THE STEADMAN CLINIC
STEADMAN PHILIPPON RESEARCH INSTITUTE

STEADMAN CLINIC REGISTRATION

PATIENT INFORMATION Today's Date _____

Patient Name _____
Last First (Legal) Initial Nickname

Date of Birth _____ Age _____ SS# _____ ❑ Male ❑ Female

Race _____ Ethnicity _____ Language _____

Cell Phone _____ Work Phone _____ Home Phone _____

Fax _____ e-mail Address _____

Permanent Mailing Address _____

City _____ State _____ Zip _____

Local Address _____ Phone _____

City _____ State _____ Zip _____

Patient's Employer _____ Address _____

City _____ State _____ Zip _____

Occupation _____ Retired? Y N

Marital Status S M W D Spouse's Full Name _____

Spouse's Employer _____ Business Phone _____

Relative to contact in case of an emergency _____
(A relative not living with you)
Relationship _____ Phone _____

Primary Physician _____ Phone _____

Address _____City _____ State _____ Zip _____

How were you referred to us? _____

Injury Information:

Date of injury _____ Work related: No ❑ Yes ❑ Auto Accident: No ❑ Yes ❑

What is injured _____

Describe injury _____

_____

_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:

Carrier _____

Address_____ City _____

State _____ Zip code _____ Phone _____

Policy ID Number _____ Group _____

Name of the Policy Holder_____ Relationship _____

Address_____ City _____ State _____Zip_____

Date of Birth _____ Social Security number _____ Sex M F

Employer_____ Occupation _____

SECONDARY INSURANCE COMPANY:

Carrier _____

Address_____ City _____

State _____ Zip code _____ Phone _____

Policy ID Number _____ Group _____

Name of the Policy Holder_____ Relationship _____

Address_____ City _____ State _____ Zip _____

Date of Birth _____ Social Security # _____ Sex M F

Employer_____ Occupation _____

WORKMAN'S COMPENSATION INSURANCE:

Carrier _____

Address_____ City _____

State _____ Zip code _____ Phone _____

Claim Number _____ Case Worker's Name _____

Case Worker's Phone Number _____ Fax _____

Employer at time of injury _____

Address _____

ASSIGNMENT OF BENEFITS:

Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered. I authorize release of
all medical information necessary to process my insurance claims or that is pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled to the above named physician or clinic. This agreement will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original.
I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Patient _____ Date _____

Responsible Party _____ Date _____

The Steadman Clinic, Professional LLC

STATEMENT OF FINANCIAL LIABILITY

I understand that I am responsible for the payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred. I understand that I am responsible for payment of office charges at the time of the visit. I understand that unless otherwise indicated below, I hereby request and authorize The Steadman Clinic to bill insurance policies written in the United States, and insurance companies based in the United States, for surgical and other charges for services provided to me, and I authorize payment to The Steadman Clinic for all such services. I further understand and agree that I will be required to provide a down payment prior to receiving the services based on my estimated financial responsibility (e.g. coinsurance and deductible amounts) under the terms of my applicable benefit plan or other health insurance coverage documents .

NOTICE OF DISCLOSURES

I also understand that The Steadman Clinic physicians are investors in the Vail Valley Surgery Center, Edwards Surgery Center, Peak One Surgery Center, and an MRI facility at which I may receive services. In the course of your surgical treatment, some of our physicians utilize FDA approved equipment and devices which they have designed, developed and patented for the purpose of improving patient care. As a result they may receive royalties from their design efforts.

NOTICE OF LIABILITY FOR "NON-COVERED" SERVICES

I understand that my insurance carrier (whether private, Medicare, or other third-party payer) may deny payment or consider some or all services performed by The Steadman Clinic, such as assistant surgeons, and supplies, to be "non-covered," and that I will then be fully responsible for payment of all such non-covered services.

WAIVER OF "USUAL, CUSTOMARY AND REASONABLE" CLAUSES

I acknowledge that the fees charged by The Steadman Clinic for services rendered to me, or to the person for whom I assume financial responsibility, may exceed the fees considered "usual, customary and reasonable," under the terms of my applicable benefit plan or other health insurance coverage documents; the specialized services and staff provided by The Steadman Clinic may not fall within third-party payer definitions of "usual and customary". However, I agree to pay all such fees in full, even if the amount is greater than the amount paid or allowed by my insurance company.

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CHANGES TO BILL TO/ PAYMENT INSTRUCTIONS

By checking the box to the left, I hereby direct that The Steadman Clinic SHALL NOT bill my insurance company for services provided to me, and instead I agree to pay all fees for services furnished to me by The Steadman Clinic.

