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 & Urgent Care
No-Show Policy

Our No-Show Policy helps us better serve our patients trying to schedule appointments. 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 or reschedule. You may leave us a message.

As a busy practice we are unable to continue to schedule patients who do not show up for their appointments. **No show limit: 2** (in last 12 months). After **2** no shows you will be discharged from the practice.

Thank you for understanding and 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: _____

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 patient information form) only the numbers and email addresses for patient that may be used for the above communications. **Yes** ☐ **No** ☐

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** 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.

Office Use Only
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: _____

Green Valley Ranch Medical Clinic &Urgent Care

Integrated Healthcare Notice

We are happy to inform you that Green Valley Ranch Medical Clinic & Urgent Care (GVRMC&UC) is an Integrated Care Facility meaning physical health care and behavioral health care are provided in the same setting by the Clinic's team of professionals who collaborate to provide care services in a most effective and efficient manner.

GVRMC&UC is partnering with Mental Health Center of Denver (MHCD) to provide comprehensive behavioral health services. These voluntary services may include screenings for behavioral concerns, consultation with a behavioral health specialist, brief interventions with you, your child or family, adult and parenting education and support. By adding these behavioral health services within your medical home at GVRMC&UC we can provide early interventions that may help you and/or your family.

I HAVE READ THE ABOVE INFORMATION AND GIVE GVRMC&UC CONSENT TO TREAT

Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____