

Injured Worker's Name: _____
Social Security #: _____ DOB: _____
Patient Address: _____
City: _____ State: _____ Zip: _____
Patient Phone: _____ Patient Cell: _____

Date of Injury: _____
Worker's Comp State Number: _____
Insurance Company Name: _____
Insurance Company Address: _____
Insurance Phone #: _____ Fax: _____
Insurance Claim Number: _____
Adjustor's Name: _____

Employer Name: _____
Contact Person: _____
Employer Phone: _____ Fax: _____

Nurse Case Manager: _____
Phone: _____ Fax: _____

Interpreter Company: _____
Company Phone: _____
Interpreter Name: _____ Phone: _____

Attorney Name: _____
Firm Name: _____
Firm Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____



PEAK TO PEAK FAMILY MEDICINE, P.C.

7768 Vance Dr., Suite B
Arvada, CO 80003
Ph: 303-427-7700
Fax: 303-427-7709

www.peaktopeakfm.com

Name of Patient: _____

First Name

Middle Name

Last Name

Date of Birth: _____ Gender: _____ Marital Status: _____ Social Security # _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip Code: _____

Main Phone: _____ Home/Work/Cell Alternate Phone: _____ Home/Work/Cell

E-mail Address: _____

Race: American Indian/Alaska Native Asian **Ethnicity:** Non-Hispanic
 Black/African American White Hispanic or Latino
 Native Hawaiian

EMERGENCY CONTACT

Name: _____ Relation: _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip Code: _____

Main Phone: _____ Home/Work/Cell

I hereby authorize payment directly to Peak to Peak Family Medicine and authorize the release of any information necessary to process insurance claims. I voluntarily consent to examination and treatment for myself and/or dependants.

I will be responsible for the full amount of the charges except those under Peak to Peak Family Medicine's contractual arrangements with payers. I will keep my account in good standing and will pay my account in full within 90 days from time of service. Should my account be turned over to collections, I will pay all costs of collection including, but not limited to, agency fees, attorney fees, and court costs.

Signature of Patient/Responsible Party: _____ Date: _____

PEAK TO PEAK FAMILY MEDICINE

MEDICAL HISTORY

Patient Name: _____ DOB: _____ Date: _____

Occupation: _____ Marital Status: S M D W

Number of Children: _____ Ages: _____

Dominant Hand: Right / Left

Hobbies/Recreation: _____

Education: _____ Regular Exercise: _____

Habits: Y/N Smoking: Former - How many years have passed since you last smoked? _____

Current - How many per day? _____ How soon after you awake? _____

Y/N Alcohol: Occasional Weekly Daily

Y/N Caffeine: Coffee Tea Other: _____

Medications: (Please list all medications taken on a regular basis)

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Allergies:

1. _____ 3. _____

2. _____ 4. _____

Health SINCE your injury:

1. The quality of your life is: **Good Fair Poor**

2. Emotionally you feel: **Good Fair Poor**

3. Your sleep habits are: **Good Fair Poor**

4. Your energy level is: **Good Fair Poor**

Medical Problems BEFORE the Work Comp Injury:

Arthritis Asthma Gout

Ulcers Heartburn (GERD) Headaches

Epilepsy Stroke Rheumatic Fever

Heart Attack (MI) Heart Failure Heart Disease, type: _____

Lymphoma Allergic Rhinitis (hay fever) Spine/Back Problems: _____

Lung Disease, type: _____ Diabetes, type: _____

High Blood Pressure Elevated Cholesterol Hepatitis, type: _____

Colitis Blood Clots Depression

Anxiety Anemia Kidney Stones

Kidney Disease Thyroid Disease Gall Bladder Disease

Irritable Bowel Syndrome Breast Cancer Ovarian Cancer

Colon Cancer Prostate Cancer Lung Cancer

OTHER: _____

Surgical/Hospitalization History: (Please list year and Type)

Trauma History: (Serious accidents/injuries)

Previous Work Comp injuries: (Please list part of body injured, year and State)

1. _____ Did you have an impairment rating? **Y/N**

2. _____ Did you have an impairment rating? **Y/N**

3. _____ Did you have an impairment rating? **Y/N**



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HIPAA Authorization for Release of Patient Information

Patient Name: Date of Birth: Social Security #: Address: Patient Phone:

Release To: Release From:

I request and authorize the release of information, written or verbal, to the organization, agency, or individual named above. I understand that the information to be released may include the following condition(s):

- 1. Drug Abuse/Alcohol Abuse (Fed. Reg. 42 C.F.R. Part 2)
2. Psychological or psychiatric conditions
3. A test for the presence of antibodies (HIV) virus which causes AIDS
4. An AIDS diagnosis and/or an AIDS related condition
5. Any third party source (hospital, specialist, lab)

According to Colorado States Statutes (6CCR 1101-1, Rule XIV), there is a charge for copies of medical records. The charge is \$14.00 for the first 10 pages, \$0.50 per page for pages 11-40, and \$0.33 per page for every additional page.

