

## PATIENT INFORMATION

Reason for today's visit.

Is this visit related to: **Motor Vehicle Accident:** \_\_\_Y\_\_\_N      **Work Injury:** \_\_\_Y\_\_\_N

Name (First, Middle, Last) \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Sex  M  F  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 Home Phone \_\_\_\_\_  
 Cell Number \_\_\_\_\_ Email \_\_\_\_\_  
 Social Security Number \_\_\_\_\_

Responsible Party or Parents Name (if minor) Guar. BD \_\_\_\_\_  
 Patient's employer or parent occupation \_\_\_\_\_  
 Work Phone \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_  
 Employer (Spouse's) \_\_\_\_\_  
 Work Phone (Spouse's) \_\_\_\_\_  
 Cell Number \_\_\_\_\_ Email \_\_\_\_\_

### In case of emergency who should we contact?

Name \_\_\_\_\_  
 Relationship \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Telephone \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Information concerning your care provided by Doctors After Hours will be forwarded to your referring doctor/source unless otherwise specified

### PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST

**Primary Insurance Carrier**

Insurance Company Name \_\_\_\_\_ Insurance Phone \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_  
 Insured Name \_\_\_\_\_ Insured SSN & DOB \_\_\_\_\_

**Secondary Insurance Carrier**

Insurance Company Name \_\_\_\_\_ Insurance Phone \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_  
 Insured Name \_\_\_\_\_ Insured SSN & DOB \_\_\_\_\_

Patient's relationship to insured:  
 Self  Spouse  Dependant  Other

Patient's relationship to insured:  
 Self  Spouse  Dependant  Other

Please remember insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

**IN ORDER TO CONTROL COST OF BILLING, WE REQUEST CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.**

I authorize the release of any medical information necessary to determine liability for payment and to obtain reimbursement on any claim. I request payment of authorized benefits be made on my behalf. I assign the benefits payable for all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance and other agency reimbursements to Doctors After Hours. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature \_\_\_\_\_

Date \_\_\_\_\_



**PATIENT HISTORY**

Patient Name: \_\_\_\_\_

Is this a workers comp claim? \_\_\_\_\_ Date of Injury \_\_\_\_\_  
 Supervisor's Name and Telephone Number: \_\_\_\_\_  
 Workers Comp. Billing Address \_\_\_\_\_

Allergies: \_\_\_\_\_

Last Menstrual Period Date: \_\_\_\_\_ Pregnant?   Y   N

Please check any of these conditions you have or have had in the past:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Heart disease                       | <input type="checkbox"/> Liver disease                 | <input type="checkbox"/> Lumbar spine disorder  |
| <input type="checkbox"/> High blood pressure                 | <input type="checkbox"/> Bowel disease                 | <input type="checkbox"/> Severe headaches       |
| <input type="checkbox"/> High cholesterol                    | <input type="checkbox"/> Cancer (past or present)      | <input type="checkbox"/> Tuberculosis/TB        |
| <input type="checkbox"/> Lung disease                        | <input type="checkbox"/> Anemia or other blood disease | <input type="checkbox"/> Muscle disease         |
| <input type="checkbox"/> Diabetes                            | <input type="checkbox"/> Blood clots                   | <input type="checkbox"/> Mental health problems |
| <input type="checkbox"/> Hypoglycemia (low Glucose)          | <input type="checkbox"/> Bleeding tendency             | <input type="checkbox"/> Depression             |
| <input type="checkbox"/> Thyroid disease                     | <input type="checkbox"/> Stroke                        | <input type="checkbox"/> Chronic skin disease   |
| <input type="checkbox"/> Stomach disease                     | <input type="checkbox"/> Seizures                      | <input type="checkbox"/> Sleep apnea            |
| <input type="checkbox"/> Kidney, bladder or prostate disease | <input type="checkbox"/> Nerve impairment              |   |
| <input type="checkbox"/> Joint replacement                   | <input type="checkbox"/> Cervical spine disorder       | Other _____                                     |

**Current Medications (includes non-prescription products)**

- |          |          |          |
|----------|----------|----------|
| 1) _____ | 2) _____ | 3) _____ |
| 4) _____ | 5) _____ | 6) _____ |
| 7) _____ | 8) _____ | 9) _____ |

**Personal Habits**

Do you drink caffeinated beverages (coffee, tea, soda)?   N   Y Daily intake? \_\_\_\_\_  
 Do you drink alcoholic beverages?   N   Y If yes, \_\_\_\_\_ drinks/□ day, □ week, □ month  
 Do you smoke or chew tobacco?   N   Y If yes, \_\_\_\_\_ /day, \_\_\_\_\_ years of use  
 If no, any prior nicotine use? \_\_\_\_\_ years

**Orthopedic or Other Major Surgeries**

Approximate Date: _____	Surgery: _____
Approximate Date: _____	Surgery: _____
Approximate Date: _____	Surgery: _____
Approximate Date: _____	Surgery: _____

**Family History (Please check any conditions that run in your family.)**

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke	Other Conditions: Please list
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Aneurysms	_____
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Disease	_____
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Mental Disorders	_____
<input type="checkbox"/> Cancer: Type: _____		

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## HIPAA Notice of Privacy Practices

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### **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.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

#### **1. Uses and Disclosures of Protected Healthy Information**

##### **Uses and Disclosures of Protected Health Information.**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglects: Food and Drug Administration requirement: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of Sections 164.500.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associated involves the use or disclosure of your protected health information we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information as necessary to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

**Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization Or Opportunity To Object Unless Required By Law.**

**You may revoke this authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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**Your Rights**

Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A “designated record set” contains medical and billing records and any other records that your physician and the practice use for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction or your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation for you as to the basis for the request. Please make this request in writing to our Privacy Contact.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at this time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

**Complaints**

You may complain to us or to the Office of Civil Rights if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. You may obtain the address of the OCR Regional Manager, Denver, CO, from our privacy officer.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at 504-885-8700.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_