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 ASSISTANT, CHRIS IRONS OR JOE HARRIS, IS NOT CONTRACTED WITH ANY INSURANCE COMPANIES SO HE IS 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 AGREEMENT WITH HIM ON BALANCE BILLING PATIENTS ON ANY DENIED CLAIMS.

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

   PLEASE MAIL AND/OR FAX TO:

   1830 FRANKLIN STREET 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 acetabulum, windowing of the IT band, greater trochanteric bursectomy or any other procedure done arthroscopically that does not yet have a code).

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Sports Medicine
Disorders of the Knee

Timothy J. Birney, M.D.
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HIP ARTHROSCOPY FINANCIAL CONTRACT

The procedure you are about to undergo is called 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 bill your insurance company, we may use an "unlisted procedure code" 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:

$10,000 - $25,000 depending on the complexity of the surgery

Our office will work diligently to get your insurance to pay at least $5,000 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:

$5,000 for Dr. White's professional services

Due to our current situation with insurance reimbursements with Aetna, Cigna, and Humana, we expect a 50% deposit prior to your surgery date if this is your insurance carrier or if you have an out of network insurance plan. 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 $2,500.00 as your deposit towards your surgery and expect the remaining balance to be paid within 6 months of your surgery date.

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

Please indicate below that you understand the above and you allow Western Orthopaedics to hold you responsible for payment of the Expected Payment amount.

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 Surgery Date

_____

Patient or Patient Guardian Signature

_____

Date

www.labralreconstruction.com

Hip Preservation Study Sheet- Brian J. White MD

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Name: _____ **Date:** _____

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

Modified Harris Hip Score:

Please select the one response that best reflects your pain:

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

- ☐ 1. No limp
- ☐ 2. Slight limp
- ☐ 3. Moderate limp
- ☐ 4. Severe limp

Which one response best reflects how far you can walk?

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

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

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

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

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

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

- ☐ 1. With ease
- ☐ 2. With difficulty
- ☐ 3. Unable

Which one response best reflects your ability to sit?

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

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

- ☐ Yes
- ☐ 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 10

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, 10-very satisfied**.

1 2 3 4 5 6 7 8 9 10

not satisfied at all very satisfied

LOWER EXTREMITY FUNCTIONAL SCALE[1]

Section 1: To be completed by patient

Name:_____ Age:_____ Date:_____

Preop 6 mos postop 1 year postop 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 you, or would you 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**

[1] adapted from Binkley J et al; Phys Ther; 79: 371-383, 1999.[Prepared Feb 01]

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CONTROLLED SUBSTANCE PRESCRIPTIONS

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 No: _____

Witness Signature: _____ Date: _____

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HIP ARTHROSCOPY

SURGICAL ASSISTANT NOTIFICATION FORM

Please be informed that a surgical assistant "S.A." or a Physician Assistant "P.A." will be required for the proper performance of the operation you need. Surgical assistants and Physician Assistants are professional members of the health care team, and are qualified by academic and clinical education to provide assistance to your surgeon during surgery.

If your doctor feels that an assistant is necessary for your procedure, he will use one (some procedures require two assistants), even if your insurance company does not recognize this as a medical necessity. The insurance company will be billed first at 75% of the surgeon's fee. If your insurance company denies the assistant surgeon, **(per our agreement) the maximum you are required to pay (for Chris Irons or Joe Harris) is $600.**

Note: Most insurance companies consider assistant surgeon's "out of network providers" or will not even contract with an assistant surgeon. Chris Irons and Joe Harris are out of network for all insurance companies.

Once you receive a bill from the outside surgical assist company please direct any questions to their billing department. Again – the assistant surgeon company is aware of the above agreement and will correct your bill accordingly. Please do not contact our billing department regarding an outside surgical assistant. Chris Irons' biller is Mandy and she can be reached at 303-503-7147. Joe Harris (Dependable Surgical Assistants) biller is Kati and she can be reached at 720-283-0960.

I have read the preceding information and acknowledge being notified.

Patient signature: _____

Printed name: _____

Today's date: _____

REV 11/09/16

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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 patient's 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:

PRINT: _____

SIGNATURE: _____

DATE: _____

MR#: _____