Information Requested:

Purpose of Release:

Treatment Date(s):

- Doctor's Notes, Pathology Reports, AIDS/HIV Information, Drug/Alcohol Abuse, Other, Diagnostic Studies, Immunization Record, History & Physical, Imaging Reports, Third Party Record, List of Allergies, Consultation Reports, Lab Results, Problem List, Medication List, Discharge Summary, ENTIRE RECORD

I understand I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present my written revocation to the Practice Manager. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I certify that this request has been made voluntarily.

This authorization expires one year from the date of signing, or, if I am a minor, on the date I legally become an adult, whichever comes first. I release the above named from liability and claims of any nature pertaining to the disclosure of requested information contained in my medical records. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Signature of Patient

Date

Witness (If patient is unable to sign)

Signature of legal guardian or executor

INFORMATION REQUESTED WILL NOT BE PROVIDED IF ANY OF THE ABOVE ITEMS HAVE NOT BEEN COMPLETED.



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THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and information used by or disclosed to us in any form be kept confidential. The federal law gives you, the patient, significant rights to understand and control how your **protected health information (PHI)** is used. HIPAA provides penalties for entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we must maintain the privacy of your PHI and how we may use and disclose it.

We may use and disclose your PHI in the following ways:

- 1. Treatment.** We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.
- 2. Payment.** We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.
- 3. Healthcare Operations.** We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.
- 4. Appointment Reminders.** We may use and disclose PHI to contact you and remind you of an appointment.
- 5. Public Health Risks.** We may disclose PHI to public health authorities that are authorized by law to collect information regarding public health risks.
- 6. Health oversight activities.** We may disclose PHI to an agency providing health oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.
- 7. Victims of Abuse, Neglect, or Domestic Violence.** We may disclose your PHI to appropriate authorities if we reasonably believe you are a possible victim of abuse, neglect, or domestic violence – or the possible victim of other crimes. We may share your PHI if it is necessary to prevent a serious threat to your health or safety – and the health or safety of others. We may share your PHI with law enforcement officials, when appropriate and lawful.
- 8. Worker's Compensation.** We may disclose PHI when authorized and necessary to comply with laws relating to worker's compensation or similar programs.
- 9. Disclosures required by law.** Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law.

Any other uses and disclosures will be made only with your written authorization. You may revoke your authorization in writing to our office. We are required to honor that written request, except to the extent that we have already taken actions relying on your authorization.

You have the right to request restrictions on certain uses and disclosures of you PHI, including those related to disclosures to family members, other relatives, close friends, or any other person identified by you. This request must be made in writing to our office. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

You also have the right to obtain a copy of your personal health information (including billing) from us at any time. The cost of providing a photocopy of your records is set by state law as follows: \$14.00 for the first 10 pages, \$0.50 per page for pages 11-40, and \$0.33 per page for every additional page.

We know that HIPAA regulations may appear lengthy and complicated, and we have done our best to summarize them for you here. If you have further questions or wish to file a complaint, please contact our office manager at 303-427-7700.

For more information about HIPAA or to file a complaint:

**The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, D.C. 90201**

1-877-696-6775

Peak to Peak Family Medicine has the right to revise this Notice of Privacy Practice and is required to notify you of such revision.



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I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your NOTICE OF PRIVACY PRACTICES wherein a more detailed description of the uses, examples of and disclosures of my personal health information (“PHI”) exists. I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICES from time to time and that I may contact this office at any time at the address noted on this form if I wish to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, facilitate payment or facilitate/comply with health care operations. I also understand that you are not required to agree or abide by my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Please indicate phone number(s) where staff may leave messages pertaining to appointment times, prescription information, and/or other Private Health Information.

Home: _____ Message OK? **Y** **N**

Cell: _____ Message OK? **Y** **N**

Other _____ : _____ Message OK? **Y** **N**

Patient Name: _____

Name of Authorized Representative(s) if **NOT** patient:

Relationship of Authorized Representative to patient:

X _____
Signature of Patient/Authorized Patient Representative *Date*



Office Policies

Prescription Refills: It is your responsibility as the patient to keep track of your medications and when a refill is needed. Please call the office three BUSINESS days prior to the time you run out of any medications. If you prefer to call your pharmacy please do so one week ahead of time to refill any medications. If you use a mail order pharmacy, please allow 2-3 weeks for a refill to process. If no refills remain on your medication, you may need an appointment prior to refills being provided. If you are on a controlled medication, it is important that you adhere strictly to your prescription schedule.

If you run out of medications and call the office for a refill, please be aware that this requires extra effort on our part and interrupts patient visits in the office. We do our very best to give all patients the time they deserve, therefore, we ask that you as a part of our office, respectfully follow our policy for medication refills.

Phone Calls: If you leave a message for one of our providers, please allow 24 hours to return your call, unless it is an emergency. If your provider is not in the office, your message will be given to the provider on duty or on call. Be assured that we take your phone calls seriously.

Physicals: Not all insurance companies will cover all costs involved with a physical exam. Some insurance companies require that you wait 12 months before having another one and will not pay for it if you schedule too early. This is your responsibility as the patient to keep track of, however we will assist with any information we can if you need. If your insurance company does not cover the costs of your physical, you will be billed for the visit.

