Colorado Center
for **Arthritis** & **Osteoporosis**, LLC

Welcome to Colorado Center for Arthritis & Osteoporosis, LLC. Our commitment to you and to your referring physician is to provide the highest quality, most efficient and caring service possible. Please read and follow the check list below.

We look forward to meeting you.

First Visit Checklist:

___1. Bring your completed Patient Health Questionnaire*.
___2. Bring your insurance card(s).
___3. Bring a photo ID.
___4. Bring your medical records (if applicable).
___5. Be prepared to pay your insurance co-pay.
___6. Arrive 10-15 minutes before your scheduled appt. time**.

*Please remember: you must have your COMPLETED Health Questionnaire with you in order to be seen.

**Please complete packet using blue or black ink ONLY.

*****Due to changes related to the Affordable Care Act, we need to collect co-pays and co-insurance at check-in, otherwise we will have to reschedule your appointment.**

*****Due to the length and complexity of a new consultation, patients arriving late may need to be rescheduled.**

Revised 9/11/2019

Colorado Center for Arthritis & Osteoporosis
New Patient Information Form

Date of first appointment: ______________

Name: ______________________________ Date of birth: ______________ Sex: ________
LAST FIRST M.I.

Address: ______________________________ Email: ______________________________
STREET Apt. #

______________________________ ____ Opt-in to patient portal
CITY STATE ZIP

Phone(s): Home: ____________________ Cell: ____________________ Work: ____________________

Primary Language (circle one): English Spanish Other: ______________

Race/Ethnicity (circle one): Caucasian Hispanic Asian African American Native American Chinese Filipino Japanese Native Hawaiian Pacific Islander Multi-Racial Decline to give/unknown Other: ________________

Referred by (circle one): Self Family Friend Physician Other health professional

Name of person making referral: ______________________________

Name of primary care provider (general or family doctor): ______________________________

Do you have an orthopedic surgeon? __________ If so, name: ______________________________

A referral letter will be sent to your **primary care provider** and to the **physician who referred you** (if any). Please list any other people that you would like to receive a letter below:

Name: ______________________________ Name: ______________________________

Address: ______________________________ Address: ______________________________

______________________________ ______________________________

Current symptoms

Briefly describe the symptoms that prompted this visit: ______________________________

____

____

____

____

Approximate date when symptoms began: ________ Are the symptoms getting **better**, **worse** or **staying the same** (circle one)?

What diagnoses have you been given? ______________________________

What treatments (other than medications, which will be listed later) have you received? ______________________________

____

Please list other practitioners that you have seen for this problem: ______________________________

____

Name: ____ Date of birth: ______________
LAST FIRST M.I.

Systems Review (check if you have these symptoms)

General:

______ Recent weight gain
(Intentional? Y / N Amount:)
Over what period? __________
______ Recent weight loss
(Intentional? Y / N Amount:)
Over what period? __________
______ Fatigue
______ Fever
______ Night sweats

Eyes:

______ Pain (**L** **R**)
______ Redness (**L** **R**)
______ Loss of vision (**L** **R**)
______ Double vision
______ Blurred vision
______ Dryness
______ Itching eyes

Ears, Nose and Throat:

______ Loss of hearing (**L** **R**)
______ Frequent nosebleeds
______ Sores in mouth
______ Dry mouth
______ Difficulty swallowing

Lungs:

______ Shortness of breath
______ Cough
______ Coughing up blood
______ Wheezing
______ Loud snoring

Heart:

______ Chest pains
______ Irregular heart beat
______ Fluid retention in legs or feet
______ Heart murmurs
______ Fingers or toes turn blue/white in the cold

Stomach and intestines:

______ Nausea
______ Vomiting
______ Vomiting of blood or coffee ground material
______ Heartburn
______ Stomach pains
______ Diarrhea
______ Constipation
______ Blood in stools
______ Black stools

Urinary and reproductive:

______ Pain or burning on urination
______ Frequent urination
______ Urination during the night (# of times ______)
______ Blood in Urine
______ Genital rashes
______ Genital ulcers

Men only:

