



# Pueblo Bone & Joint Clinic, PLLC

*Matthew P. Simonich, M.D.*  
Board Certified ABOS - FAAOS

*Drew D. Ritter, M.D.*  
Board Certified ABOS - FAAOS

*Lance R. Farnworth, M.D.*  
Board Certified - ABOS

*Robert W. Simmons, PA-C*

## Welcome to our practice

### **Patient Bill of Rights**

As a patient you have the right to be treated fairly and honestly. You have the right to be treated on an emergent basis when warranted. You have the right to quality and timely treatment regardless of age, sex, religion, national origin.

### **As A Provider We Reserve The Right To:**

Discharge you:

- For not adhering to practice policies after 30 day written notice.
- For abusive treatment of our staff.
- For routinely missing appointments and not calling to cancel.
- For activities that can be considered potentially fraudulent or abusive by your carrier or the government.

### **As A Patient You Are Required To:**

Present for all appointments 15 minutes prior to the scheduled time for paper work and financial arrangements.  
Present your insurance information/changes to policies at each visit.  
Pay Co-Payment and/or deductible  
Clear all prior balances before receiving additional treatment.

### **Your Insurance Carrier Requires You To:**

Pay Co-payments  
Pay deductibles/coinsurance amounts  
Sign ABN

**PUEBLO BONE & JOINT CLINIC**

**MATTHEW SIMONICH, M.D.**  
**LANCE FARNWORTH, M.D**

**DREW RITTER, M.D.**  
**ROBERT SIMMONS, P.A.**

REFERRING PHYSICIAN \_\_\_\_\_ TODAYS DATE \_\_\_\_\_  
Name & Phone of Family Doctor: \_\_\_\_\_

**NEW PATIENT CONFIDENTIAL INFORMATION**

Name of Patient: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Marital Status: Married\_\_\_ Single\_\_\_ Widowed\_\_\_ Divorced\_\_\_ Sex: \_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_  
Social Security No.: \_\_\_\_\_ Phone No. \_\_\_\_\_  
Specific Occupation of Patient or Parent \_\_\_\_\_  
Employer \_\_\_\_\_ Phone: \_\_\_\_\_  
Name & Phone of Nearest Relative/Friend to Contact in Case of Emergency: \_\_\_\_\_

Spouse/Guardian: \_\_\_\_\_ Birthday: \_\_\_\_\_ Age: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Mailing Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Employer's Address: \_\_\_\_\_  
Did You Bring X-Rays? \_\_\_\_\_ Obtained From: \_\_\_\_\_  
\*\*\*\*Is This Injury Under Litigation? \_\_\_\_\_  
\*\*\*\*Name and Address of Attorney \_\_\_\_\_

**INSURANCE INFORMATION**

Medicare? Yes\_\_\_ No\_\_\_ Number \_\_\_\_\_  
Medicaid? Yes\_\_\_ No\_\_\_ Number \_\_\_\_\_  
Primary Insurance Company Name: \_\_\_\_\_  
Policy/Subscriber Number \_\_\_\_\_ Name of Policy Holder \_\_\_\_\_  
Group Number: \_\_\_\_\_  
Secondary Insurance Company Name: \_\_\_\_\_  
Policy/Subscriber Number \_\_\_\_\_ Name of Policy Holder \_\_\_\_\_

A: Is this a Workman Compensation Claim? \_\_\_\_\_ if yes, please answer the following:  
Insurance Name \_\_\_\_\_ Comp Number \_\_\_\_\_  
Date of Accident? \_\_\_\_\_ How did it Happen? \_\_\_\_\_

B: Is Injury the Result of an Auto Accident? \_\_\_\_\_ Date of Accident \_\_\_\_\_  
Name of Insurance Company \_\_\_\_\_  
Claim Number \_\_\_\_\_

**INSURANCE INFORMATION**

I hereby Authorize Pueblo Bone & Joint Clinic to furnish information to my insurance carrier(s) concerning my examination, findings, and treatments. I understand that I am responsible for any amount not covered by Insurance.

**Patient's Signature (or Parent if Patient is a Minor)**

**Date**



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## FINANCIAL POLICY

Thank you for choosing The Pueblo Bone and Joint Clinic as your healthcare provider. We are committed to providing the best medical care possible. Please understand that payment of your bill is considered a part of your treatment. The following statement explains our Financial Policy which we ask you to read, sign and return to us prior to your treatment.

- All patients should provide accurate and complete personal and insurance information prior to being seen by the doctor.
- All applicable co-pays, personal balances, both current and prior, are due at time of service.
- We accept cash, check, debit or credit cards, Mastercard, Visa and Discover.

