Surgery Center of Colorado 761 SouthPark Drive Littleton, CO 80120 phone: 303-783-1003 fax: 303-783-1001

PATIENT INFORMATION:

Name: (Last) _____ (First) _____ (MI) ___ □ Male □ Female

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Email Address: _____

Marital status: □ Single □ Married □ Divorced □ Widowed Race:_____

Employer: _____ Occupation: _____

NAME OF SURGEON(S): _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship: _____

City/Location: _____ Phone Number: _____

PROCEDURE(S):

☐ Breast Enlargement ☐ Liposuction ☐ Botox/Fillers ☐ Body Lift ☐Resurfacing/Peels/Laser
☐ Facelift ☐ Eyelid lift ☐ Nose Reshaping ☐ Ear Reshaping
☐ Tummy Tuck ☐ Breast Lift ☐ Breast Reduction ☐ Lipolysis ☐ Other _____

HEALTH AND MEDICAL INFORMATION:

Age: _____ Height: _____ Weight: _____ Primary Care Physician and Location: _____

Have you ever smoked? □ yes □ no If yes, ____ packs/day for ___ Still smoke? □ yes □ no Date you quit: _____

How much alcohol do you drink? __ drinks per □ day □ week □ month How many cups of coffee/caffeine per day? _____

Additional Health History List the dates of your most recent:

Physical/Check-up _____ Normal? □ Yes □ No EKG (heart tracing) _____ Normal? □ Yes □ No
Chest X-Ray _____ Normal? □ Yes □ No Blood work _____ Normal? □ Yes □ No

Women Only: How many pregnancies have you had? _____ How many children born alive? _____ How many c-sections? _____

Is there any chance you could be pregnant? □ Yes □ No Date of most recent breast exam: _____

Are you having regular menstrual periods? ? □ Yes □ No Date of most recent mammogram: _____

Heavy bleeding with your periods? ? □ Yes □ No

MEDICATIONS: Please list all the medications you are currently taking, prescription and non-prescription, supplements, vitamins, diet pills and those medications you may not take *every* day. Please also include the dose of the medication.

Medication/Dose	Medication/Dose

ALLERGIES: Please list all allergies to medications, tape, latex, iodine, etc. and the reaction you have when exposed.

	☐ I have no known drug allergies

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Name: _____

SURGICAL HISTORY:

Please list your surgical history and/or serious accidents or injuries. Please include the date of the surgery, accident or injury.

PROCEDURE	DATE

Have you and/or any of your family members had any anesthesia complications? ☐ Yes ☐ No

If yes, please describe: _____

PAST MEDICAL HISTORY/REVIEW OF SYSTEMS: Please check all that apply to *YOU*:

NEUROLOGICAL
- ☐ Migraines
- ☐ Stroke
- ☐ Seizures
- ☐ Head Injury
- ☐ Depression

BLOOD
- ☐ Anemia
- ☐ Bleeding disorder
- ☐ Blood clots/DVT
- ☐ AIDS/HIV+
- ☐ Nose Bleeds
- ☐ Prior Transfusion

PULMONARY
- ☐ Asthma
- ☐ Tuberculosis (TB)
- ☐ Emphysema
- ☐ Pulmonary Embolism

CARDIOVASCULAR
- ☐ Heart Disease
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Swollen legs/ankles
- ☐ Palpitations

SKIN/IMMUNE
- ☐ Arthritis/Joint Pain
- ☐ Back/Neck
- ☐ Skin disorder
- ☐ Autoimmune
- ☐ Lupus/Scleroderma
- ☐ Pigmentation

GENERAL
- ☐ Fever
- ☐ Weight loss/gain
- ☐ Night Sweats
- ☐ Loss of Appetite

HEAD/NECK
- ☐ Change in vision
- ☐ Nasal blockage
- ☐ Sore throat
- ☐ Sinusitis
- ☐ Wear contacts/glasses

ENDOCRINE
- ☐ Heat/Cold intolerance
- ☐ Diabetes
- ☐ Thyroid Problems

GASTROINTESTINAL
- ☐ Constipation
- ☐ Reflux disease
- ☐ Diarrhea
- ☐ Hepatitis/Jaundice
- ☐ Frequent Urinary Infection

ALLERGY
- ☐ Tape Allergy
- ☐ Environmental
- ☐ Iodine Allergy
- ☐ Latex Allergy

☐ **CANCER**, type:

☐ **OTHER:**

☐ **NONE OF THE ABOVE LISTED**

Family History Please check those that apply to your family members:

☐ **NONE OF THE FOLLOWING**

☐ Blood clots/DVT ☐ Bleeding disorder ☐ Asthma ☐ Breast Cancer ☐ Stroke
☐ High Blood ☐ Heart Disease ☐ Diabetes ☐ Other

PHYSICIAN NOTES:

_____

_____

_____

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PRIVACY FORM

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. You will be given a copy of this notice.

Patient Health Information: Under federal law, your patient health information is protected and confidential. This information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information includes payment, billing, and insurance information.