Test Results: Please allow 1 week for test results to come back from the labs, imaging facilities and other locations. We will contact you by phone once your results or reports have been reviewed by a provider. If you have not heard from our office within 2 weeks, please call us.

Referrals: Please allow 7 business days for a referral authorization to be processed. We do all that we can to process referrals promptly and efficiently. Once you receive authorization, you may call the specialist/testing facility to schedule your appointment.

Medical Records: Please allow 2-3 weeks to process medical record requests.

If you have any questions about our office policies, please ask your provider or one of our office staff. We are happy to answer any questions you may have.

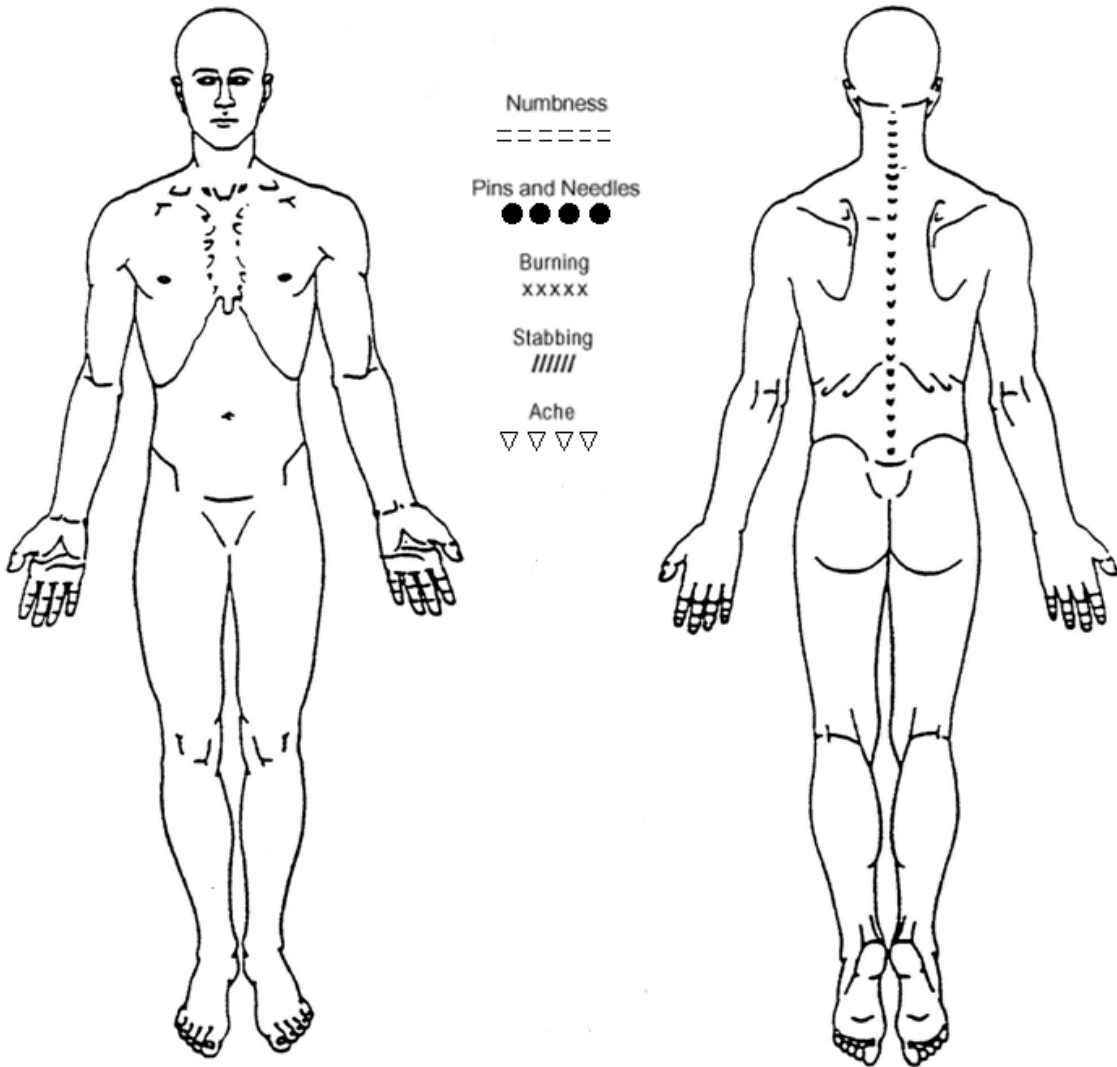
I have read and understand these office policies and agree to abide by them.

Signature of patient or responsible party

Date

Please mark the areas on your body where you feel discomfort, using the symbols found below.

Include ALL affected areas. CIRCLE the area where your pain is the worst.



Right

Left

Left

Right

List all current symptoms related to this injury: _____

Please mark on the line below how bad your pain is now.

0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Possible Pain

Patient Name: _____ Today's Date: _____