WESTERN ORTHOPAEDICS
1830 Franklin Street, Suite 450
Denver, Colorado 80218

DR WHITE HIP ARTHROSCOPY SURGICAL PACKET

PLEASE NOTE THE ATTACHED INFORMATION NEEDS TO BE FILLED OUT AND RETURNED TO OUR OFFICE IN ORDER TO SCHEDULE SURGERY WITH DR. WHITE

1. THE HIP ARTHROSCOPY FINANCIAL CONTRACT WHICH MUST BE SIGNED AND RETURNED IS REQUIRED FOR CASES WHERE THE INSURANCE MAY DENY YOUR SURGERY. FOR QUESTIONS ABOUT THIS YOU MAY CONTACT OUR OFFICE AND SPEAK TO CANDICE OR LOLI AT 303-321-1333.

2. AT THE BOTTOM OF THIS PAGE YOU WILL FIND A COPY OF THE CPT CODES FOR THE PROCEDURE. YOU MAY CONTACT YOUR INSURANCE COMPANY WITH THESE CODES TO CHECK YOUR BENEFITS ON OUT-PATIENT SURGERY. DR. WHITE DOES NOT HAVE CODES FOR ALL PROCEDURES PERFORMED SO IN MOST CASES A 29999 UNLISTED PROCEDURE IS BILLED.

3. ENCLOSED IS A COPY OF OUR SURGICAL ASSISTANT FORM. PLEASE NOTE DR. WHITE'S SKILLED ASSISTANTS, CHRIS IRONS OR JOE HARRIS, ARE NOT CONTRACTED WITH ANY INSURANCE COMPANIES SO THEY ARE CONSIDERED OUT OF NETWORK. IN MOST CASES THEY ARE ABLE TO GET PAID BY THE INSURANCE HOWEVER WE DO REQUIRE YOU TO READ AND SIGN OUR AGREEMENTS WITH THEM ON BALANCE BILLING PATIENTS ON ANY DENIED CLAIMS.

4. WE HAVE ALSO INCLUDED 2 PAGES TO BE FILLED OUT THAT DR. WHITE REQIRES FOR ALL HIS PATIENTS. PLEASE COMPLETE THESE 2 FORMS (PRESERVATION STUDY SHEET & LOWER EXTREMITY FUNCTIONAL SCALE) FOR YOUR HIP PAIN AT PRIOR TO SURGERY. ALSO INCLUDED IS A PAIN MEDICATION CONTRACT.

   PLEASE MAIL AND/OR FAX TO:

   1830 FRANKLIN ST, SUITE 450 DENVER, CO 80218

   FAX: 303-253-7405

   29914-FEMOROPLASTY (shaving of the femur head)

   29915-ACETABULOPLASTY (rim trimming)

   29999-UNLISTED ARTHROSCOPIC PROCEDURE (labral reconstruction, iliopsoas release, microfracture of the acetabulurn, windowing of the IT band, greater trochanteric bursetomy or any other procedure done arthroscopically that does not yet have a code).

WESTERN ORTHOPAEDICS
Excellence in Motion

1830 Franklin Street, Suite 450
Denver, CO 80218
Phone: 303-321-1333
Toll-Free: 888-900-1333
Fax: 303-321-0620

James C. Holmes, M.D.
Orthopaedic Specialist
Sports Medicine
Disorders of the Knee

Timothy J. Birney, M.D.
Orthopaedic Specialist
Disorders of the Spine

Edward (Ted) H. Parks, M.D.
Orthopaedic Specialist
Sports Medicine
Joint Replacement/Reconstruction
Arthroscopy

Armodios M. Hatzidakis, M.D.
Orthopaedic Specialist
Shoulder and Elbow

Raj Bazaz, M.D.
Orthopaedic Specialist
Shoulder and Knee
Sports Medicine

Kevin K. Nagamani, M.D.
Orthopaedic Specialist
Foot and Ankle Surgery

Brian J. White, M.D.
Orthopaedic Specialist
in Disorders of the Hip

Steven M. Traina, M.D.
Orthopaedic Specialist
in Disorders of the Knee
Shoulder and Sports Medicine

