**ALL INFORMATION IS REQUIRED TO BE FILLED OUT FOR BILLING AND INSURANCE PURPOSES**

## PATIENT INFORMATION

LEGAL LAST NAME | FIRST NAME | MI

ADDRESS

CITY | STATE | ZIP

DATE OF BIRTH / / | M F | MARITAL STATUS

SOCIAL SECURITY NUMBER (required for online payment) | EMAIL (required for online payment)

CELL PHONE NUMBER | HOME PHONE: | PHARMACY NUMBER:

RACE | REFUSE | LANGUAGE | REFUSE

## POLICY HOLDER INSURANCE INFORMATION (IF NOT ABOVE LISTED PATIENT)

PRIMARY INSURED LAST NAME | FIRST NAME | MI

DATE OF BIRTH | M F | ADDRESS (if not same)

CITY | STATE | ZIP | PHONE

RELATIONSHIP TO PATIENT

PRIMARY INSURACE NAME | ID | GROUP | PCP

SECONDARY INSURANCE NAME | ID | GROUP | PCP

**IF MINOR:** IT IS REQUIRED TO HAVE AUTHORIZATION FOR MEDICAL CARE DELIVERED TO MINORS WITH OR WITHOUT GUARDIAN PRESENT

| | |
|---|---|
| PARENT/LEGAL GUARDIAN NAME (1): | PARENT/LEGAL GUARDIAN NAME (2): |
| CELL PHONE: WORK PHONE: | CELL PHONE: WORK PHONE: |
| SIGNATURE: | SIGNATURE: |

NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU: | PHONE:

**AUTHORIZATION TO RELEASE INFORMATION**: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims. **AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:** I hereby authorize payment directly to the Physician of Medical Benefits, if any, otherwise payble to me for his/her serives as described, realizing that I am responsible to pay for non-covered services.

Who else may we share your test results with on your behalf | Name: | PHONE:

Name: | PHONE:

May we leave test result messages at your: Home Phone YES OR NO
Cell Phone YES OR NO

SIGNATURE (Patient or parent/guardian if minor) | PRINT | DATE

PATIENT'S NAME_____DATE:_____

Y N **ARE YOU ALLERGIC**
❒ ❒ to **MEDICINES**?
❒ ❒ to other things

List Medicine Allergies Below:

Medicine Allergies

_____
_____
_____
_____
_____

Y N **HAVE YOU HAD ANY SERIOUS CHILDHOOD**:
❒ ❒ asthma
❒ ❒ rheumatic fever
❒ ❒ chicken pox, measles, mumps

Y N **HAVE YOU HAD ANY:**
❒ ❒ severe accidents
❒ ❒ fractures (broken bones)
❒ ❒ concussions

**CURRENT MEDICATIONS:**

_____
_____
_____
_____
_____
_____

SURGERIES OR BIOPSIES **You** HAVE HAD:

❒ Tonsillectomy
❒ Appendectomy
❒ Hernia-Rupture
❒ Gallbladder
❒ Breast Biopsy
❒ Tubal Ligation
❒ Hysterectomy
❒ C-Section
❒ D & C
❒ Vasectomy
❒ Hemorrhoidectomy
❒ Blood **Transfusion**
❒ Other Surgery:

_____
_____
_____
_____

❒ Any other hospitalizations?

_____
_____
_____
_____

**IMMUNIZATIONS:**

Tetanus_____
Other:
Type Date

_____
_____
_____

DISEASES **You** HAVE HAD:

❒ Anemia
❒ Cancer
❒ Leukemia
❒ Diabetes
❒ Thyroid Disease
❒ Glaucoma
❒ Lung Disease
❒ Tuberculosis
❒ Heart Attack, Angina
❒ Other Heart Disease
❒ High Blood Pressure
❒ Stroke
❒ Ulcers
❒ Colitis
❒ Liver Disease
❒ Gallbladder Trouble
❒ Kidney Stones/disease
❒ Gout
❒ Phlebitis
❒ Venereal Disease
❒ Seizure, Epilepsy
❒ Mental Illness
❒ Spine/back problems
❒ Other:

_____
_____
_____
_____
_____

**YOUR FAMILY** (brothers, sisters, parents, grandparents, aunts, uncles) HAVE HAD

❒ Anemia
❒ Cancer
❒ Leukemia
❒ Diabetes
❒ Thyroid Disease
❒ Glaucoma
❒ Lung Disease
❒ Tuberculosis
❒ Heart Attack, Angina
❒ Other Heart Disease
❒ High Blood Pressure
❒ Stroke
❒ Ulcers
❒ Colitis
❒ Liver Disease
❒ Gallbladder Trouble
❒ Kidney Stones/disease
❒ Gout
❒ Phlebitis
❒ Venereal Disease
❒ Seizure, Epilepsy
❒ Mental Illness
❒ Spine/back problems
❒ Other Serious Family Diseases:

