Healthy Futures, PC

PATIENT DEMOGRAPHICS

Last_____ **First** _____ **Middle** _____ **Preferred Name**_____

SS# _____ **DOB** ____/____/____ **Sex:** M F

Relationship Status: Single Married Divorced Separated Domestic Partner
Race: American Indian/ Alaska Native Asian Asian/Pacific Islander Black/African American
Caucasian Hispanic Native Hawaiian/Other Pacific Islander Other
Ethnicity: Hispanic/Latino Non Hispanic/Latino
Nationality: _____ **Language:** _____
Street Address: _____
City, State, Zip _____
Email Address: _____ **would you like an invite to patient portal? YES NO**
Home Phone # _____ OK to leave message/ results? _____
Cell Phone #_____ OK to leave message/ results? _____
Employer Name _____ Work Phone # _____
Emergency Contact/ who may we speak to on your behalf? _____
& their relationship to you _____ Phone #_____
Parent/ Guardian Name _____ Phone # _____

How did you hear about our office? _____
Preferred Pharmacy and Cross-streets of location: _____
Pharmacy Phone Number: _____

INSURANCE INFORMATION

PRIMARY INSURANCE:
Name of Insured: _____ Relationship to Patient: _____
Insurance Co. Name: _____ Ins. Co. Tel#: _____
Ins. Co. Address: _____ City: _____ State: _____Zip:_____
SSN of Insured: _____ DOB of Insured: _____/_____/_____
Insurance ID #: _____ Policy/Carrier #:_____Group #:_____

SECONDARY INSURANCE:
Name of Insured: _____ Relationship to Patient: _____
Insurance Co. Name: _____ Ins. Co. Tel#: _____
Ins. Co. Address: _____ City: _____ State: _____Zip:_____
SSN of Insured: _____ DOB of Insured: _____/_____/_____
Insurance ID #: _____ Policy/Carrier #:_____Group #:_____

PATIENT OR AUTHORIZED PERON'S AGREEMENT:
I hereby give consent to the providers and staff of Healthy Futures, PC to render such care and treatment as might be required by my condition. I also authorize my insurance company to pay any benefits to my provider. I understand that I am financially responsible for all charges whether or not covered by my insurance. I authorize the release of any medical information necessary to process my insurance claims, and hereby request payment directly to Healthy Futures, PC for services rendered. I also have read and understand the cancellation and no-show policy and agree to those terms. I have been offered a copy of the HIPPA Regulation, which is available to me at the office front desk.

Patient's (Authorized Person's) Signature _____ **Date**_____

Healthy Futures, PC

Medical History Review

Date_____

Name_____ **Date of Birth**_____

Do you have any specific health issues today? Yes No
Please explain: _____
_____
_____
_____.

Medical History (please check all that apply): _____ Heart disease _____ Asthma
_____ Diabetes _____COPD _____Hepatitis _____ Stroke _____Bleeding disorder
_____ High blood pressure Please list any other conditions: _____
_____
_____.

Please list all medications you are currently taking and dosages:

Name:	Dosage:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Over-the-counter medications, vitamins, herbal supplements, dietary supplements? _____
_____
_____
_____.

Past hospitalizations and surgeries (please list dates): _____
_____
_____
_____.

Please list any allergies you may have including environmental: _____
_____
_____.

Social History:
Do you ever drink alcohol? Y/N _____ occasionally ☐ weekly ☐ daily Do you use tobacco? _____
How many pack(s) a day? _____ For how long?_____ Do you use recreational/street drugs? _____
Do you smoke marijuana? _____ Stress at home? _____ Stress at work? _____ Stress about money? _____ Abusive relationship? _____

Prevention:
Last flu shot _____ Last eye exam _____
Last pneumonia shot _____ Last dental exam _____
Last tetanus shot _____ Last colonoscopy _____/normal?_____
Last mammogram _____/normal? _____ Last dexascan _____/normal?_____

Are you currently experiencing or have concerns with (circle all that apply):

General:
Allergies
High blood pressure
Diabetes
High cholesterol
Fatigue
Arthritis
Fever
Weight Change
Memory problems

