Foothills Family Practice

PATIENT INFORMATION FORM

*Todays Date:*_____ *Patient #*_____

****

PATIENT'S NAME

(LAST)_____ **(FIRST)**_____**(M.I)**_____

ADDRESS_____ **APT #** _____**CITY**_____**STATE**_____**ZIP**_____

HOME PHONE_____**CELL**_____

DATE OF BIRTH_____ **AGE**_____**SEX**_____ **MARITAL STATUS** ☐

SOCIAL SECURITY #_____ **E-MAIL ADDRESS:** _____

*EMPLOYER*_____
(NAME) (ADDRESS) (CITY/ST/ZIP)

OCCUPATION_____**Work Phone**_____**MAY WE CONTACT YOU AT WORK?** Y☐ N☐

Primary Language_____ **Race**_____ **Ethnicity**_____ **(Hispanic/Non Hispanic)**

Preferred Pharmacy _____ **Pharmacy Phone** _____

RESPONSIBLE PARTY/INSURED PERSON

(LAST)_____**(FIRST)**_____**(M.I.)**_____

ADDRESS_____**CITY**_____**STATE**_____**ZIP**_____

HOME PHONE_____**CELL**_____

DATE OF BIRTH_____**AGE**_____**SEX**_____

SOCIAL SECURITY #_____**MARITAL STATUS**_____

PRIMARY MEDICAL INSURANCE **Date of Accident/Injury** _____

_____
(Primary Insurance Company Name) (ID#) (Group#)

_____
(Address) (City/State/Zip) (Phone)

_____
(Policy Holder Name) (ID#) (INSURED Date of Birth)

WORKERS COMPENSATION (If applicable) **Date of Injury:**_____

_____
(Insurance Company Name) (Claim #) (Adjuster Name and Phone)

Has an Incident Report been filed with your employer? _____

SECONDARY MEDICAL INSURANCE

_____
(Primary Insurance Company Name) (ID#) (Group#)

_____
(Address) (City/State/Zip) (Phone)

_____
(Policy Holder Name) (ID#) (Date of Birth)

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EMERGENCY CONTACT INFORMATION

_____

(Name) (Phone) (Relationship)

_____

(Address) (City) (State) (Zip)

AGREEMENT TO PAY FOR TREATMENT

I, the responsible party, herby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization with which this office has a contractual agreement, I agree to pay all applicable co-payments, co-insurance and deductibles, which arise during the course of treatment for the patient. The responsible party also agrees to pay for treatment rendered to the patient, which is not considered to be a covered service by my insurer and/or a third party insurer or other payor.

X_____

RESPONSIBLE PARTY DATE

RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO THE PROVIDER

I, the undersigned responsible party hereby authorize this office/its employees to release and disclose all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.
I, authorize the release and disclosure of any and all of my or my child's medical records to any other entity, including, but not limited to specialty physicians, hospitals, or other health care providers which may be of assistance in the opinion of this office, in providing treatment of the patient.
I, authorize the release of records necessary to assist in the reimbursement of benefits to which I may be entitled.
I, authorize this office and/or its employees to release, via fax machine, medical records which are needed in order to provide the patient with the most appropriate medical care.
I, authorize and request that payment of any third party or insurance company benefits be made directly to this office for any services furnished to the patient. The signature furnished below shall suffice for all insurance forms on a continuing basis.

X_____

RESPONSIBLE PARTY DATE

NOTICE OF PRIVACY PRACTICES

I, the undersigned have received a copy and understand the Privacy Practices of Foothills Family Practice.

X_____

RESPONSIBLE PARTY DATE

Foothills Family Practice may disclose my health care information to:

NAME:_____ **RELATIONSHIP**_____

This authorization is effective from _____ **to** _____ **and includes only personal health information pertaining to Foothills Family Practice and its providers.**

X_____

RESPONSIBLE PARTY DATE

- **Patients with Health Plans, please present your insurance ID Card to the receptionist after completing this form.**
- **Some contract Health Plans (HMO, PPO, IPA, etc) require a co-payment at the time of service – Please have this ready.**

FOOTHILLS FAMILY PRACTICE, 850 E. HARVARD AVE DENVER, COLORADO 80210
PATIENT MEDICAL HISTORY FORM

Name:_____Age_____Date of Birth_____ Date_____

Pharmacy Phone Number (or Store name and Cross Streets)_____
Do you also use a Mail Order Pharmacy? Which One?_____
Referred By_____

Present Medical Concerns Please provide a **brief** description of your current health concerns below.