_____
_____
_____
_____

**GYN HISTORY**: (Females Only)

Y N
❒ ❒ Using Birth Control
❒ ❒ Are you pregnant? Due Date_____
❒ ❒ Any problems with previous pregnancies?
❒ ❒ Have you had Rhogam?
❒ ❒ Do you have persistent spotting?
❒ ❒ Do you have frequent or prolonged periods?
❒ ❒ Have you passed through menopause?
❒ ❒ Have you had any abdominal pap smears?
_____Your age when you had your first period
_____Number of pregnancies
_____Number of live births
_____Number of miscarriages
_____Number of abortions
_____Date of last menstrual period
_____Number of days between periods
_____Number of days period lasts
_____Number of workdays per month lost to periods

❒ Married ❒ Single ❒ Divorced ❒ Separated

Occupation_____

Y N
❒ ❒ Do you feel depressed?
❒ ❒ Do you have trouble eating or sleeping?
❒ ❒ Do you fee nervous much of the time?
❒ ❒ Do you smoke?
Number of packs per day_____
Number of years smoked_____
Have not smoked since_____
❒ ❒ Do you drink alcohol?
Number of alcoholic drinks per week_____
Type of alcoholic drinks_____
❒ ❒ Do you drink coffee?
Number of cups of coffee per day_____

# PATIENT HIPAA CONSENT FORM

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____day of _____ 20_____.

Print Patient Name _____

Signature _____

Relationship to Patient _____

(Copies of this consent are available upon request)

Ranch View Family Medicine
8080 Park Meadows Dr, Suite 100
Lone Tree, CO 80124

# Financial Policy

At Ranch View Family Medicine

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies. With the increasing complex arena of insurance coverage, reimbursement, and high deductible plans understanding your benefits is especially important.

*Please read the following information carefully:*

1. **Payment is due at the time of service** unless arrangements have been made in advance by your insurance carrier. We accept Visa, Mastercard, debit cards, checks and cash.
2. Please remember that **your insurance policy is a contract between you and your insurance company.** As a service to you, we file the insurance claim and you assign the benefits to the doctor (in other words, you agree to have the insurance company pay the doctor directly). If the insurance company does not pay the practice in a reasonable period, we will have to look to you for the payment. If we later receive reimbursement from your insurance company, we will issue a refund.
3. **Insurance cards** We ask each time that you have your insurance card presented to us. It is the patient's responsibility to provide the most current and updated insurance information. If for any reason it is not provided you will be asked to sign our Insurance Waiver form.
4. **Insurance companies often assign co-pays** to visits and services. We are legally obligated to honor these assigned co-pays. Failure to collect co-pays from patients may qualify Ranch View for accusations or prosecutions of medical fraud. Please understand we collect these co-pays as much for business compensation as for compliance with legal propriety. If you cannot pay a copay at time of service you may be asked to reschedule your appointment.
5. **Not all insurance plans cover all services.** In the event you insurance determines a service is "not covered", you will be responsible for the complete charge. Payment is due upon receipt of an invoice from our office.
6. We currently allow 6 months for a balance to be paid in full, if for any reason your account defaults to collections you are subject to dismissal from the practice.
7. There will be a **"no show" or "cancellation"** fee assessed in the amount of $50.00 for appointments missed or not cancelled at least 3 hours prior to appointment time.
8. Ranch View Family Medicine provides some **specialty laboratory services**. Some of the lab tests that are ordered, particularly those that are used in support of wellness consultations or are kits sent to labs using innovative approaches to diagnostics may also not be reimbursed.
9. Yearly Physicals are subject to special billing policies. Please check with your provider or consult the Ranch View Family Medicine Yearly Physical Exam Policy.
10. If you have a high deductible plan, we ask that you pay $75.00 at the time of service.

**Thank you for choosing us for your medical care and thank you for your help!**

_____ _____

**Signature of Patient or Legal Guardian** **Date**

_____

Printed patient. Name and D.O.B.

# Patient Acknowledgements and Agreements

**Online Communications:** I acknowledge that I have read and fully understand the consent form for online communications. I understand the risks associated with communications online between my physician and myself, and consent to the conditions outlined herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that my physician may impose to communicate with patients via online communications. I have had a chance to ask any questions that I had and to receive answers. I have been proactive about asking questions related to this consent agreement. My questions have been answered and I understand and concur with the information provided in the answers.

Patient name: _____

Patient Signature: _____

Date: _____

**Complementary and Alternative Medicine Use:** I have read and understand the nature of the services provided by Ranch View Family Medicine. I represent that I am seeking treatment in order to further my own health and for no other reason. I agree to take a responsible role in improving my own health and discuss advice and suggestions given by Ranch View providers, I acknowledge that if I do not follow the treatment plan as provided, I may not receive the full benefit of the treatments, and I accept responsibility for less satisfactory results. I am aware that I may withdraw this consent and discontinue following the recommendations at any time. If adverse reactions are not serious, I will notify Ranch View physicians to ask for assistance; and if serious I agree to seek emergency care first before notifying Ranch View Family Medicine.
I also acknowledge that I am not required to purchase recommended products from Ranch View and that similar products can be purchased at other locations including local pharmacies and nutrition shops.

Patient name: _____

Patient Signature: _____

Date: _____

**Office Policies:** I acknowledge that I have read and understand the policies set forth by Ranch View Family Medicine. I will notify staff if I have a question or grievance regarding office policy.

Patient name: _____

Patient Signature: _____

Date: _____