Welcome

Thank you for selecting our healthcare team! Aspen Sports Medicine is committed to excellence in serving the health needs of the community. We are dedicated to giving each Patient a personal service that thay can rely on and trust. To help us meet your needs please fill out this form completely. If you have any questions or need help, please ask- we will be happy to assist you.

For office use only

Acct_____

RX Code_____

PT/Provider _____

INTAKE COMPLETED BY _____

DATE: _____

Patient Information

*Name Last*_____ *First* _____ *MI* ____ *Date*_____
*Current address*_____
City _____ *State* _____ *Zip* _____
LOCAL *Phone H*_____*W* _____*Social Security*_____
☐ *Male* ☐ *Female* ☐ *Student* ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Separated*
Date of Birth: month _____ *day* _____ *year* _____ *Email*_____
*Permanent Address*_____*Phone*_____
City _____ *State,*_____ *Zip* _____
*Employer*_____ *Occupation*_____
*Employer address*_____
City *State* *Zip*

General information

*Referring Doctor*_____ *Family Doctor*_____
*Description of Problem*_____ *Date of Onset* _____
*Was there an Accident? Auto*_☐__ *Work* __☐___*Other*_☐___ *Claim Number* _____
Adjuster _____ *Adjusters Phone Number* _____
Have you had Surgery? Y☐*N*☐ *If yes when?* _____ *Surgeon*_____

Responsible party

Who is responsible for the account?
*Name Last*_____ *First*_____ *MI* ___ *Relationship to Patient*_____
Address _____
City _____ *State* _____ *Zip*_____
*Social Security Number*_____ *Insurance ID number*_____
☐ *Male* ☐ *Female* ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Separated*
Date of Birth: month _____ *day* _____ *year* _____ *Drivers License* _____
Employer _____ *Occupation* _____
*Home phone*_____ *Work Phone* _____
*Insurance Company*_____ *Insurance Phone* _____
Plan Number *Is There Secondary Insurance? Y* ☐ *N* ☐

Medical Release of Information: I authorize the release of any medical information necessary to process this claim.

Signature _____ **Date** _____

Assignment of Benefits: I hereby assign payment directly to Aspen Sports Medicine who represents this clinic to Payor Groups. The basic benefits as well as major medical benefits herein specified and otherwise payable to me, but not to exceed the regular charges for this treatment period. I understand I am financially responsible for any charges not covered by this assignment. I understand I will be held responsible for any costs incurred regarding collection of payment for services rendered.

Signature _____ **Date** _____

Unaccompanied Minors

The parents (or guardians) are responsible for full payment at the initial visit. Subsequent charges may be billed to the insurance company, but co-payments, deductibles, and non-covered amounts must accompany the minor at each visit.

Initial ☐

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments. Please help us serve you better by keeping scheduled appointments. Please let us know if you have any questions of concerns.

☐

PATIENT RESPONSIBILITY AND AGREEMENT

- No Show or Late Cancellation Policy – I understand that there is a 24-hour cancelation policy. I understand that if I do not cancel 24 hours before my scheduled appointment, or do not show for my appointment, I accept responsibility of being charged.
- If medical insurance is to be applied, I request that payment of benefits be made on my behalf to Aspen Sports Medicine for any services rendered.
- I understand and acknowledge that submission of claims is not a guarantee of payment. If for any reason my carrier does not cover any and/or all of my office visits, I agree that I am responsible fro the payment of the entire amount.
- I understand that is is my responsibility to make sure that my bills are paid in a reasonable time frame (no longer than 3 months from the date of treatment). If for any reason any portion of my bill is not paid, I understand that I am financially responsible for charges for services rendered.
- I understand and agree that if my carrier makes any payments directly to me for services rendered I will remit the same payment to Aspen Sports Medicine.
- I understand it is my responsibility to know my insurance benefits and to notify Aspen Sports Medicine of any changes in my insurance carrier or coverage. Any failure to reports such changes will result in the patient being financially responsible for any lapse in coverage or authorization.
- I authorize Aspen Sports Medicine and Flatirons billing company to contact me by cell phone or email for billing or collection purposes.

SIGNATURE: _____ DATE: _____

CREDIT CARD AUTHORIZATION

I hereby authorize Aspen Sports Medicine to charge my credit card account for services rendered to apply as payment to my account balance for services not reimbursed by my insurance (co-pays, deductibles, co-insurance).

Card Holder's name as it appears on card: _____

Card #: _____Exp: _____Billing zipcode: _____

Signature: _____ Date: _____

Aspen Sports Medicine
616 E. Hyman Ave
Aspen, CO 81611

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Purpose: The following privacy policy is to ensure **that Aspen Sports Medicine (ASM)** complies with requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) as well as Colorado privacy protection laws and regulations. Protection of patient privacy is of paramount importance to **ASM**.

Minimum Necessary Use and Disclosure of Protected Health Information
ASM will ensure that for all routine and recurring uses and disclosures of PHI (except for uses and disclosure made for treatment purposes; to or as authorized by the patient; or as required by law for HIPAA compliance) such uses and disclosure of PHI must be limited to the minimum amount of information needed to accomplish the purpose of disclosure.

Verification of Identity
ASM will ensure that the identity of all persons who request access to protected health information be verified before such access is granted.

Safeguards
Appropriate safeguards will be in place at **ASM** to reasonably protect health information from any intentional or unintentional use or disclosure that is in violation of HIPAA Privacy Rule. These safeguards include physical protection of premises and PHI, technical protection of PHI maintained electronically and administrative protection of PHI. These safeguards will extend to the oral communication of PHI and to PHI removed from **ASM**.

Training and Awareness
ASM will ensure that all employees are trained on the policies and procedures governing protected health information and how **ASM** complies with HIPAA Privacy. New employees will receive training within a reasonable time of employment.

Retention of Records
ASM will adhere to the HIPAA Privacy records retention requirement of seven years. All records designated by HIPAA in this retention requirement will be maintained in a manner that allows for access within a reasonable period of time. This records retention time requirement may be extended by **ASM's** discretion to meet with other governmental regulations or those requirements imposed by our professional liability carrier.

ASPEN SPORTS MEDICINE

Patient acknowledgement of Receipt of Notice of Privacy Practices

I am in receipt of the Aspen Sports medicine Notice of Health Information Practices

Patient Name: _____ Date: _____