_____
_____
_____

Medications: Please include both prescription and non-prescription medications, vitamins, herbs, etc. Also include the dose and how many times a day you take them.

Allergies or Reactions to Medications: Please list the medication and the associated side effect

Personal Medical History: Please indicate whether you have had any of the following medical problems (with approximate date of illness or diagnosis).

_____Heart Disease
_____Myocardial Infarction
_____Diabetes
_____High Cholesterol
_____High Blood Pressure
_____Hepatitis
_____Kidney Disease
_____Migraine Headaches
_____Osteoarthritis
_____Sleep Apnea
_____Cancer *type/status*_____

_____Thyroid Problem
_____Lung Disease
_____Depression/Suicide Attempt
_____Alcoholism
_____Stroke
_____Bladder Problems
_____Allergies
_____Osteoporosis
_____Autoimmune Disorder
_____Heart Murmur

Other Problems *please list*
_____
_____
_____
_____
_____
_____
_____
_____

Surgical History Please indicate the operation and approximate date

Page two on other side

Family History Please indicate if any of these relate to your Mom, Dad, or direct family relatives (which relative?).

Diabetes_____ Heart Disease_____
High Cholesterol_____ High Blood Pressure_____
Heart Attack_____ Auto Immune Disorder_____
Kidney Disease_____ Stroke_____
Depression_____ Thyroid Disorders_____
Cancer_____

_____

Other_____

Social History:

Tobacco Use (cigarettes? pipe? cigar? chew?)
☐ Never
☐ Quit *specify date*_____
☐ Current: Smoker: packs/day_____#years_____
Are you interested in quitting?____
Sexuality:
Are you sexually Active? YES☐NO☐
Current sex partner(s) is/are: male female both
Current Birth Control Method_____
Do you feel safe in your current relationship?_____

Occupation_____
Marital Status_____
Spouse/Partner's Name_____
Number of Children: _____
What do you do for exercise?_____
How often do you exercise?_____
Do you use seat belts?_____
Do you use a bike helmet?_____
How much Alcohol do you consume?_____
Do you use any illicit Drugs?_____

Emotions screening:

1. In the past year, have you had 2 weeks or more during which you felt sad, blue or depressed; or when you lost all interest or pleasure in things that you usually cared about or enjoyed? Yes☐ No☐
2. Have you had 2 years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes? Yes☐ No ____
3. Have you felt depressed or sad much of the time in the past year? Yes____ No ____

Adult Immunizations: To the best of your knowledge, please indicate the approximate month and year of each one.

Hepatitis A ____ Zostavax (shingles)____ Tetanus☐
Hepatitis B____ Pneumovax (pneumonia)____ Guardasil (HPV) series _____

Preventative Care: If applicable, please list approximate month and date of your last tests below.

_____Complete Physical Exam _____Prostate Exam/PSA *(men)*
_____Pap Smear*(women)* _____Colonoscopy *(all men &women >50)*
_____Mammogram *(women)* _____Eye Exam
_____Bone Density*(women over 60)* _____Routine Bloodwork

Please help us by listing any family members, spouses, or partners affiliated with you who also come to this practice.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Foothills Family Practice to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Foothills Family Practice describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Foothills Family Practice reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Bill Johnson at Foothills Family Practice, 4260 South Wadsworth Blvd., Littleton, CO 80123.

With this consent, Foothills Family Practice may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Foothills Family Practice may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Foothills Family Practice may fax to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Foothills Family Practice restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Foothills Family Practice to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Foothills Family Practice may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable

FOOTHILLS
FAMILY PRACTICE, P.C.

Policies and Procedures

Foothills Family Practice honors your choice of entrusting to us you and your family's healthcare. In order to help us serve you it is important that our patients understand our Policies and Procedures.

Hours and After Hours:

Business Hours: Monday – Friday 7:30 am to 5:00 p.m.

We provide an after hours call return service for patients with healthcare emergencies. Please be aware that our providers do not have access to medical records and can only provide basic medical information. They can not diagnose or treat illnesses after hours. Providers are also unable to refill prescriptions after hours.

Appointment Cancellations:

Missed appointments not canceled within 12 hours will incur a $25 charge. Missed thirty minute appointments for procedures or physicals not canceled within 12 hours will incur a $50 charge. Patients who need to reschedule their appointment due to excessive delays at our office will not be charged a missed appointment fee.