______ Discharge from penis
______ Difficulty with erections

Women only:

______ Vaginal dryness
Number of pregnancies ________
Number of miscarriages ________
Age at which periods stopped (menopause): ______________
Was menopause **natural** or **surgical** (hysterectomy)? (circle one)
Have your ovaries been removed?
Yes **No** **One removed**

Blood/Lymph:

______ Anemia
______ Low white blood cells
______ Low platelets
______ Bleeding tendency
______ Blood clots

Nervous System:

______ Headaches
______ Dizziness
______ Fainting/Loss of consciousness
______ Seizures
______ Numbness or tingling of hands
______ Numbness or tingling of feet
______ Memory loss
______ Difficulty concentrating
______ Difficulty with balance/falling
______ Difficulty falling asleep
______ Difficulty staying asleep

Psychiatric:

______ Depression
______ Anxiety

Skin:

______ Rash
______ Hives
______ Sun sensitivity
______ Sores or ulcers
______ Hair loss

Endocrine:

______ Intolerant of cold
______ Intolerant of heat

Allergic/Immunologic:

______ Hay fever
______ Recent infection
______ Frequent infections

Muscles/Bones /Joints:

______ Muscle weakness
______ Muscle pain
______ Neck Pain
______ Back Pain
______ Morning stiffness
Lasting how long?
________ Minutes / Hours
______ Joint pain
______ Joint swelling
______ Joint redness
Joints affected in the last 6 months:
____
____
____

Name: ____ Date of birth: ______________
LAST FIRST M.I.

Personal Medical History (check if you have ever had these conditions)

Arthritic conditions:

______Osteoarthritis ______Rheumatoid arthritis ______Fibromyalgia

______Lupus ______Ankylosing spondylitis ______Osteoporosis

______Gout ______Arthritis (unknown type) ______Childhood arthritis ______Osteopenia

Other conditions:

______Epilepsy/seizures ______Heart problems ______Kidney disease ______Tuberculosis

______Migraine headaches ______High blood pressure ______Asthma ______Diabetes

______Emphysema/COPD ______High cholesterol ______Cataracts ______Rheumatic fever

______Depression ______Stroke ______Glaucoma ______Underactive thyroid (hypothyroidism)

_____Bipolar disorder ______Psoriasis ______Stomach ulcers ______Overactive thyroid (hyperthryoidism)

______Cancer ______Celiac Disease ______Hyperparathyroidism

Type of cancer:___________ ______HIV infection ______Hepatitis B infection ______Hepatitis C infection

Other significant illness: ____

____

Surgical History

Type of operation Year Reason

____

____

____

____

____

Any serious injuries/accidents? **Y** **N** Describe: ____

Health Maintenance

Date of last physical: ____________ Date of last bone density scan (DXA): _____________

Date of last eye examination: ____________ Date of last TB skin test: _______________Result: **+** **–**

Bone Health

Have you ever broken a bone? **Y** **N** If so, when, how and which bone: ______________________________

How tall were you at your tallest? ___________ Have you lost height? **Y** **N** If so, how much? _________

Have you ever taken prednisone or similar steroid for more than a few weeks at a time? **Y** **N** If so, give details as to when, how much, for what reason and how long? ____

Does anyone in your family have osteoporosis? **Y** **N** If so, who? ________________________________

Did anyone in your family break a hip? **Y** **N** If so, who? ____________________________________

Name: ____ Date of birth: ______________
LAST FIRST M.I.

Medications

Present medications (include vitamins, supplements and over-the-counter medications)

Name of medication	Strength	Times per day	Date started	How much did it help?		
				A lot	Some	Not at all

Calcium intake (please make your best guess at average amounts)

Number of glasses of milk per day: ____________ Number of cups of yogurt per day: ________________

Number of servings of cheese per day (1 serving = 1 slice = 1 oz.): ______________

Calcium supplements: Type: ______________ Milligrams per tablet: ________ Number per day: __________

Medication Allergies

Name of medication	Type of Reaction	Date

Name: ____ Date of birth: _____________
LAST FIRST M.I.

