

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 Lafayette Office: 150 Old Laramie Trail, Suite 130 Lafayette, CO 80026

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 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

Directions to the Lafayette Office Creekside Offices at Old Laramie Trail
150 Old Laramie Trail, Suite 130, Lafayette, CO 80026

From I-25 (Coming from the North)

Take I-25 South

Take Exit 228 toward Broomfield

Merge onto Northwest Parkway

Take exit 52 for Dillon Rd. toward US-287/Lafayette/Broomfield

Keep right at the fork. Follow signs for Route 287 and merge onto US-287 N/S 112th St.

From I-25 (Coming from the South)

Take I-25 North

Take exit 217A on the left to merge onto US-36 W toward Boulder

Take the Colorado 121 exit toward U.S. 287/Broomfield/Lafayette

Turn right onto CO-121 N which immediately merges with US-287

Continue onto US-287 N for 4 miles

From the East

Take I-70 West

Take I-25 North

Merge onto US-36 W/Denver Boulder Turnpike W via Exit 217A on the left toward Boulder

Merge onto Dillon Rd via Exit 52 toward US-287

Take the 1st right onto S 112th St/US-287N.

From the West

Take I-70 East

Take I-25 North

Merge onto US-36 W/Denver Boulder Turnpike W via Exit 217A on the left toward Boulder

Merge onto Dillon Rd via Exit 52 toward US-287

Take the 1st right onto S 112th St/US-287N.

***** Turn right onto Public Rd. (Look for a sign that says "To Old Town Lafayette")

Take the 2nd exit from the roundabout and continue on Public Rd.

Take the first left past the roundabout on Old Laramie Trail

Take the second entrance into the parking lot of Creekside Offices

Our office is the office facing you as you enter the parking lot

The signage is for **Colon and Rectal Clinic of Colorado**

150 Old Laramie Trail, Suite 130

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

- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 5 _____
- 6 _____
- 7 _____
- 8 _____

Please list all Medications and their doses:

ASPIRIN YES OR NO	Dose
2	Dose
3	Dose
4	Dose
5	Dose
6	Dose
7	Dose
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: _____ Today's 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__ | History 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)__
- Hoarseness-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__
- Nausea/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: _____

	<u>May we leave a message?</u>		<u>May we discuss your care?</u>	
	Yes	No	Yes	No
HOME PHONE: _____				
WORK PHONE: _____				
CELL PHONE: _____				
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

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