Head/Neck:
Ear pain
Hearing loss
Sore throat
Nasal congestion
Vision problems
Red eyes
Drainage from eyes
Sneezing
Thyroid problems

Cardiac:
Chest pain
Shortness of breath
Dizziness
Palpitations
Fainting
Fluid retention
Varicose veins
Heart attack

Pulmonary:
Cough
Wheezing
Painful breathing
Asthma
Emphysema

Abdominal:
Pain
Indigestion
Constipation
Black stools
Blood in stools
Diarrhea

Orthopedic:
Joint pain
Back pain
Shooting pain
Injury
Decrease in height

Skin:
Sore that doesn't heal
Rash
Color changes
Worrisome lesion/mole

Neurologic:
Vision changes
Weakness
Slurred speech
Stumbling
Seizures
Choking/food

Mood:
Suicidal
Irritability
Low energy
Guilt
Poor concentration
No motivation
Sad
Insomnia
Loss of interest
Poor concentration
Anxiety
Sleeping too much

Urinary:
Increased frequency
Increased urgency
Pain with urination
Incontinence

Females:
Last period _____
Last PAP _____
?Abnormal PAP_____
Pain with sex _____
Birth control _____
Vaginal discharge, sores, rash _____
Change in periods_____
Breast changes_____
Hot flashes _____
Mood swings _____

Males:
Genital pain, sores rash _____
Discharge from penis _____
Difficulty getting or maintaining an erection _____
Prostate problems _____

Notes:

Provider:_____

Family History: Do any of your blood relatives have (did have) any of the medical conditions noted below?
(Use the following key and circle affected family members for each condition below)
[M = mother, GM = grandmother, S = sister, A = Aunt]
[F = father, GF = grandfather, B = brother, U = uncle]

Allergies	M	GM	S	A	F	GF	B	U
Asthma	M	GM	S	A	F	GF	B	U
Bleeding disorder	M	GM	S	A	F	GF	B	U
Brain tumor	M	GM	S	A	F	GF	B	U
Cancer	M	GM	S	A	F	GF	B	U
(type)_____								
Depression	M	GM	S	A	F	GF	B	U
Diabetes	M	GM	S	A	F	GF	B	U
Heart disease	M	GM	S	A	F	GF	B	U
Hypertension	M	GM	S	A	F	GF	B	U
Parkinson's disease	M	GM	S	A	F	GF	B	U
Arthritis	M	GM	S	A	F	GF	B	U
(type)_____								
Epilepsy	M	GM	S	A	F	GF	B	U
Ulcers	M	GM	S	A	F	GF	B	U
Other	M	GM	S	A	F	GF	B	U

_____.

HEALTHY FUTURES, PC
FINANCIAL POLICIES

Insurance coverage: If we are participating physicians with your insurance plan, we will bill them for the care you receive from our providers. Your **copayment** is a contract between you and your insurance company, and it is requirement of this contract that **you pay your copayment at the time of your visit**. If you cannot pay at the time of your visit, there will be a $30.00 administrative fee billed to you. **You are responsible for knowing which services are covered by your insurance plan**. If we recommend a service we feel is medically prudent and this is a non-covered benefit of your plan, you are responsible for payment if you choose to accept the treatment (many plans do not cover routine physicals).

Payment is expected at your present visit for any balance due on your account for copay's, coinsurances, deductibles and non-covered benefits of your insurance plan.

Appointment cancellations: Our practice is getting busier, and we would appreciate your consideration in keeping your appointments when scheduled. We know your time is valuable, as is ours. When you don't show up for a scheduled appointment, it takes away the opportunity for another patient to be seen. This has happened frequently enough that we have implemented a new policy: without giving 24 hour notice (at least one business day) that you are canceling or rescheduling your appointment, a charge of $35.00 will be assessed and continue to go up additional $15.00 thereafter. We do realize that some circumstances will arise that you will not be able to give us a 24 hour advance notice, but these will be discussed on a case-by-case basis.

