



Alpine Surgical
4745 Arapahoe Avenue Suite 300
Boulder CO 80303
www.alpinesurgical.net
Phone 303.449.3642 Fax 303.440.7298

ALPINE SURGICAL FINANCIAL POLICY

Alpine Surgical is pleased to welcome you to our office. We appreciate the trust that you have placed in our practice by asking us to evaluate and treat you. We will do our absolute best to make the experience a positive one.

As surgical specialists, we charge a consultation fee for an office visit or inpatient evaluation. This includes our medical evaluation, review of diagnostic tests and decision-making. A fee is assigned to each surgical procedure performed. **We will estimate your out of pocket expenses for office visits and office procedures based on your deductible and coverage, and require that you pay this at the time of service.** If the estimated cost differs from the actual insurance payment we will send you a statement once we have received your balance from the insurance company. **We require payment within 30 days.**

We are contracted with most insurance plans (including Medicare). Our fees are set at a contracted rate that varies by insurance plan. You are responsible for verifying that our physicians are in your insurance network. We recommend that you verify your coverage benefits with your insurance company.

Prior to elective surgery, we will contact your insurer to obtain pre-certification and verify your benefits. This process does not guarantee payment from the insurance company. **We will also estimate your out of pocket expenses based on your deductible and coverage, and require that you pay this BEFORE the procedure.** If you do not have medical insurance, payment is expected at time of service for office visits. Payment arrangements must be made prior to any surgical services.

Many times, a surgeon requires an assistant. If your surgery requires an assistant, you will receive a separate bill from his or her office. Routine follow-up after *most* operations is included in the surgical fee.

The charges from Alpine Surgical are **usually** 20-25% of your total charges. The hospital fees, anesthesiologist, pathologist, surgical assistant, and lab often make up the rest. **Even if you have insurance, you, the patient, are ultimately RESPONSIBLE for the bill.** As a service to our patients, we will submit a proper medical insurance claim **once** per visit on your behalf. You must provide up-to-date insurance information at every visit. If you do not provide us with effective insurance information at the time of service, you may be responsible for the entire bill.

For further details regarding our office policies, please contact Tina at 303-449-3642. For information about hospital charges, please contact Boulder Community Hospital Financial Counselors at 303-440-2139.

If no attempt has been made within 60 days to pay your bill or make payment arrangements, the account will automatically be turned over to a collection agency and will adversely affect your credit report. **If you have a special circumstance, you may contact Tina directly to make arrangements and avoid being placed in collections.**

No-Show Policy: Often times, our schedule is full and other patients need to be seen sooner. Please contact us within 24 hours of your appointment if you intend to cancel. A charge of \$50 may be added to your account for not providing adequate notice.

Customer hereby acknowledges and agrees that any account that becomes delinquent will be subject to a collections agency. The Customer agrees to pay all court costs and reasonable attorney fees for collection of all past due amount owed plus interest thereon at 18 (eighteen) percent per annum on all such amounts outstanding. Customer agrees to this financial policy.

Patient Name (Print): _____

Patient (or Guardian) Signature: _____ Date: _____



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WHEN REGISTERING, PLEASE PRESENT YOUR PROOF OF INSURANCE, OR PAYMENT IN FULL IS EXPECTED AT THE TIME OF SERVICE

	<u>Primary Insurance</u>	<u>Secondary Insurance</u>	<u>Other</u>
Name of Insurance Co.			
Policyholder			
Policyholder's SS#			
Policyholder's DOB			
Policyholder's Place of Employment			
Relationship to Patient			
Policy/ID Number			
Group/Account Number			
PPO? HMO? Other?			
Co-pay Amount			

I hereby instruct and direct my Insurance Company to pay by check made out and mailed to:
 Alpine Surgical, LLC, P.O. Box 848926, Boston, MA 02284-8926

A photocopy of this agreement shall be considered effective as the original.

I also authorize the release of any information pertinent to my claim and all future claims to my insurance company or adjuster involved in this case and certify that this insurance information is current and valid.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I agree to pay in full for any services rendered within 30 days of receiving a bill. **All co-pays are due at the time of service.** I understand that failure to supply the office with all of my insurance and/or referral information could result in denial of my insurance claim. If patient does not have insurance coverage, or if the services rendered are not covered by insurance, payment is expected at the time of service.

Check Here If No Insurance!

Patient Signature: _____ **Date:** _____

(Parent, if patient is a minor)

Is this a work related injury? No: _____ Yes: _____ Date Of Injury: _____

Claim Number: _____ Employer: _____

Person to contact at employer for insurance information: _____

Phone Number: _____

Please describe what happened: _____

Is this an auto-related injury? No: _____ Yes: _____ Date Of Injury: _____

Claim Number: _____ Insurance Company: _____

Adjuster: _____ Phone Number: _____

Were you the driver or passenger? _____



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PERSONAL INFORMATION:

Today's Date: _____

NAME: Last, First, MI: _____ Male Female

Mailing/Billing Address: _____ City: _____ State: _____ Zip: _____

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

Home Phone Number: _____ Cell Phone Number: _____

Work Phone Number: _____ Email Address: _____

The office may leave detailed messages on my: Home Phone Cell Phone Work Phone

Date of Birth: ___/___/___ Age: _____ Social Security Number: ___/___/___

Height: _____ Weight: _____

Employer: _____ Occupation: _____

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

Marital status Single Significant Other Married Legally Separated Divorced Widowed

Spouse's/Other's Name: _____ Work/Cell Phone Number: _____

Primary Care Physician: _____ Phone Number: _____

Whom may we thank for referring you to us: _____ Friend Doctor Other

WHAT PHARMACY DO YOU CURRENTLY USE? (pharmacy name/location) _____

EMERGENCY CONTACT:

Name: _____

Relationship: _____

Address: _____

Home Phone: _____

City: _____ State: _____ Zip: _____

Work Phone: _____



This is a confidential record of your medical history and will be kept in this office.
Information contained herein will not be released to any person except when you have authorized us to do so.