Habits

Have you ever smoked? _______ If so: What year did you start? _________ How many packs per day? _________

If you have quit smoking, when did you quit? ______________

Do you drink alcohol? ___________If so, how many drinks per day? _________ Per week? ____________

Do you use marijuana? **Y / N** If so, how do you use it? **Ingest / Topical / Smoke** Is your use **Medical** or **Recreational** (circle one)

Do you use any "street drugs" or any prescription drugs for non-medical reasons? _____________

If so, which drugs? _________________________________ Have you ever used IV drugs? ____________

Do you exercise regularly? _________ If so, describe your exercise routine: _____________________________

____

Social History

Where were you born: ____________________ Where did you grow up: ______________________________

Current Marital status (circle one): **Never married** **Married** **Widowed** **Divorced** **Separated** **Domestic partnership**

Spouse/significant other name: ____________________ Major illnesses of spouse: ____________________

Who else lives in your household: ____

Educational level: **Did not finish H.S.** **H.S. Graduate** **Some college**
Bachelor's degree **Master's degree** **Doctoral degree (list type)** ___________

Occupation: ____________________ Presently employed? _________ Number hours per week: ___________

Does your medical condition interfere with your ability to do your job? _____________

Do you receive disability income? _______________ Are you applying for disability? ____________________

Family History

	If living		If deceased	
	Age	Current Health	Age at death	Cause
Father				
Mother				

Number of brothers ______ Number living _________ Number of sisters _________ Number living ____________

Serious illnesses in siblings ____

Number of children ______ Number living _________ Ages: ____

Serious illnesses in children ____

Do you know of any blood relative who has had (**give relationship**): Cancer (list type) ________________________

Rheumatoid arthritis __________ Fibromyalgia _______________ Stroke __________________

Ankylosing spondylitis _________ Lupus _____________________ Asthma _________________

Osteoarthritis ________________ Osteoporosis _______________ Bleeding tendency __________

Gout ___________________________ Heart problems _____________ Alcoholism ______________

Childhood arthritis ____________ High blood pressure _________ Psoriasis _______________

Arthritis (unknown type) _________ Depression _______________ Diabetes _______________

Acknowledgment of Notice of Privacy Practices

______________________________________ ________________

Name of Patient (please print) **Date of Birth**

I hereby acknowledge that I received Colorado Center for Arthritis & Osteoporosis, LLC's Notice of Privacy Practices.

______________________________________ ________________

Signature of Patient or Patient Representative **Date**

______________________________________ ________________

Signature of Parent or Legal Guardian **Date**
(If patient is under 18)

Financial Policy

I. General Purpose

The following policy is provided to clarify your financial responsibility for services you receive from our practice.

II. Insurance

Your insurance carrier defines your eligibility and benefits for services rendered by our practice. It is your responsibility to understand these benefits. Your assistance may be required if there are any complications receiving payment from your insurance carrier for services provided to you by our practice. If we are unsuccessful in receiving payment from your insurance carrier, the remaining balances for services rendered to you may become your responsibility.

CCAO will bill your secondary insurance carrier as a courtesy (if applicable). If there are any complications receiving payment from your secondary insurance carrier, the remaining balances for services rendered to you will become your responsibility.

If CCAO does not have a contract with your insurance carrier, you will be responsible for all balances not covered by your health insurance plan.

It is your responsibility to report any updates or changes to your insurance plans to CCAO immediately. If a claim is denied due to changes not being reported, the associated balance will be your responsibility.

III. Payments Due At Time of Service

Copayments are determined by your insurance carrier and are due at the time of service for every visit. If copayments are not paid at the time of service, a $30.00 non-payment fee may be assessed.

Payments for new patient visits are due at the time of service. The payment amount is an estimate based on information provided by your insurance plan including any applicable copayment, coinsurance, or deductible. In the occasion of an over or underpayment, you will receive a refund check or a statement with the remaining balance from CCAO.

Self-pay patients are required to pay for their visits at the time of service. CCAO will calculate the cost of the visit prior to services being rendered. If any unplanned services are performed during the visit, you will be required to pay an additional cost for those services.