Past due accounts: Your account will be considered past due if we have not received payment in full within 60 days of the balance becoming your responsibility. At such time, there will be a $15.00 administrative fee to continue billing you. If payment is not received at the 120 days mark, your account can be turned over to a collection agency, and you may be dismissed from the practice. We understand that sometimes families run into hardships; however, if you find yourself unable to pay your balance, we are willing to work out a budget plan with a monthly payment. Please let us know if this is the case with you account.

_____ _____

Print Patient Name Date

_____ _____

Responsible Party Signature Date

PRESCRIPTION REFILL POLICY

- No prescription will be refilled on Fridays, Saturdays, Sunday and Holidays
- We require 72 hour minimum to process prescription renewal and/ or pick-up request.
- The patient is responsible for knowing when medications will need to be refilled (no early refills).
- Prescription phone-in/pick-up: Monday-Thursday during business hours **ONLY** (9:00am-4:30pm)
- Prescription will not be filled for unauthorized "walk-in" patients.
- Non-controlled/non-narcotic prescriptions require a follow up appointment ever 3-6 months.
- Controlled substances-narcotic prescriptions require a follow up appointment every 30-90 days.
- New symptoms and/ or events require a clinic appointment. Provider is unable to diagnose via phone.
- No early refills if medications are overused/ abused misused. Must follow prescription directions.
- No medication prescription will be replaced if lost, stolen, misplaced, overused etc. (treat like money!!)
- Medications are for the prescribed individual's use only. It is illegal to "SHARE" your medicine.
- Patient must pick-up his/her prescription(s) in person, unless pre-authorized by staff.

These protocols are per recommendations of the Colorado Board of Medical Examiners & DEA.

I understand and accept the protocol listed above, Failure to comply results in immediate termination of prescription medications.

Patient Name: _____ Date: _____

Signature: _____

Name of person picking up Rx: _____

Healthy Futures, PC

HIPAA Acknowledgement and Consent Form

I understand that under the Health Insurance Portability and 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 care among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information available in the office in print form. I have reviewed such Notice of Privacy Practices prior to signing this consent; and acknowledge that I have studied the Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact Healthy Futures, P.C. at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is abounding to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Medical Information Release Form

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be release to:

- ☐ Spouse _____
- ☐ Child (ren) _____
- ☐ Other_____

☐ Information is not to be release to anyone.

This Release of Information will remain in effect until terminated by me in writing.

_____ _____

Patient's Name DOB: (mm/dd/yy)

_____ _____

Signed (Patient or Legal Representative for Patient) Date:

_____

Legal Representative's Relationship to Patient

Healthy Futures, PC

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS INFORMATION

OBTAIN FROM: (*who is releasing information?)*

_____
Name

_____
Address

_____
City State Zip

_____
Phone Fax

Release to: (who is receiving information?)

HEALTHY FUTURES, PC
300 E HAMPDEN AVE SUITE 201
ENGLEWOOD, CO 80113
PHONE: 303-991-7700
FAX: 303-991-7701

SPECIFIC INFORMATION REQUESTED: For the Following Dates: _____

__ All Medical Records
__ Final Summary
__ Medical/ Surgical Final Summary
__ Progress Note
__ Psychiatric Assessment
__ History & Physical Exam
__ Lab/ Path Results
__ Psycho-Social Assessment
__ Operative Report

Other: _____

THE INFORMATION ABOVE IS TO BE USED FOR:

__ Continuity of Care
__ At the Request of Individual
__ Legal Purposes

Other: _____

I understand that the information disclosed may contain testing or treatment information relating to mental health; drug and or alcohol abuse treatment; sexually transmitted diseases; HIV/AIDS virus.
I understand that once the information is disclosed, the information is subject to re disclosure and may no longer be protected by the federal privacy regulations.
I understand that this authorization will expire in one year from the date signed below.
I understand that this form may be revoked at any time providing the information has not already been disclosed. I may revoke this information by notifying, in writing, the medical records department.
I understand I can refuse to sign this authorization. I need not sign this form to assure medical treatment or services.
I may receive a copy of this signed authorization upon request.
INITAILS: _____

_____

Printed Name of Patient **Date of Birth**

_____

Patient Signature/ Authorized Guardian **Today's Date**