PERMISSION TO RELEASE MEDICAL INFORMATION

I authorize The Steadman Clinic to release information from my medical record, or from the medical record of the person for whom I am legally responsible, to my/their insurance company, other third-party payers or their reviewing agencies, as reasonably necessary to expedite claim processing and procure payment from such parties for services rendered by The Steadman Clinic. This authorization is valid for every visit to The Steadman Clinic or its affiliates until written notice revoking it is provided. I release The Steadman Clinic of all responsibility or liability for use and disclosure of such information, or other information disclosed in compliance with this authorization.

I have read all of the above and understand/agree to all provisions there in regarding responsibility for payments and release of information.

Patient's Name: _____

Patient or Legal Guardian's Signature: _____ Date:_____

If Legal Guardian, Relationship to Patient: _____

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Acknowledgement of Notice of Privacy Practices

Name of Patient *(please print)* ..... Date of Birth .....

I hereby acknowledge that I received the Steadman Clinic´s Notice of Privacy Practices.

Signature of patient or patient representative ..... Date .....

Documentation of Good Faith Efforts
To obtain patient´s acknowledgement that they received provider´s Notice of Privacy Practices

(For use when acknowledgement cannot be obtained from the patient.)

The patient presented to the office/hospital on ..... and was provided with a copy of Covered Entity´s Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- ☐ Patient refused to sign
- ☐ Patient was unable to sign or initial because: .....
- ☐ The patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity
- ☐ Other reason (describe below): .....

Signature of Employee Completing Form ..... Date .....

[Note: Providers are required to make good faith efforts to obtain acknowledgement that each patient has received their Notice of Privacy Practices. Should the individual refuse to acknowledge receipt of provider´s Notice of Privacy Practices, the provider should document the "Good Faith Efforts" taken to obtain such acknowledgement. The regulation does not specify how those "Good Faith Efforts" should be documented.
This example form is meant to serve as an example of one way that a provider could satisfy this requirement.]

181 W. Meadow Dr. ▪ Suite Number 400 ▪ Vail, CO 81657 ▪ (970) 476-1100 ▪ Fax (970) 479-5835
360 Peak One Drive ▪ Suite 340 ▪ P.O. Box 4815 ▪ Frisco, CO 80443 ▪ (970) 668-6760 ▪ Fax (970) 668-6761
www.thesteadmanclinic.com

ACCOMMODATIONS and TRANSPORTATION

Four Seasons Hotels, Vail	303-389-3301
The Sonnenalp Resort, Vail	970-476-5656
The Sebastian, Vail	800-354-6908
The Lodge at Vail	970-476-5011
Antlers at Vail	970-476-2471
Vail Mountain Haus	800-237-0922
Evergreen Lodge	970-476-7810
Vail Cascade Resort	800-420-2424
Holiday Inn , Vail	970-476-2739
The Arrabelle/Rock Resorts, Vail (hotel/condo)	866-662-7625
Comfort Inn (Avon, CO)	800-545-8422
Simba Run Resort (Condos-Vail)	800-746-2278
Sitzmark Lodge	970-476-5001

Transportation
Airport Shuttle Services:

Colorado Mountain Express (CME)	800-525-6363
Airport Shuttle of Colorado	800-222-2112

Rental Cars:

Thrifty- Eagle Airport	800-367-2277
Dollar- Eagle Airport	970-524-7334
Hertz- Eagle Airport	800-654-3131

Limousines, Taxies & Bus Service:

Silent Partner Limo-Rick Silverman	970-470-2587 www.silentpartnerlimousine.com
RJ Limousine/Suburban's	800-442-5422 www.rjlimo.com
Vail Valley Taxi	970-476-8294
Here-to-Help Vail	970-949-4248

Directions

Steadman Clinic
181 West Meadow Drive, Suite 400
Vail, Colorado 81657
970-476-1100

FROM DENVER (EAST) TO VAIL (WEST)

Exit the Denver International Airport and take Pena Boulevard to Interstate 70 heading west. Go approximately one hundred and twenty miles (120) to Vail, Exit 176. Follow the roundabout half way around and exit in the direction of Vail Village. Enter the second roundabout and exit in the direction of Vail Road. Go to the stop sign and turn right onto West Meadow Drive. Go ¼ mile and turn right at the Vail Valley Medical Center. Enter through the main entrance and take the main elevators to the third floor. The Steadman Clinic is located on the third floor of the hospital.

FROM EAGLE (WEST) TO VAIL (EAST)

Exit Eagle County Airport left onto Cooley Mesa Road. At stop light turn right (east) onto Highway 6. Follow the signs to Interstate 70 East. Take Interstate 70 East approximately 30 miles to Vail, Exit 176. Exit the roundabout in the direction of Vail road. Go to the stop sign and turn right on West Meadow Drive. Go ¼ mile and turn right at the Vail Valley Medical Center. Enter through the main entrance and take the main elevators to the third floor. The Steadman Clinic is located on the third floor of the hospital.