Thomas G. Mordick, II, M.D.
Hand Surgery

Benjamin W. Sears, M.D.
Orthopaedic Specialist
Disorders of the Shoulder
and Elbow

Sean Baran, M.D.
Orthopaedic Specialist
Disorders of the Hip and Knee
Sports Medicine
Joint Replacement

www.Western-Ortho.com

Revision Hip Arthroscopy Financial Contract

The procedure you are about to undergo is a revision Arthroscopy of the Hip with management of Femoracetabular Impingement and Labral Reconstruction. Currently all aspects of this type of surgery have not been fully coded by the American Medical Association. As a result when we ill your insurance company we may use an "unlisted procedure code" of 29999 to describe portions of the surgery which have not yet been given a code.

Since we are forced to use an unlisted procedure code to describe all of the work that will be put into your hip, Insurance companies frequently pay only a small portion of our bill or on occasion pay nothing at all. This is a comprehensive procedure designed to reshape your hip joint and requires advanced training and 3-4 hours of surgery.

Our fees for these services are as follows:

29999 (Labral Reconstruction Revision) $10,000-$25,000 depending on the complexity of the surgery.

29915 (Acetabuloplasty) $6,000.00
29914 (Femoroplasty) $5,000.00
29861 (Removal of loose body or foreign body) $2054.00

In the event that a Z-plasty or Ligamentum Teres Recon is needed the global cost of your surgery will increase by $1,500.

Our office will work diligently to get your insurance to pay at least $7,000 for this service. However, if they do not pay, we will expect you to be responsible for Dr. White's services. In the case your insurance does not pay for your surgery, we are willing to offer you the following reduced fee.

$7,000 for Dr. White's professional services

Due to our current situation with insurance reimbursements with Aetna, Anthem BCBS, Cigna, Humana, PHCS, Rocky Mountain Health Plans, Bright and Friday Health Plans or if your insurance carrier denies authorization for procedure code 29999, we expect a deposit prior to your surgery date. If your insurance pays the claim and you do not have any financial obligation due to your insurance policy, we will refund you. However, if they retract that decision and recoup our funds we will be forced to balance bill you. We will therefore collect $3,000 as your deposit towards your surgery and expect the remaining balance to be paid within 6 months of your surgery date.

If you have questions regarding this, please ask prior to your procedure.

I, the undersigned (or as legal guardian of the patient), understand the above and allow Western Orthopaedics to hold me responsible for the expected amount as above.

_____
Print Patient Name

_____
Patient Signature or Patient Representative

_____
Date

WESTERN ORTHOPAEDICS
1830 Franklin Street, Suite 450
Denver, Colorado 80218

Hip Preservation Study Sheet- Brian J. White MD

Name: _____ Date: _____

O Before surgery
O Already had surgery: O 6 weeks ago O 3 months ago O 6 mos ago O 1 year ago
O More than 1 year, please specify: _____

Modified Haa-ris Hip Score:

Please select the one response that best reflects your pain:

O 1. None or you ignore it.
O 2. Slight, occasional, no compromise at all
O 3. Mild, no effect on average activities
O 4. Moderate pain, tolerable but concessions to pain are made. Some limitation of ordinary activity or work. May require pain medication stronger than aspirin.
O 5. Marked pain, serious limitation of activity.
O 6. Totally disabled, crippled, pain in bed, bedridden

After 6-9 blocks (about 1 mile), please describe how you would walk: (Please select only one response)

O 1. No limp
O 2. Slight limp
O 3. Moderate limp
O 4. Severe limp

Which one response best reflects how far you can walk?

