Parker Family Care™

Patient Information Form

This is a legal document.

Legal First Name:_____ Last Name: _____ Middle Initial:___

SSN: _____-_____-_____ Birth Date: _____ Sex: M F

Race: Caucasian | African American | Asian | Hispanic or Latino
American Indian / Alaska Native | Native Hawaiian / Pacific Islander | Patient Declined

Ethnicity: Hispanic or Latino | Not Hispanic or Latino | Patient Declined

Address: _____

City: _____ State: _____ Zip Code: _____ Marital Status: _____

Home Phone: _____ Cell Phone: _____

Email we may contact you with: _____

Employer: _____ Work Phone: _____

If using a phone, do you have a preferred time you would like us to call you? _____

Do you want phone reminders to be confidential? Yes No

Can a message be left on voice mail? Yes No

Which phone would you prefer **voicemail** to be left on: Home Cell

Can a message be left with family? Yes No

If yes, list the names:

_____

If by mail, indicate address if different than home: _____

_____

Emergency Contact:

Name: _____ Relationship to you: _____

Home phone number: _____ Cell phone number: _____

Is there a specific provider at our office would you prefer to be scheduled with: _____

Is there someone we can thank for your referral (another office, family member, coworker, another patient)?

_____

Guarantor / Person Responsible for Account (if other than yourself):

Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Birth Date: _____

Relationship to You: _____ SSN: _____-_____-_____

Primary Insurance information:

Insurance company name: _____

Identification number:_____ Group number: _____

Policy holder's name:_____

Policy holder's DOB:_____

Policy holder's address (if different than above):_____

Relationship to Patient: _____

Secondary Insurance information:

Insurance company name: _____

Identification number:_____ Group number: _____

Policy holder's name:_____

Policy holder's DOB:_____

Policy holder's address (if different than above):_____

Relationship to Patient: _____

Medicaid Information

We are not contracted with any Medicaid plan. We are unable to see you as a medical patient if you have Health First Colorado (Medicaid) coverage. We cannot bill you as a cash pay patient for medical services as this would be insurance fraud. By signing this you agree that you do not have Health First Colorado or any other form of Medicaid (primary or secondary).

_____ _____

Patient / Guardian Signature **Date**

____ Initial. Financial: I understand that all copays and past due balances are due at the time of my visit. I will pay my/family balance in full in 30 days. If I am unable to do so, it is my responsibility to contact the PFC office to make arrangements to pay my balance with an EFT payment plan. If I choose not to pay my balance or contact the office within 60 days, I understand my account may be turned over to an outside collection agency. $25 late co-pay fee may be billed. $40 collection fee for delinquent accounts may also be billed.

____ **Initial. Insurance:** I have provided current insurance information and will continue to inform the office when I have an insurance or address change.

____ **Initial.** If you have Advanced Directives, please notify the medical staff and provide PFC with a copy.

____Initial. Assignment of Benefits: I authorize payment of medical benefits to Parker Family Care for services rendered. In addition, I authorize Parker Family Care to release any information that they are requested to release in order to obtain payment on my behalf.

____ **Initial. Cancellation**. A $50 charge will be assessed for office visits that I do not appear for or which I cancel less than 24 hours prior to appointment time. A $100 charge will be assessed for physicals and CIMT that I do not appear for or cancel less than 24 hours before the scheduled appointment time.

_____**Initial. Establish care policy:** I understand that Parker Family Care has a policy that you see a physician or physician assistant for the first time to establish care. This visit will NOT be coded as preventative and I am responsible for whatever my insurance does not cover, i.e. copay, coinsurance, deductible.

_____**Initial. E-mail Consent:** I understand that the e-mail address I have provided may be used to send me appointment confirmations or other electronic communication related to Parker Family Care. I have provided the e-mail I wish to receive such confidential information at and understand that Parker Family Care cannot be held liable for who reads my e-mails. Anyone I have given my e-mail login information to, such as family members, may receive these e-mails.

I request the following restrictions to the use or disclosure of my health information:

_____

_____

Please provide your signature below to indicate that you have read the above consent.

_____ _____

Signature of Patient or Legal Represent Witness

_____ _____

Date Effective Date

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Whenever you see the word "you" in this document, it means "you or your child" (if applicable.)

Understanding your Health Information
Each time you visit Parker Family Care, a record of your visit is made. This record contains information about your symptoms, examinations, test results, medications you take, and the plan for your care. This information is referred to as your health or medical record. It is an essential part of this healthcare provided for you. Your health record contains personal health information and there are state and federal laws to protect the privacy of your health information.

USES AND DISCLOSURES OF HEALTH INFORMATION
Parker Family Care will use your information for treatment. The counselor will document information in your record about your examination and the care planned for you. Your health information may be used and disclosed by those who are involved in your care for the purpose providing, coordinating or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may also use health information about you to call you or send you a letter to remind you about an appointment, to follow up with test results, or to provide you with information about other care that could benefit your health.

Parker Family Care will use your health information for payment.
Parker Family Care will send a claim to your insurance company. Parker Family Care may include information that identifies you, as well as your diagnoses, procedures, healthcare providers and supplies used. Parker Family Care also may contact your insurance company to determine if they will pay for your medical care as part of their certification process. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of patient health information necessary for purposes of collection.

Parker Family Care will use your health information for regular healthcare operations.
Healthcare operations include the business aspects of running the practice. Parker Family Care may use or disclose, as needed, your health information in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, quality assessment and improvement activities, auditing functions, cost-management analysis, customer service and conducting or arranging for other business activities. For example, we may share your health information with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your health information. For training or teaching purposes your health information will be disclosed only with your authorization.

Other disclosures: Business Associates
There are some services provided through contacts with business associates. To protect your health information, however, Parker Family Care requires the business associate to protect your information.

Required by Law
Parker Family Care may also disclose health information required by law to the following entities or types of entities that includes, but is not limited to:

- Food and Drug Administration
- Public Health or legal authorities charged with disease prevention
- Correctional institutions
- Workers Compensation Agents
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors, Coroners and Medical Examiners
- National Security and Intelligence Agencies
- Law enforcement as required by law or in accordance with a valid subpoena

Patient Rights: You have the right to:

- Inspect and obtain a copy of your health record. There may be a charge to cover the cost of copying your record
- Request an amendment to your health records
- Obtain and accounting of disclosures
- Request communication of your health information in a certain way or at a certain location. For example, you can ask Parker Family Care to contact you by mail and not by telephone, or that we contact you at a specific telephone number, or that we use an alternative address for billing purposes, or that we not leave messages on certain voicemails.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Parker Family Care has the duty to:

- Maintain the privacy of your protected health information as required by law
- Provide you through this notice with information as to our legal duties and privacy practices with respect to information we collect about you
- Abide by the terms of the notice currently in effect
- Notify you if we are unable to agree to a requested restriction
- Follow reasonable requests you make to communicate with you as you instruct-for example, contact you at a certain telephone number or address
- Provide you a paper copy of this notice of privacy practices upon request

Your signature below indicates that you have read this document and have had the opportunity to have any questions answered to your satisfaction.

Patient Signature:_____

Printed Name:_____

Patient Date of Birth:_____Date: _____

*Signature of parent or guardian, if applicable:*_____