1421 S Potomac Street, **Suite 220**, Aurora, CO 80012
Phone 303.337.5600 Fax 303.337.7734
www.surgicalconsultantsaurora.com
Michael C. Fraterelli, MD

Thank you for choosing Surgical Consultants of Aurora for your medical needs.

On the day of your *New Patient Appointment*, you are expected to know and to have the following items available to complete your registration in order to be treated by our physician. The first visit is a consult or determination if surgery is needed; it is not your surgery date.

We are located next to the Medical Center of Aurora on South Potomac Street in Aurora.

Our physical address is 1421 S. Potomac St, Suite 220, Aurora CO 80012.

Parking is located in the open lot across from the building and in the parking garage. There is a shuttle provided by the hospital if the walk is further than planned or for days of inclement weather.

Arrive at the office at _________________AM/PM for your scheduled appointment, ____________________.

_____ New Patient paperwork (unless provided prior to appointment)
_____ Insurance Cards
_____ Photo ID (Drivers License, Passport, or other photo ID)
_____ Co-pay, percentage due, or self-pay total
_____ Referring physician information
_____ Primary Care Provider information
_____ Local Pharmacy Name and Telephone number
On other notes:

* Plan time for parking.

* Be prepared to complete additional paperwork if necessary.

* Be prepared to pay a deposit or your deductible towards scheduled surgery as our fees are separate from the fees from the hospital.

* If you are unable to keep your appointment or would like to reschedule, we request a 24-hour notice.

Thank you for your cooperation.

Surgical Consultants of Aurora

***Additional Notes:
____
____
____

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Patient Information

Last Name: ____ First Name: ____________________ MI: ____

Preferred Name: ___________________ Maiden Name: __________________ Prefix: _______ Suffix: _________

Date of Birth: ________________ Sex: _______ Primary Language: __________________Marital Status:___________

Race: (circle one)
- African American/Black
- American Indian/Alaska Native
- Asian
- Caucasian/White
- Hawaiian/Pacific Islander
- Declined
- Other______________________

Ethnicity: (circle one)
- Hispanic or Latino
- Not Hispanic or Latino
- Declined
- Other________________________

Address: ____ Apt #: _____________

Zip: __________________ City: _______________________________ State: ________ County: _________________

Cell Phone #: _____________________________________ Secondary phone #?_______________________________

Email Address: ____Contact Preference? Mail? Phone?

<u>*MUST</u>** <u>provide</u> **<u>LOCAL</u>** Pharmacy Name and Direct Phone Number.

***No** prescriptions can be written **after surgery** if not provided.*

Pharmacy Name:____

Pharmacy DIRECT Phone #:____

Primary Care Doctor: ____Phone:___________________________

Referring Doctor (if different)**:** _______________________________________Phone:__________________________

Emergency Contact:

Name: ____ Phone Number: ___________________________

Relationship to emergency contact you have listed:____________________________________

Responsible Party? (Insurance Policy Holder)

Your relationship to the insured: _____________________________________ Ins. Date of Birth: _________________

Ins. Last Name: _________________________________First Name: ___________________________Middle Ini: _____

Patient Employer:(Complete ONLY if Workman Comp visit)

Company: _______________________________________ Occupation: ________________________________

Phone# to Employer: ____

YOU MUST PROVIDE US WITH YOUR PHOTO ID AND ALL CURRENT INSURANCE CARDS.

Patient write your Last Name:______________________________DOB:________________

Acknowledgement of Privacy Practice (HIPAA)

I acknowledge that I have seen and/or received a copy of the Notice of Privacy Practices for Surgical Consultants of Aurora, P.C. regarding the use and disclosure of my protected health information.

___________________________________ X ____

Patient's Name (Please Print) *Signature* *Date*

Is it acceptable for a physician/staff member to leave a message from our office on your answering machine? __Yes __No
Is there a family member permissible to leave test results or medical information with?
Name: ____ Relationship: ___________________________________

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Financial Policies & Agreement (Effective 9/1/05, updated 9/2018)

Read, review, and sign this financial statement for a better understanding of the financial aspects of your care.

BASIC PRINCIPLES

1. Our practice is a business concern. Our business is to render professional services to our patients. In order for our business to continue to operate, certain financial expenses must be met. Among these are salaries for employees, rent, insurance, supplies, equipment, repairs and maintenance.
2. Our expenses can only be met if we receive compensation for our services.
3. *Each patient is responsible for the cost of our services*. Insurance plans are available to assist with this responsibility. If you have insurance, we will submit the appropriate claims to your insurance. You will be responsible for balances assigned to you by your insurance plan and claims denied by your insurance plan. **These fees are for the surgeon and are separate from any other fees incurred such as hospital, labs, surgical assistants, etc…**
4. Physicians are NOT responsible for coverage decisions made by insurance plans or employers who sponsor such plans. Most insurance plans involve discounted contracts with physicians. We agree to accept these discounted payments from the insurance plan in exchange for appearing on the plan's list of preferred providers. The discount depends on the plan itself and the specific service rendered.