REASONS FOR THE OFFICE VISIT TODAY (Please list primary symptoms/concerns):

- 1. _____ Right/Left
2. _____ Right/Left

PERSONAL MEDICAL HISTORY (PLEASE COMPLETELY FILL IN BUBBLES THAT APPLY TO YOUR HISTORY)

Table with 4 columns: Condition, Yes/No bubbles, Condition, Yes/No bubbles. Includes items like Diabetes, HyperThyroidism, Peptic Ulcer Disease, GERD, etc.

Other Medical History: _____

SURGICAL HISTORY: (Circle all that apply and include approximate dates of Surgeries)

Hernia: Inguinal/Umbilical/Other
Rectum: Hemorrhoids/Fistula/Fissure/Other
Abdomen: Gallbladder/Appendix/Stomach/Intestine/Colon
Breast: Lumpectomy/Mastectomy/Reconstruction/Biopsy
Head/Neck: Thyroid/Parathyroid/Tonsils/Other
Chest: Heart Bypass/Heart Valve/Heart Catheterization
Kidney: Stone/Other
OB /GYN: Hysterectomy/Tubes or Ovaries/C-Section
Orthopedic: Shoulder/Knee/Hip/Other
Other Surgeries and Dates:



MEDICATIONS: List any medications you are currently taking (including herbals and supplements).

Check here if NONE

Medication	Frequency	Medication	Frequency

ALLERGIES: Please specify if you are allergic to any medicines or medical supplies (including iodine, tape, latex, and shellfish). Check here if NONE

ALLERGY and REACTION (example: Latex-Rash)

ALLERGY and REACTION

SOCIAL HISTORY:

Alcohol Yes No How Often _____

Smoking Yes No How Many Per Day/Week _____

Recreational drugs Yes No Explain What and How Often _____

FAMILY MEDICAL HISTORY: Please indicate if any blood related family members have ever had any of the following

Indicate either Maternal or Paternal side AND Family Member Relationship (i.e. Maternal Grandmother, Paternal Aunt, etc.)

Bleeding problem _____

Heart attack / Stroke _____

Problems with anesthesia _____

Epilepsy/Seizures _____

Diabetes _____

Asthma _____

High blood pressure _____

Cancer (List Type and Family Member) _____

IMAGING: Have you had any imaging for this problem (including MRI, X-Ray, Mammogram, Ultrasound).

Check here if NONE

Type	Date	Location (Facility)



Personal Review Of Systems: Have you had any of these recently?

Please Completely Darken ALL Bubbles. Answer ALL Questions.

Constitutional

Weight Change Yes No
Loss of Appetite Yes No
Fever Yes No
Weakness Yes No
Fatigue Yes No
Night Sweats Yes No

Dermatology

Rash/Hives Yes No
Moles/Lumps/Skin Cancer Yes No

Endocrinology

Excessive Sweating Yes No
Heat/Cold Intolerance Yes No
Anxiety Yes No
Jitteriness Yes No
Hair Change Yes No
Low Libido Yes No
Memory Loss Yes No

Neurology

Headache Yes No
Tingling/Numbness Yes No
Seizures Yes No
Dizziness Yes No

Ophthalmology

Diminished Vision Yes No
Blurring of Vision Yes No

Hematology

Easy Bleeding Yes No
Bruising Yes No
Swollen Glands Yes No

Gastroenterology

Difficulty Swallowing Yes No
Heartburn Yes No
Abdominal Pain/Cramping Yes No
Nausea/Vomiting Yes No
Diarrhea Yes No
Blood in Stool Yes No

Genitourinary

Changes in Urination Yes No
Blood in Urine Yes No
Groin Bulges Yes No
Testicular Pain Yes No

Psychology

Tension/Stress Yes No
Sleep Disturbances Yes No
Suicidal Ideation Yes No
Eating Disorder Yes No
Depression Yes No

Musculoskeletal

Joint Pain Yes No
Joint Swelling Yes No

ENT/Respiratory

Cough/Cold Yes No
Change in Voice Yes No

Cardiovascular

Chest Pain Yes No
Palpitations/Murmurs Yes No
Leg Cramping Yes No
Leg Pain at Rest Yes No
Varicose Veins Yes No



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Today's Date: _____

PATIENTS FULL NAME (please print): _____ Date of Birth: _____

GUARANTOR INFORMATION : Person who is responsible for payment.

Name: _____	Employer Name: _____
Address: _____	Employer Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Home Phone: _____	Employer Phone: _____
Date of Birth: _____	Relationship to Patient: _____

Please complete the section below if you are over 18 and wish to allow a friend, spouse, parent, or other family member to discuss medical and/or billing information with our office.

Authorization to Discuss Medical and Billing Information

I, _____, hereby authorize Dr. Richard Fox and the staff of Alpine Surgical to discuss my medical and billing information with the following listed persons.

First and Last name of authorized person:	Relationship: (ie: mother, son, spouse, friend)
1: _____	1: _____
2: _____	2: _____
3: _____	3: _____
4: _____	4: _____

Patient Signature: _____ Date: _____

HIPPA PRIVACY PRACTICE NOTICE

I acknowledge reviewing the HIPPA Privacy Practice Notice and understand the policy of this office. A copy has been offered to me for my records.

Patient/Guardian Signature: _____ Date: _____