Green Valley Ranch Medical Clinic & Urgent Care

Patient Information Form

Patient Name (Last) _________________________________ (First) ____________________________(M.I)_______

Date of Birth_____/_____/_______ Age_____ Sex______ Marital Status_____________________________

Social Security Number____________________ Employment Status (Full Time) (Part Time) (Ret) (Un-Employed)

Address____Apt________City___________State________Zip______

Home Phone (______)_____________________________________ Cell (_______)__________________________

Mailing Address (If Different From Above)

Address____Apt_________City_________State_________Zip_______

Employer ____
(Name) (Address) (City/ST/Zip)

Work Number (______) _______________________Ext________ May we contact you at work? Yes No

Would you like online access to your medical records?

No [ ] Yes [ ] Email address ____

For Worker's Compensation Patients Only: Has an accident report been filed with your employer? Circle: Yes No

Date of Accident__________________________ Claim Number____

Emergency Contact Information

____
Name Phone Relationship

____
Address City State Zip

Responsible Party (Last) ________________________________ (First) _________________________ (M.I.) ________

Address____City____________________State_______Zip___________

Home Phone (_____) ___________________________________Cell (____) _____________________________________

Date of Birth_____/_____/______ Age_____ Sex______ Social Security Number_____________________________

Primary Medical Insurance (copy of insurance card required)

____
Primary Insurance Company Name Member ID# Group#

____
Address City/State/Zip Phone

____
Policy Holder Name Member ID# Date of Birth Effective Date

Secondary Medical Insurance (copy of insurance card required)

____

Secondary insurance company name | Member ID # | Group #

____

Address | City/State/Zip | Phone

____

Policy Holder Name | Member ID # | Date of Birth | Effective Date

I certify the previous information is true and correct to the best of my knowledge. I understand that it is my responsibility to notify Green Valley Ranch Medical Clinic of any changes in the information listed above.

____

Patient/Responsibility Party **Date**

Agreement to Pay For Treatment

I, the responsible party listed below, hereby 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 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 the third party insurers or payors. Returned checks shall have a $10.00 fee plus any bank fees incurred.

____

Responsible Party **Date**

Release and Statement to Permit Payment of Private Insurance Benefits to the Provider

I, the undersigned responsible party, hereby authorize Green Valley Ranch Medical Clinic or its employees to release and disclosure 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 Green Valley Ranch Medical Clinic 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 the payment of any third party insurance company benefits the made directly to this office for any service furnished to the patient. The signature furnished below shall suffice for all insurance forms on a continuing basis.

____

Responsible Party **Date**

Green Valley Ranch Medical Clinic &Urgent Care
Authorization To Release Medical Records/Information

Physician/Institution/Agency____

Address_______________________________________City___________________ST____________Zip___________

Telephone (____) ____________________ Fax (____) _____________________

I, Patient's Full Name____

Social Security #_________________________________ Date of Birth____

Hereby authorize the party above to release information specified below to **Green Valley Ranch Medical Clinic/Urgent Care**. I specifically authorize the use and disclosure of the following:

Initial

------- Release all medical records at this facility (or)

Release ONLY:

------- Drug Abuse, If any

------- Substance abuse, If any

------- HIV/AIDS, If any

------- Psychiatric and/or Psychological Conditions, If any

------- Only records generated by this facility (not including records received from other sources)

------- Only some portions of records maintained at this facility, specifically ________________________

____

Please send my Medical Records to:

Green Valley Ranch Medical Clinic & Urgent Care
4809 Argonne St. Suite 100
Denver, CO 80249
Ph (303) 344-8700
Fax (303) 344-0200

I understand that I may revoke authorization at any time in writing. I understand that a copy of this authorization may be utilized with the same effectiveness as an original.

___________________________________ ___________________

Patient/Legal Guardian **Date**

Green Valley Ranch Medical Clinic & Urgent Care
Consent to Use and Disclosure of Health Information

By signing this form, you are granting consent to Green Valley Ranch Medical Clinic/Urgent Care to use and disclose your protected health information for the purpose of treatment, payment and healthcare operations. Our Notice of Health Information Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Health Information Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our notice of Health Information Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at (303) 344-8700, or by requesting a copy at the front desk. You have the right to request that we restrict how we use and disclose your protected health information for the purpose of treatment, payment or healthcare operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing except to the extent we already have used or disclosed your protected health information in reliance with your consent.

________________________________ ____________________

Patient/Legal Guardian **Date**

Green Valley Ranch Medical Clinic & Urgent Care
4809 Argonne St. Suite # 100
Denver, CO 80249

Green Valley Ranch Medical & Urgent Care
No-Show Policy

Our No-Show Policy helps us better serve our patients trying to schedule appointments when we are booked.

We would greatly appreciate a call from you if you cannot make your scheduled appointment or if you will be late. Please call us at least **24 hours before your appointment time** if you need to cancel. This will enable us to give that time slot to another patient.

In the event that we do not hear from you and you do not show up for your appointment, there will be a No-Show charge of **$25.00.**

Thank you for your cooperation.

I have read and understand the above Policy.

____ _____________________

Patient/Legal Guardian **Date**

Green Valley Ranch Medical Clinic & Urgent Care
4809 Argonne St. Suite #100
Denver, CO 80249

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: ________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Green Valley Ranch Medical Clinic & Urgent Care (GVRMC&UC). A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

________________________________ ________________________________

Print name of Patient | Signature of Patient / Guardian of Patient

________________________________ ________________________________

Legal Representative / Guardian | Relationship of Legal Representative / Guardian

I consent to the use of my first name only in the reception area for my privacy Yes☐ No☐

PLEASE LIST ANY **OTHER** PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: ____________________________ Relationship: ____________________________

Name: ____________________________ Relationship: ____________________________

Name: ____________________________ Relationship: ____________________________

Your comments regarding Acknowledgements or Consents or Revocations: ______________________________

____

CONSENT TO EMAIL, TEXT OR LEAVE VOICE MESSAGES FOR APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS

Patients in our practice may be contacted via email and/or text messaging or voice calls to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

I agree to provide (on our demographics form) only the numbers and email addresses for patient that may be used for the above communications. Yes☐ No☐

I APPROVE BEING CONTACTED ABOUT **<u>SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO</u>** on behalf of GVRMC&UC via:

- ☐ Phone Message
- ☐ Text Message
- ☐ Email
- ☐ **Any of the Above**
- ☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

<u>Office Use Only</u>

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ___

____
Signature of Privacy Officer