FINANCIAL POLICIES

1. **Current insurance information is absolutely vital. It is your responsibility to provide your current insurance ID card.**
2. Patients without insurance are expected to pay all charges at the time services are rendered or prior to surgery performed.
3. We accept cash, debit and credit cards, checks, and money orders. (accepted: Visa, MasterCard, Discover, and American Express)
4. Office visit copayments must be paid at the time of the appointment. We will review your card and online eligibility in order to collect the correct amount. If the copay amount is higher than expected we will bill you for the difference.
5. If you will be having surgery, we will contact your insurance company to determine an estimate of the deductible or coinsurance that is due and **may choose to collect this amount prior to surgery**. You will be given a receipt and may present to the hospital at the time of preadmission. If our estimate of services was incorrect, you will be billed for the difference or refunded overpayment after the claim is processed and we receive an Explanation of Benefits (EOB)
6. As a courtesy, we will send a claim to your insurance plan after services have been rendered. (Office Visits and Surgery) Your insurance will process the claim and then send an Explanation of Benefits (EOB) to you and to us. If there is a payment from your insurance company to us, it is attached to our EOB or transmitted electronically. The payment process usually takes less than 45 days. Once we receive the EOB, our billing department enters the appropriate data into your account. We will send a bill to you based on what your insurance plan has stated is "patient responsibility".
7. You are responsible for paying your account balance within thirty (30) days of our first statement to you.
8. Checks returned to us due to "insufficient funds" or "closed account" will be handled as follows. We will assess a $20.00 charge to your account. We will attempt to contact you by phone or by mail. Future payments must be by either cash or money order.
9. DELINQUENT ACCOUNTS. Any account more than thirty (30) days old is deemed delinquent. We then begin a series of steps to collect the amount due. A bill will be mailed to you two times. If we **do not** receive a response, your account will be sent to a collection agency. If the collection agency deems it necessary, we will authorize legal action on their part. **Please contact us if you have questions about your account at 303-337-5600 ext 104 or "0".**

I understand this statement of policies and this Agreement. I agree to be bound by the terms and conditions above.

X ____ ________________________________

Signature of Patient (or Responsible Party) Date

Health Questionaire **Last Name:**____________________________DOB:____________ Age: ________

Purpose of visit: ___________________Primary care doctor: _______________Referring doctor: ______________

Patients Medical History (Circle ALL that apply)

Abdominal pain
Abnormal bleeding
Blood clot
Cancer? Type?_________
Change in bowel habits
COPD
Reflux/GERD
Seizures

Diabetes
Difficulty swallowing
Emphysema
Head injury
Heartburn
Heart disease
Shortness of breath
Sleep Apnea

Heart surgery
Hepatitis?
High blood pressure
Hoarseness
Loss of appetite
Pressure in throat
Stroke
Weight gain / loss

Problems with anesthesia
Thyroid disease
Tuberculosis?

OTHER?______________
____

Past Surgical History (Circle ALL that apply)

Abdominal surgery
Adhesions
Appendectomy

Cesarean section
Colon surgery
Gallbladder

Hernia repair
Hysterectomy
Laparotomy

Ovary removed
Thyroid
Tonsillectomy

Other surgeries not listed: ____
____

Medications

*List all **medications and dosage** you are currently taking,*

Include vitamins and herbal supplements. You may attach a separate list if needed.

_________________________ _________________________ ___________________________
_________________________ _________________________ ___________________________
_________________________ _________________________ ___________________________

Do you take Coumadin? Yes No

Do you take aspirin? Yes No

Allergies & Adverse Reactions

______**NO ALLERGIES or** Circle ALL that apply.

Adhesive tape
Antibiotics

Latex Penicillin
Percocet

Sulfa antibiotics
Vicodin

Other______________

Reactions? ____

Family History Has any member of **your family,** mother/father, had any of the following? (Circle ALL that apply)

Abnormal bleeding/clotting
Cancer
Diabetes

Heart Disease
Hypertension
Stroke

Other?
____

Social History

Smoker? ___Yes ___No I use to smoke. ___Yes ___No I have never smoked. ___Yes ___No

HIV/AIDS Infection Risk _____ At risk for HIV/AIDS _____ No known infection risk

Substance Use? (Circle ALL that apply)

Alcohol (rare, moderate, other?)
Caffeine

Cocaine
Heroin

Marijuana
Other?_____________________

Transfusion Directive

_____ ***I will accept a blood transfusion if necessary, during surgery.***

_____ ***I will not accept a blood transfusion.***

Health Directives **If you are over 18 years of age, do you have the following?**

_____ Advance Directive _____ Living Will _____ Personal Directive _____ None