IV. Unpaid Balances

A statement will be sent to you via mail for any charges not paid by your insurance carrier. Payment for these balances is expected within 30 days of receipt of the statement. CCAO reserves the right to assess a re-billing fee for any balances in which we have not received within 30 days.

If you are unable to pay your balance within 30 days, a payment plan option may be available. Please contact the CCAO billing department to initiate a payment plan.

All unpaid balances are due prior to any subsequent service and should be paid upon check-in. An unpaid balance may prevent you from scheduling future services at CCAO.

Any past due balances are subject to collections. If a balance is sent to collections, you will subsequently be financially discharged from the practice.

Your signature below confirms that you have read the above policy and accept financial responsibility for serveries rendered to you by Colorado Center for Arthritis and Osteoporosis. This document cannot be altered.

Select One:

_____ CCAO may bill my insurance directly and my insurance may pay CCAO directly for medical services.

_____ I decline to assign my insurance benefits to CCAO. I am aware that I will be responsible for payment at the time of service.

Patient Name (Print):____

Responsible Party Name (Print): ____

(Parent or Legal Guardian if under 18 years old)

Signature: ____ Date: ________________

COLORADO CENTER FOR ARTHRITIS AND OSTEOPOROSIS, LLC

RELEASE OF MEDICAL AND BILLING INFORMATION TO PERSONAL CONTACTS

PATIENT NAME: ____ Date of Birth___/___/___

Under federal law, a patient's protected health information cannot be shared with other people, even family members, without explicit permission from the patient. This means that if a family member or other individual calls us to discuss any aspect of your medical care, such as test results or a message from your doctor, we cannot discuss this with them without your explicit permission. If you wish to grant us permission to discuss your medical or billing information with a family member or other trusted individual, please complete and sign this form. Also, if you are comfortable with us leaving this information on your voice mail, please indicate below. If you wish to revoke this permission at any time, you must do so in writing.

PERMISSION TO DISCUSS MEDICAL AND BILLING INFORMATION WITH OTHERS

☐ **I give permission to CCAO to discuss my medical and/or financial information with the following personal contacts:**

Name	Phone	Relationship to you	Medical	Financial
			☐	☐
			☐	☐
			☐	☐

-OR-

☐ **I DO NOT give permission to CCAO to discuss my medical and financial information with any personal contacts.**

PERMISSION TO LEAVE MEDICAL INFORMATION ON VOICE MAIL

☐ **I give my permission for CCAO Staff to leave medically privileged information on the following voicemail:**

Voice mail number: ______________________________

-OR-

☐ **I DO NOT give permission for CCAO Staff to leave medically privileged information on voicemail.**

____ ______________________

Patient Signature Date

____ ______________________

Parent or Legal Guardian Signature Date
(If patient is under 18)

Rev. 2/14/2022

Discrimination is Against the Law

Colorado Center for Arthritis and Osteoporosis complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, or sexual orientation. Colorado Center for Arthritis and Osteoporosis does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, or sexual orientation.

Colorado Center for Arthritis and Osteoporosis:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact **Katie Shafenberg**

If you believe that Colorado Center for Arthritis and Osteoporosis has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, or sexual orientation, you can file a grievance with: Katie Shafenberg, Civil Rights Coordinator, 1715 Iron Horse Dr, Ste 100; Longmont, CO 80501, Phone: 720-494-4700, Fax: 720-494-4706, office@ccao.net. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Katie Shafenberg, Civil Rights Coordinator, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Appendix B to Part 92—Taglines Informing Individuals With Limited English Proficiency of Language Assistance Services

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 303-485-5200.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 303-485-5200.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 303-485-5200。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 303-485-5200 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 303-485-5200.

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 303-485-5200.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 303-485-5200

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 303-485-5200.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 303-485-5200.

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 303-485-5200 ।

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 303-485-5200.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。303-485-5200まで、お電話にてご連絡ください。

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 303-485-5200.

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 303-485-5200 تماس بگیرید.

Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ [Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀] jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Đá 303-485-5200

Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 303-485-5200.

AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 303-485-5200