credit card information, then all charges are due at the time of service.

Acceptable Forms of Payment: For your convenience, we accept Visa, MasterCard, and Discover as well as cash and checks (U.S. banks only).

This credit card authorization will be valid until the expiration date of the credit card provided below, unless you contact SurgOne, P.C. by phone or by U.S. Mail and specifically revoke this authorization.

By signing below, you:

Acknowledge you have read, understand, and agree to the terms and conditions set forth in this Payment Policy

- Understand that it is your responsibility to obtain any referrals that may be required by your health insurance plan and accept all financial responsibility for services rendered to you by SurgOne, P.C.
- Authorize SurgOne, P.C. or its designated financial institution to store your credit card information
- Authorize SurgOne, P.C. to charge your stored credit card for all outstanding balances and patient financial responsibilities associated with services rendered to you by SurgOne, P.C.
- Understand that this authorization will continue until the expiration date of the credit card provided below and that you may not earlier revoke this authorization unless your account with SurgOne, P.C. has been satisfied in full

_____ _____

Patient or Guardian Date