How we use your Health Information: We use health information about you for treatment, to obtain payment, and for healthcare operations including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances we may be required to use or disclose the information without your permission.

Examples of Care, Payment, and Healthcare Operations: **Treatment**—We will use and disclose your health information to provide your medical treatment. For example, nurses, physicians, and other members of your treatment team will record and use it to determine your care. We may also disclose information to other healthcare providers who are helping in your treatment, to pharmacists filling your prescriptions, and to family members helping with your care. **Payment**—We will disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain your records of payment. **Health Care Operations**—We will use and disclose your health information to conduct our standard internal operations, including the administration of records, the evaluation of the quality of treatment, and the assessment of outcomes. **Quality Assurance-**We will also use your health information in the performance of physician's peer reviews, as required by law.

Special use: We may use your information to contact you with appointment reminders, if your physician requests that you be seen at this facility pre- or post-operatively.

Other Uses and Disclosures: We may use or disclose health information about you for other purposes. Subject to certain **HIPAA** requirements, we are permitted disclosure for the following purposes: **Required by Law—**We may be required by law to report gunshot wounds, suspected abuse, suspected neglect, or similar events. **Research—**We may use or disclose information for approved medical research. **Public Health Activities—**As required by law, we may disclose vital statistics, disease, information related to recalls of products, and similar information to health authorities. **Health Oversight—**We may disclose information to assist in investigation and audits, and eligibility for government programs. **Judicial Proceedings—**We will disclose information in response to subpoena or court order. **Law Enforcement Purposes—**We may disclose information subject to certain restrictions. **Workers' Compensation—**We may release information about your workers' compensation or other programs providing benefits for work-related injuries or illness. **Military or Special Government Functions—**If a member of the armed forces, we will release information as military authorities or correctional facilities command, or for national security. **Death—**We must report information regarding deaths to the coroner, medical examiner, funeral directors, and organ donation programs. **Serious Threat to Health and Safety—**We may share information when needed to prevent a serious threat to your health, safety, and/or to the public.

Individual Rights: You have the following rights with your health information. **Request Restrictions—**You may request restrictions on some uses of this information, although we are not required to agree with this request. **Confidential Communications—**You may request that we communicate with only you. You may request a special address or phone number. **Inspect and Obtain Copies—**In most cases you have the right to look and receive a copy of your information. **Amend Information—**If you believe there are errors in your information, or information is missing, you may request that it be modified. **Accounting of Disclosure—**You may request a history of the disclosure of the information about you for reasons OTHER than treatment, payment, or operations.

Our Legal Requirement: We are required to provide you with this notice, to protect your information, and to abide by the terms of this notice.

Changes in a Privacy Practice: We may change these terms at any time. We will change our notice to reflect the terms that we change. We will also post the terms changes in our waiting room. You may request a copy of this notice and/or the changes at any time. You may contact the Surgery Center directly to answer any questions.

Complaints: If you have a complaint that may reveal we have violated this privacy statement, or do not agree with a decision that we made in regard to your information, please notify the Contact Person listed below. You may also contact the US Department of Health and Human Services. The Contact Person may provide you with the correct address upon request.

Contact Person: Lyndsay Wilson, ASC Administrative Coordinator

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Patient Name: _____ Sex: _____ Physician Name: _____

MR Number: _____ DOB: _____ Admission Date: _____

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FINANCIAL INFORMATION

You may receive bills from several different providers for the care rendered to you today: the physician performing the procedure, the Ambulatory Surgery Center (ASC), and a laboratory if specimens are obtained during your procedure.

FINANCIAL AGREEMENT

If you have insurance, we will help you receive maximum benefits by filing for you; however, we will expect payment of co-pays, co-insurance, and deductibles at the time of service. The undersigned individual guarantees prompt payment of all charges if the insurance carrier rejects the claim of any charges related to this account. If charges remain unpaid, it may become necessary to turn the account over to a collection agency.

ASSIGNMENT OF INSURANCE BENEFITS

Medicare/Medicare/Other Insurance

I hereby assign benefits to be paid, on my behalf, to the ASC that renders service to me. I understand and agree to be financially responsible for charges not paid within a reasonable time by insurance or other third party payer. I certify the information given with regard to insurance coverage is correct.

RELEASE OF INFORMATION

I authorize the ASC to release all or part of my medical records when required for the submission of any insurance claims for payment to the Centers for Medicare and Medicaid Services and their agents, my insurance company(s), or to my employer (if this is a worker's compensation claim).

I also authorize reports of my evaluation, treatments, and any follow up evaluations to be sent to or discussed with my referring Doctor, the Doctor requesting the consultation, my family Physician(s), as well as any other healthcare providers, hospitals, or outpatient facilities that I have or will identify to you.

I permit a copy/fax of this form to serve as an original signature of authorization.

DISCLOSURE OF OWNERSHIP

I have been advised of the following:

A physician performing the procedure may have an ownership interest in this facility.