### **Regarding Insurance**

We participate in multiple insurance plans. For some other insurances we accept assignment benefits but in all cases we require that the guarantor, the person who is financially responsible, is *personally* liable for all balances not covered by insurance. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements. Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under the Medicare Program or by other medical insurance companies.

### **Past Due Accounts**

Overdue accounts will be referred to a collection agency. Legal fees that we pay to secure past due balances will be added to your account.

### **Co-Pays**

Payment for co-pays are expected at time of service.

### **Returned Checks**

For checks returned to us as unpaid by your bank, we will charge a \$25.00 fee.

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Please contact our Billing Office if you have any questions or concerns at (719) 544-4265 or (719) 543-4664

I have read the Financial Policy. I understand and agree to the Financial Policy.

- You have authorization to charge my credit card for any current or past due personal balances upon receiving my verbal or written permission.

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Print Name

Signature

Date

**MEDICAL HISTORY**  
**PLEASE FILL OUT COMPLETELY!**

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

**HISTORY & PRESENT ILLNESS:**

What are you seeing the Doctor for? (Please be Specific):

\_\_\_\_\_

Date of Injury? \_\_\_\_\_

How long have you had these symptoms?

\_\_\_\_\_

**PAST MEDICAL HISTORY:**

All Previous Medical Problems and Hospitalizations:

- Yes\_\_\_ No\_\_\_ Rheumatic Fever **When** \_\_\_\_\_
- Yes\_\_\_ No\_\_\_ Childhood Diseases **Circle** (measles, mumps, pox, ext.) **When** \_\_\_\_\_
- Yes\_\_\_ No\_\_\_ Allergies, hives or drug reactions **When** \_\_\_\_\_
- Yes\_\_\_ No\_\_\_ Asthma **When** \_\_\_\_\_
- Yes\_\_\_ No\_\_\_ Diabetes **When** \_\_\_\_\_
- Yes\_\_\_ No\_\_\_ Thyroid Problems **When** \_\_\_\_\_
- Yes\_\_\_ No\_\_\_ Bronchitis, Emphysema **When** \_\_\_\_\_
- Yes\_\_\_ No\_\_\_ Stroke **When** \_\_\_\_\_
- Yes\_\_\_ No\_\_\_ Heart Attack **When** \_\_\_\_\_
- Yes\_\_\_ No\_\_\_ High Blood Pressure **When** \_\_\_\_\_
- Yes\_\_\_ No\_\_\_ Murmurs **When** \_\_\_\_\_
- Yes\_\_\_ No\_\_\_ Ulcers **When** \_\_\_\_\_
- Yes\_\_\_ No\_\_\_ Migraines **When** \_\_\_\_\_
- Yes\_\_\_ No\_\_\_ Sexually transmitted diseases **When** \_\_\_\_\_
- Yes\_\_\_ No\_\_\_ Cancer **When** \_\_\_\_\_

Other Problems not listed above:

\_\_\_\_\_

**PAST SURGICAL HISTORY:**

Have you had any previous surgeries?

<b>Procedures:</b>	<b>Date:</b>	<b>Name of Physician:</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any Previous Fractures?

When \_\_\_\_\_ Type of Fracture \_\_\_\_\_

Do you use a Walker, Cane, or Brace, if so which one? \_\_\_\_\_

Read and Reviewed: \_\_\_\_\_ Date \_\_\_\_\_

**(Physician Signature)**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**MEDICATION:**

What Medications are you **Currently** taking?

**Name:** \_\_\_\_\_ **Doses:** \_\_\_\_\_ **Times/Day:** \_\_\_\_\_ **Reason:** \_\_\_\_\_

Name:	Doses:	Times/Day:	Reason:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are You Allergic to **ANY** Medications? If so What?

\_\_\_\_\_

**SOCIAL HISTORY:**

Have you ever Smoked? \_\_\_\_\_ How many Packs a day? \_\_\_\_\_ How many years? \_\_\_\_\_  
When did you quit? \_\_\_\_\_

Do You Drink Alcoholic Beverages? \_\_\_\_\_ How Often? \_\_\_\_\_

Have You Lost Weight Recently? \_\_\_\_\_

Have You Had Faintness, Numbness, and Convulsions? \_\_\_\_\_

Do You Use Drugs? (Marijuana, LSD, Heroin, Cocaine) \_\_\_\_\_

Do You Live Alone or with Family? \_\_\_\_\_

Do You Drive? \_\_\_\_\_

Occupational Duties: \_\_\_\_\_

**FAMILY HISTORY:**

(PLEASE CHECK)