O Unlimited
O 6 Blocks
O 2-3 Blocks
O Indoors only
O Bed and Chair

Which kind of support do you use when you walk? (Please select only one response)

O 1. None
O 2. Cane for long walks
O 3. Cane most of the time
O 4. One crutch
O 5. Two canes
O 6. Two crutches
O 7. Not able to walk

Which one response best reflects your ability to go up and down stairs?

O 1. Normally without using a railing
O 2. Normally using a railing
O 3. In any manner
O 4. Unable to use stairs.

How can you put on your socks and shoes? (Please select only one response)

O 1. With ease
O 2. With difficulty
O 3. Unable

Which one response best reflects your abiJity to sit?

O 1. Comfortably in an ordinary chair for one hour
Q 2. On a high chair for one-half hour
Q 3. Unable to sit comfortably in any chair

Are you or would you be able to use public transportation?

O Yes
Q 2. No

VAS Scale:

Please rate your pain at rest on a scale from 1 (none) to 10 (severe):

1 2 3 4 5 6 7 8 9 IO

Please rate your pain with daily activities:

1 2 3 4 5 6 7 8 9 10

Please rate your pain with your athletic activity:

1 2 3 4 5 6 7 8 9 10

Please rate your level of satisfaction with your surgery. 1-not satisfied, I0-very satisfied.

1 2 3 4 5 6 7 8 9 10

not satisfied at all very satisfied

LOWER EXTERMITY FUNCTIONAL SCALE

Section 1: To be completed by patient

Name: _____ Age: _____ Date: _____

0 Preop 0 6 mas postop 0 1 year postop 0 Other: _____

Section 2: To be completed by patient

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. Please provide an answer for each activity.

Today do ou, or would ou have difficulty at all with: (Circle one number on each line)

	Extreme Difficulty or Unable to Perform Activity	Quite a bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
a. Any of your usual work, housework or school activities.	0	1	2	3	4
b. Your usual hobbies, recreational or sporting activities.	0	1	2	3	4
c. Getting into or out of the bath.	0	1	2	3	4
d. Walking between rooms.	0	1	2	3	4
e. Putting on your shoes or socks.	0	1	2	3	4
f. Squatting	0	1	2	3	4
g. Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
h. Performing light activities around your home.	0	1	2	3	4
i. Performing heavy activities around your home.	0	1	2	3	4
j. Getting into or out of a car.	0	1	2	3	4
k. Walking 2 blocks.	0	1	2	3	4
l. Walking a mile.	0	1	2	3	4
m. Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
n. Standing for 1 hour.	0	1	2	3	4
o. Sitting for 1 hour.	0	1	2	3	4
p. Running on even ground.	0	1	2	3	4
q. Running on uneven ground.	0	1	2	3	4
r. Making sharp turns while running fast.	0	1	2	3	4
s. Hopping.	0	1	2	3	4
t. Rolling over in bed.	0	1	2	3	4
COLUMN TOTALS:					

Section 3: To be completed by provider

SCORE: out of 80 (No Disability 80, SEM 5, MDC 9) Initial FU ___ weeks

adapted from Binkley J et al, Phys Ther, 79. 371-383, 1999.[Prepared Feb 011

WESTERN ORTHOPAEDICS
Excellence in Motion

1830 Franklin Street, Suite 450
Denver, CO 80218
Phone: 303-321-1333
Toll-Free: 888-900-1333
Fax: 303-321-0620

James C. Holmes, M.D.
Orthopaedic Specialist
Sports Medicine
Disorders of the Knee

Timothy J. Birney, M.D.
Orthopaedic Specialist
Disorders of the Spine

Edward (Ted) H. Parks, M.D.
Orthopaedic Specialist
Sports Medicine
Joint Replacement/Reconstruction
Arthroscopy