Billing & Insurance:

It is ultimately the patient's responsibility to make sure that we are compensated for the services we provide to you and your family. As a service to our patients, we will submit a proper medical insurance claim once per visit on your behalf. Please bring your insurance card with you for every visit. We will re-copy it periodically and ask you to initial it as your authorization to us that it is current. Please be aware that it is each patient's responsibility to make sure that we have your most current valid address and insurance information on file. If we properly submit your claim with the information you provide us, and it is denied, you will be responsible for paying all charges incurred and for submitting a corrected medical claim to your insurance yourself. Because of the time and expense required to submit insurance claims, we can not re-bill insurance carriers as a result of patients providing us with incomplete or incorrect information.

Cell Phones:

As a courtesy to other patients and staff we ask that cell phones be turned off prior to entering the building.

Collections:

Patients who disregard their balance with us for 90 days will have their account turned over to a collections bureau. Patients in collections need to pay their balance in full and will be asked to seek future medical care elsewhere.

Conduct:

Patients and their family members are required to maintain acceptable conduct at all times. Any patient who is disrespectful of any staff member or other patient will be asked to leave the practice and seek future medical care elsewhere. Any verbal or physical threat, no matter how small, will be reported to law enforcement and have appropriate charges filed. Parents are responsible for the conduct of their children. Children under the age of 13 can not be left alone in the waiting room or children's room. Children should not be excessively noisy or disruptive to other patients.

Co-pays:

Insurance co-pays are required to be paid at check-in. We can not bill co-pays.

Patient Past Due Balances:

Patients with a past due balances on their account are required to pay their balance in full prior to receiving future service. A past due balance is defined as any balance which has been invoiced to the patient 30 days prior.

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Patient Invoices:

All invoices sent to patients are expected to be paid in full promptly upon receipt. Patients who disregard their invoice with us will receive one warning invoice prior to having their account turned over to a third party collections company. Patients in collections will be discharged from the practice and asked to seek future treatment elsewhere. Discharged patients are still responsible for paying all account balances plus late charges, collection and legal fees. Invoices that our patients believe have an error can always be appealed in writing for immediate review.

Payment Plans:

Foothills Family Practice expects all services to be paid in full at time of service. Foothills Family Practice does not accept payment plans unless they are arranged in writing with the billing office prior to services being rendered. Payment plans never extend past four monthly quarterly payments. Patients who fail to make their agreed upon payments on time will have their account sent to collections and will be asked to seek future medical care elsewhere.

Phone Calls with Providers:

Phone calls with providers can incur charges if they provide more than a basic level of information. If your provider needs to make medical decisions, interact with other medical professionals, facilities or make medical notes in your chart while on the phone then charges will be incurred. Please note that many insurance plans do not reimburse for phone consultations. In these cases it will be the patient's responsibility for all charges incurred. Many insurance carriers prefer that you make an appointment and meet face to face with your provider.

Prescription Refills:

For fastest service, prescriptions refills (including prescriptions with "zero refills") should be conducted through your pharmacy. Your pharmacy will contact us and your provider will either refill the prescription or notify you that they require an office visit. Please allow up to seven days for refill requests. We can not refill prescriptions for patients who have past due balances.

Referrals:

Referrals to other specialists can be time consuming as often times insurance authorizations require the review of medical records before an appointment can be made. While we will do everything we can to assure a fast and smooth referral process, it is ultimately the patients' responsibility to verify with their insurance carrier that any services rendered by other specialists are authorized and covered.

Returned Checks:

Patients whose checks are returned will incur a $25 returned check fee and will lose future check writing privileges.

Tests with Outside Labs:

Our providers will occasionally need to send blood or tissue samples to an outside lab so that we can obtain specialized tests. In these cases we will pass on your current insurance and demographic information and you will be billed separately by these medical service companies.

Third Party Billing:

We regret that we can not bill any third parties (employers, landlords, people who caused injury, etc) for services rendered as we have no way to know that they will compensate us for services provided to you. We will submit a claim to valid health, auto and workers compensation insurance carriers whom we have contracts with only.

Wait Times & Appointments:

Our providers put quality patient care ahead of schedules. Sometimes this means that our patients have to wait if their provider has gotten behind with an unexpected complication or a complex condition to diagnose and treat. Please note that while we will do all that we can to reduce our patients' wait times, it is often unavoidable in quality "patient first" healthcare. A temporarily idle staff member is probably not affecting your wait time as our providers' will see each patient in order of appointment time (or sometimes severity). Each provider will have several different patients in exam rooms at any given time- some of which can have complex and potentially life threatening conditions. Our staff will be happy to assist you as best as they are able in determining your wait time. Due to circumstances outside of our control it is possible that we might need to request that a patient see a different provider other than the one they are scheduled with.