A schedule of typical fees for services provided by this facility is available upon my request. These procedures are performed at hospitals and other outpatient facilities in this community. I have the right to choose where to receive services, including a facility where my physician does or does not have an ownership interest. I have chosen to be treated at this facility.

CERTIFICATION

I have read and fully understand the information in this form.

Patient Signature	**Date**
Witness Signature	**Date**

Patient Name: _____ Sex: _____ Physician Name: _____

MR Number: _____ DOB: _____ Admission Date: _____

Surgery Center of Colorado 761 SouthPark Drive Littleton, CO 80120 phone: 303-783-1003 fax: 303-783-1001

Patient Name: _____

MUTUAL AGREEMENT TO MAINTAIN PRIVACY

The Surgery Center of Colorado agrees to maintain Privacy of the above-named patient as outlined in the HIPAA form. We take pride in being able to extend a greater degree of privacy than is required by HIPAA, state confidentiality mandates and common law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, HIPAA forbids physicians from receiving money for selling lists of patients or protected health information to companies to market their products or services directly to patients without authorization. Some medical practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal date is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. The Surgery Center of Colorado sees this as improper and possibly not in the patients' best interest. Accordingly, we agree not to provide any list for marketing or be paid for selling patient lists or protected health information to any party for the purpose of marketing directly to patients.

Publishing is intended to include attribution by name, by pseudonym, or anonymously. The Surgery Center of Colorado has invested significant financial and marketing resources in developing this Facility. *In addition, Patient (i) will not denigrate, defame, disparage or cast aspersions upon this Facility; and (ii) will use all reasonable efforts to prevent any member of their immediate family or acquaintance from engaging in any such activity***.** Derogatory comments on web pages, blogs and/or mass correspondence, however well intended, could severely damage this Facility.

The Surgery Center of Colorado feels strongly about each Patient's privacy as well as the Facility's right to control its public image and privacy. Both Physician and Patient will work to prevent the publishing or airing of commentary about this Facility from being accessed via Internet, blogs or other electronic, print or broadcast media without prior written consent. Finally, this Agreement shall be in force and enforceable for a period of ten (10) years from the Surgery Center of Colorado's last date of service to Patient. As a matter of office policy, we are requiring all Patients to sign the Mutual Agreement to Maintain Privacy so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Physicians and Patients. Further, this Agreement will survive for a minimum of five (5) years beyond any termination of the Physician and or Patient relationship with Surgery Center of Colorado.

Patient and Physician acknowledge that breach of this Agreement may result in serious, irreparable harm. In addition to compensation for consequential damages, Patient and Physician agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses and attorney fees associated with the litigation.

Patient and Physician have been given the opportunity to ask questions and receive satisfactory and adequate explanation.

Signature of Patient _____ Date _____

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Surgery Center of Colorado, LLC agrees to provide treatment to: _____.
(Please print patient's name)

We take pride in being able to extend a greater degree of privacy than is required by law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, physicians are forbidden by law from receiving money for selling lists of patients or medical information to companies to market their products or services directly to patients without authorization. Some medical practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal date is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. **Surgery Center of Colorado** believes this is improper and may not be in the patients' best interest. Accordingly, **Surgery Center of Colorado** agrees not to provide medical information for the purpose of marketing directly to patients. Regardless of legal privacy loopholes, **Surgery Center of Colorado** will never attempt to leverage the relationship with a patient by seeking a patient's consent for marketing products for others.

We want your feedback. If our office gets it right, tell us. If we could do something better, tell us. We take quality improvement seriously. While there are scores of "rating sites" in cyberspace, many fail to provide useful information. Let's get it done right. We can make recommendations as to which sites follow minimum standards for fairness and balance. Just ask us.

Surgery Center of Colorado has invested significant financial and marketing resources in developing this facility. Nothing in this Agreement prevents a patient from posting commentary about treatment received at **Surgery Center of Colorado** – on web pages, blogs, and/or mass correspondence. In consideration for treatment and the above noted patient protection, if a patient prepares such commentary for publication on web pages, blogs, and/or mass correspondence about **Surgery Center of Colorado**, the patient exclusively assigns all Intellectual Property rights, including copyrights, to **Surgery Center of Colorado** for any written, pictorial, and/or electronic commentary. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary.

This Agreement shall be in force and enforceable for a period of five years from **Surgery Center of Colorado's** last date of service to the patient. As a matter of facility policy, **Surgery Center of Colorado** is requiring all patients treated here sign the Mutual Agreement so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all of their patients. Further, this agreement will survive for a minimum of three years beyond any termination of the **Surgery Center of Colorado**'s relationship with the patient.

Patient and **Surgery Center of Colorado** acknowledge that breach of this Agreement may result in serious, irreparable harm. Patient and **Surgery Center of Colorado** agree to the right of equitable relief (including but not limited to injunctive relief.) Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanation.

Signature of Patient _____ Date _____

Signature of Physician _____