Armodios M. Hatzidakis, M.D.
Orthopaedic Specialist
Shoulder and Elbow

Raj Bazaz, M.D.
Orthopaedic Specialist
Shoulder and Knee
Sports Medicine

Kevin K. Nagamani, M.D.
Orthopaedic Specialist
Foot and Ankle Surgery

Brian J. White, M.D.
Orthopaedic Specialist
in Disorders of the Hip

Steven M. Traina, M.D.
Orthopaedic Specialist
in Disorders of the Knee
Shoulder and Sports Medicine

Thomas G. Mordick, II, M.D.
Hand Surgery

Benjamin W. Sears, M.D.
Orthopaedic Specialist
Disorders of the Shoulder
and Elbow

Sean Baran, M.D.
Orthopaedic Specialist
Disorders of the Hip and Knee
Sports Medicine
Joint Replacement

www.Western-Ortho.com

CONTROLED SUBSTANCE PRESRIPTIONS

So that we may provide you with the highest quality care, the following contract must be agreed upon to assure a productive doctor/patient relationship.

PAIN MEDICATIONS

1. If during the course of your treatment at our clinic you require surgery, a maximum of two pain medication prescriptions will be prescribed to you pre-operatively and a maximum of three prescriptions will be prescribed post-operatively. In the unlikely case you require more than three prescriptions post operatively; you agree to follow up with a primary care physician or a pain management specialist.

2. Medications should be taken only as prescribed. Medications used in greater quantities than the amount prescribed will not be refilled until the planned renewal date. If you experience any side effects, please notify our office at once.

I have read, understand and accept the contract and understand the same has been explained to me by Brian White, M.D.

_____ _____
Patient Signature: Date:

_____
Medical Record Number:

_____ _____
Witness Signature: Date:

Hip Arthroscopy
Surgical Assistant Contract

A Surgical Assistant or SA is absolutely required for every element of your Hip Arthroscopy. They are critically helpful for assistance during the operation including but not limited to positioning you properly on the bed, positioning your leg during the reshaping of your hip, placing anchors to fix your graft, the meticulous preparation of your graft and closing your wounds. This is at least a 4-hour commitment from them, and I cannot perform your operation without them.

I work with Chris Irons and Joseph Harris. One of them will be assigned to your operation, and I have worked with them since I started my career in 2008. I trust and value them implicitly. You will meet them on the day of your surgery.

Often your insurance company does not recognize their service as being medically necessary and often will not reimburse them for all that they have done to help me to fix your hip properly. They are not "In Network" with insurance companies. They will attempt to bill your insurance company for their service at up to 75% of the surgical fee for this operation. It is not likely that they will be successful. To this end, a deposit is expected at surgical booking and balance billing from them will occur within 45 days of your surgical date if your insurance company denies payment to them. Should they be reimbursed by your insurance company, they will refund you your deposit or payment directly.

Surgical Assistant Fee: $500

Chris Irons and Joseph Harris are not employed by me or Western Orthopaedics.
Billing questions for their services should NOT be directed to Western Orthopaedics.
*All billing questions should be directed to:
-Mandy Irons for Chris: 303-503-7147
-Katie at Dependable Surgical Assistants for Joe: 720-283-0960

Date and Amount of Payment: _____

I have read the preceding information, understand this agreement, and acknowledge being notified:

Printed Name: _____

Signature: _____

Date: _____

WESTERN ORTHOPAEDICS
1830 Franklin Street, Suite 450
Denver, Colorado 80218

SURGERY CANCELLATION NOTICE

Due to the complex nature of booking this procedure we have found it necessary to implement an administrative fee for those who cancel their surgery with less than a two week notice. (This is only for non-medically documented cancellations, if you have a doctor's note we will waive this fee). We will swipe the patients credit/debit card when the surgery is scheduled and keep the information stored in a secured credit card vault. Upon a late cancellation we will charge a $250.00 fee to the card.

I have read and agree to the late cancellation fee:

_____

PATIENT PRINTED SIGNATURE:

_____

PATIENT SIGNATURE:

_____

DATE:

_____

MR#: