

**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 Denver Office: 1601 E 19<sup>th</sup> Ave. Suite 6300 Denver, CO 80218**

**Our Website is: [crccolorado.com](http://crccolorado.com)**

Please return your completed forms:

**By mail: 1601 E. 19<sup>th</sup> 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 than 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 and Dr. Craig Brown and Dr. Warren Strutt at the Professional Plaza West**

1601 E. 19<sup>th</sup> Ave. Suite 6300, Denver, CO 80128

Phone: 303 839-5669

**From I-25 (coming from the South)**

Take the University Blvd exit 205,

Turn right (north) on University Blvd

At 1<sup>st</sup> Ave, University Blvd. becomes Josephine Street, continue driving north.

At 18<sup>th</sup> Avenue (just north of Colfax) turn left, heading west, this is a one way street

Turn right (north) on Gilpin \*\*\*

**From the West side of Denver**

Take Colfax east to Gilpin, turn left (north) on Gilpin\*\*\*

**From I-70 (coming from the West)**

Stay on I-70 and follow the northbound directions below starting with the York St Exit

**From I-25 (coming from the North)**

From I-25 southbound take the I-70 exit heading east towards Limon Exit 214-A

Take the York St exit, 275C toward Josephine St.

Keep right to take the York St. South ramp, this is a one way street

Turn slight left onto York St.

Turn right on 18<sup>th</sup> Ave; this is a one way street

Take 18<sup>th</sup>, heading west to Gilpin\*\*\*

**From I-70 (coming from the East)**

Take Colorado Blvd exit, 267B South

Travel on Colorado Blvd to 17<sup>th</sup> Ave

Turn right onto 17<sup>th</sup> Ave traveling west

17<sup>th</sup> Ave becomes 18<sup>th</sup> Ave at Josephine Street; 18<sup>th</sup> Ave is a one way street

Continue on 18<sup>th</sup> to Gilpin take a right (north) on Gilpin\*\*\*

**\*\*\*When you get to the four way stop sign at Gilpin and 19<sup>th</sup>, proceed straight thru onto Visionaries Dr.**

**Presbyterian St. Luke's Hospital is on the East side of the driveway; Professional Plaza West is on the West side of the driveway**

**You may take any entrance on the left into the free underground parking garage, or you may use the free valet service at the Main Entrance to the hospital and walk across the driveway.**

**Take the elevator up to the 6<sup>th</sup> floor, Suite 6300**

# 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: \_\_\_\_\_

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:	
1	ASPIRIN YES OR NO	Dose
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__   | History of UTI__                    | High Blood Pressure__           |
| Multiple Sclerosis__          | Kidney Disease__                    | History of Blood Clots__        |
| Heart Attack__                | Thyroid Abnormalities__             | Malignant Hyperthermia__        |
| Supplemental Oxygen__         | Asthma__                            | History of Ulcerative Colitis__ |
| Heart Disease__               | Pulmonary Embolism__                | Pancreatitis__                  |
| Congestive Heart Failure__    | Problems with Surgical Anesthesia__ | Diabetes__                      |
| Excessive Bleeding Disorder__ | Emphysema__                         | Difficult Airway Intubation__   |
| Herpes/Genital__              | COPD__                              | History of Artery Stent__       |
| AIDS/HIV__                    | Sleep Apnea__                       | DVT__                           |
| Glaucoma/Cataracts__          | Historoy of Colitis__               | Stomach Ulcers__                |
|                               | History of Warts (HPV)              | History of Crohns Disease__     |

## Review of Symptoms

### Constitutional:

- Fevers\_\_
- Chills\_\_
- Weight Loss\_\_
- Night Sweats\_\_
- Fatigue\_\_

### Cardiac:

- Heart Murmur\_\_
- Palpations/Heart Racing\_\_
- Chest Pain\_\_
- Fainting\_\_

### Ears/Nose/Throat:

- Ringing in Ears\_\_
- Vertigo (Dizziness)\_\_
- Hoarsness-Chronic\_\_

### Genitourinary:

- Pain Urinating\_\_
- Burning\_\_
- Blood in Urine\_\_
- Increased Nighttime Frequency\_\_

### Cancer:

- Type: \_\_\_\_\_
- When: \_\_\_\_\_
- Treatment: \_\_\_\_\_

### Neurologic:

- Numbness\_\_
- Memory Loss\_\_
- Loss of Strength\_\_
- Convulsions\_\_
- Headache\_\_

### Respiratory:

- Shortness of Breathe\_\_
- Bloody Cough\_\_
- Wheezing\_\_

### Endocrine:

- Tired/Sluggish\_\_
- Loss of Hair\_\_
- Easy Bleeding\_\_
- Easy Bruising\_\_
- Temp. Intolerance\_\_

### Musculoskeletal/Skin:

- Back/Neck/Joint Problems\_\_

### GI:

- Abdominal Pain\_\_
- Naseau/Vomiting\_\_
- Constipation\_\_
- Diarrhea\_\_
- Jaundice\_\_
- Change in Bowel Habits\_\_
- Rectal Bleeding or Pain\_\_

### Skin:

- Chronic Itching\_\_
- Skin Rash\_\_

### Eyes:

- Double Vision\_\_

### Psychological/

### Emotional:

- Depression\_\_
- Anxiety\_\_
- Mood Swings\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# 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

\_\_\_\_\_  
 Legal Guardian Printed Name

\_\_\_\_\_  
 Legal Guardian Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Relationship to patient

\_\_\_\_\_  
 Date



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