- |                             |                     |
|-----------------------------|---------------------|
| ___ Frequently Broken Bones | Family Member _____ |
| ___ Diabetes                | Family Member _____ |
| ___ Heart Disease           | Family Member _____ |
| ___ Heart Attack            | Family Member _____ |
| ___ Asthma                  | Family Member _____ |
| ___ Cancer                  | Family Member _____ |
| ___ Ulcer                   | Family Member _____ |
| ___ High Blood Pres         | Family Member _____ |
| ___ AIDS/HIV                | Family Member _____ |
| ___ Hepatitis               | Family Member _____ |
| ___ Kidney/Bladder          | Family Member _____ |
| ___ Kidney Stones           | Family Member _____ |
| ___ Blood Urine             | Family Member _____ |

Read and Reviewed: \_\_\_\_\_ Date \_\_\_\_\_

**(Physician Signature)**



# PUEBLO BONE & JOINT CLINIC, LLC

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Lance Farnworth, M.D.

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Pueblo, CO 81008

(719) 253-7102 • Fax: (719) 253-7114

Drew Ritter, M.D.  
Robert Simmons, PA-C

## AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

**Patient Name:** \_\_\_\_\_ **DOB** \_\_\_\_\_

I hereby authorize the use and disclosure of individually identifiable health information relating to me, which is called "protected health information" (PHI) under a federal health privacy law, as indicated or described below:

- All health information relating to me.
- NO information, other than that required or allowed by law.
- ONLY the following specified information. (Describe specific information including dates of service).

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Please List the Individual(s) or Organization(s) to whom the Disclosure May be Made:

<u>Name</u>	<u>Relationship</u>
_____	_____
_____	_____
_____	_____
_____	_____

I understand in making this request that:

- If the individual(s) or organization(s) that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

- I may revoke this authorization at any time by notifying you in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by you before receiving my revocation.

**This authorization expires one year from the date signed, as indicated below, or until revoked by me in writing.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(or Legal Guardian)

If signed by the patient's personal representative the personal representative hereby states and represents they have been appointed, or have received authorization, to act as the patient's personal representative.

Witnessed by: \_\_\_\_\_ Date: \_\_\_\_\_



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## IMPORTANT NOTICE REGARDING THE PRIVACY OF YOUR HEALTH INFORMATION

Effective April 14, 2003, revised federal regulations restrict the use and disclosure of your private health information (PHI) by our practice and other organizations. It has been, and continues to be, the policy of our practice to protect the privacy of our patient's health information and to comply with any regulations regarding the use and disclosure of patient health information. The following summarizes the new law and under what circumstances it may be disclosed.

### Permitted Disclosures

Our practice is permitted to use and disclose your PHI for treatment, payment and health care operation purposes. These uses include sharing your PHI with other health care providers for confirmation of a diagnosis, using your PHI to accurately bill services we provide to you, providing your PHI to your insurance company for reimbursement, to remind you of appointments and as part of our quality improvement program.

We are also permitted to disclose your PHI in compliance with guidelines outlined by law and when required to do so by various government agencies. We may also disclose your PHI to family members, relatives or close personal friend when the information we disclose is relevant to the individual's involvement with your care or is required to assist in your health care (e.g., pick-up prescriptions or other documents, note follow-up care instructions, etc.). We will disclose your PHI when we refer you to other physicians or providers of health care. Finally, we reserve the right to change a privacy practice described in this notice as may be permitted or required by law and to make such change effective for all protected health information.

### Restricted Disclosures

You have the right to request restrictions on certain uses and disclosures of your PHI and to request portions of your PHI be amended. However, our practice is not obligated to agree to requested restrictions or to amend your PHI in the manner you request. You also have the right to inspect and receive a copy of your PHI, but must pay a reasonable charge for the labor and costs associated with copying your PHI. Finally, you have a right to receive an accounting of disclosures of your health information.

### Authorization for Other Uses

Our practice will make other uses and disclosure of your protected health information only after obtaining your written authorization. If you authorize a use not contained in this notice, you may revoke authorization at any time by notifying us in writing that you wish to revoke your authorization.

### Concerns

If you believe your privacy rights have been violated, you may make a complaint by contacting Jerry Horton, Director of Business Operations, of Pueblo Bone and Joint Clinic, LLC, 3676 Parker Blvd., Suite 110, Pueblo, Co 81008, (719) 253-7102, or the Secretary of Health and Human Services. No individual will be retaliated against for filing a complaint.

### Acknowledgement

I acknowledge that I have received this summary and a copy of the Notice of Privacy Practices regarding the use and disclosure of my private health information.

\_\_\_\_\_  
Patient Signature  
(or Legal Guardian)

\_\_\_\_\_  
Date