



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

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BOARD CERTIFIED IN RHEUMATOLOGY

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.**

LONGMONT

1715 Iron Horse Drive
Suite 100
Longmont, CO 80501

BOULDER

1840 Folsom
Suite 105
Boulder, CO 80302

BROOMFIELD

2095 West 6th Avenue
Suite 106
Broomfield, CO 80020

WHEAT RIDGE

3455 Lutheran Parkway
Bldg. 8, Suite 100
Wheat Ridge, CO 80033

NORTHGLENN

11990 Grant St
Suite 108
Northglenn, CO 80233

PHONE 720.494.4700

TOLL FREE 1.877.508.5510

FAX 720.494.4706

WEBSITE www.ccao.net

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. #

CITY STATE ZIP _____ Opt-in to patient portal

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: _____

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 Osteoporosis
 Lupus Ankylosing spondylitis
 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 (hyperthyroidism)
 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 _____



Colorado Center
for Arthritis & Osteoporosis, LLC

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
(If patient is under 18)

Date



Financial Policy

Thank you for choosing us as your provider for your rheumatology needs. Our commitment to you and to your referring physician is to provide the highest quality, most efficient and caring service possible.

The following policy is provided to clarify financial responsibility for you and your insurer for services you receive from our practice, and to be certain that we follow applicable laws. Please read entirely, ask any questions that you may have, and sign in the space provided. A copy will be provided upon request.

Your insurance carrier defines your eligibility and benefits. CCAO will bill your primary and secondary (if applicable) insurance carrier for services provided. If you have a copayment, coinsurance and/or deductible, you are required to pay those amounts, as they are your responsibility.

Payments due at time of service (upon check-in):

Consult - we will determine an estimated cost (applied to copayment/coinsurance/deductible) according to your insurance plan. In the occasion of under or over payment, you will either receive a statement with the remaining balance or a refund check.

Copayment – due at every visit

Self-pay – we will calculate the amount owed for your visit

Current balances – if you have an unpaid balance, you will need to pay this during check in

Non-contracted insurance (out of network): If CCAO does not have a contract with your health insurance carrier, you will be responsible for all charges not covered under your health insurance plan.

Once CCAO has received the processed claim/payment from your insurance, a statement with the remaining charges for both covered and non-covered services will be sent to you by mail. Payment is expected in full within 30 days of receipt of statement. Unless CCAO approves other arrangements, payments not received within 30 days will be assessed a \$20.00 rebilling fee for every 30 days not paid and is subject to collections.

Your signature below confirms that you have read the above policy and accept financial responsibility for services rendered 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 and for collecting any benefits from my insurance.

Patient Name (print): _____ Date: _____

Responsible Party Signature: _____

(Parent or Legal Guardian if under 18 years old)



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
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

-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
(If patient is under 18)

Date

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 **Jess Houwen**

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: Jess Houwen, 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, Jess Houwen, 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 አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል። 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 dɛ nìà kɛ dyédé gbo: ɔ jũ ké m̀ [ˈBàsóò-wùdù-po-nyò] jũ ní, níí, à wuɖu kà kò dò po-poò béìn m̀ gbo kpáa. Dá 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