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
__Black/African American __White
__Native Hawaiian

Ethnicity: __ Non-Hispanic
__Hispanic or Latino

SUBSCRIBER'S INFORMATION (Policy holder of insurance)

Name of Patient: _____
First Name Middle Name Last Name

Date of Birth: _____ **Social Security #**_____

Address: _____ **Apt. #** _____

City: _____ **State:** _____ **Zip Code:** _____

Main Phone: _____ Home/Work/Cell **Employer Name:** _____

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 **Children:** _____
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: _____
Y/N Recreational Drugs

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

1. _____ **4.** _____
2. _____ **5.** _____
3. _____ **6.** _____

Allergies:

1. _____ **3.** _____
2. _____ **4.** _____

Health Promotion:

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**
5. Have you had your cholesterol tested? **Y/N**
6. Your most recent Tetanus immunization? _____
7. Your most recent Influenza immunization? _____
8. Your most recent Pneumonia immunization? _____

Men:

1. Do you have any problems with urination? **Y/N**
2. Do you have any problems with impotence? **Y/N**

Women:

1. When was your last pelvic/breast exam? _____
2. Have you ever had an abnormal PAP? **Y/N**
3. Have you ever had a mammogram? **Y/N**
4. Have you ever had a breast lump? **Y/N**
5. Do you have problems with your periods? **Y/N**
6. Number of Pregnancies: _____
7. Number of live births: _____
8. Have you experienced menopause? **Y/N**

Current AND Past Medical Problems:

__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)

_____
_____
_____
_____

Family History: (List any major health problems that your PARENTS, GRANDPARENTS, AUNTS, UNCLES, or SIBLINGS have had.)

Heart Attack: _____	Lung Cancer: _____	Prostate Cancer: _____
Stroke: _____	Diabetes: _____	Blood Clots: _____
Colon Cancer: _____	Hypertension: _____	Other: _____
Breast Cancer: _____	Depression: _____	Other: _____
Ovarian Cancer: _____	Alcoholism: _____	

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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	**__ Diagnostic Studies**	**__ Third Party Record**	**__ Problem List**
__ Pathology Reports	**__ Immunization Record**	**__ List of Allergies**	**__ Medication List**
__ AIDS/HIV Information	**__ History & Physical**	**__ Consultation Reports**	**__ Discharge Summary**
__ Drug/Alcohol Abuse	**__ Imaging Reports**	**__ Lab Results**	**__ ENTIRE RECORD**

__ Other: _____

****

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 **1-877-696-6775**
Office of Civil Rights
200 Independence Avenue, SW
Washington, D.C. 90201

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*

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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 tract 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**

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No Show/Cancellation & Account Policy

____ I understand that there are times when I must miss an appointment due to emergencies or obligation for work or family. However, when I do not call to cancel and appointment, I may be preventing another patient from getting treatment. The situation may also arise where another patient fails to cancel, and the office cannot arrange a visit for me, due to a "full" schedule.

____ I understand that delays happen; however, the office must try to keep other patients and the providers on time.

____ If I am more than 15 minutes late for my appointment, I will need to reschedule.

____ If my appointment is not cancelled at least 24 hours in advance, I will be charged a $35.oo fee. This will not be covered by my insurance company.

____ If I have two or more No Show visits within the same year, it may lead to being discharged from our practice.

____ I am responsible for all charges not paid by my insurance company, including deductibles and co-insurance.

____ I acknowledge my access to medical care may be restricted without immediate payment on my account.

When you schedule an appointment, we reserve that block of time for you. Please be respectful of our time as well as the time of other patients. Thank you!

_____

Printed Name

_____ _____

Signature of Patient/Responsible Party Date