PRACTICE POLICIES SUMMARY

As a new patient, you need to be aware of how your care will be delivered. It may vary from that of other medical practices. Be aware that:

- **We may not have all of your medical records on file before your first visit.** In order to facilitate getting you into the practice quickly, we may not have received all of your records from your previous provider. If you would like us to wait for all of your records to arrive prior to the first visit, please communicate this to the receptionist that is scheduling your appointment. As such, we request that you are thorough as you fill out this packet.
- **Generally, we do not prescribe chronic pain medications.** Our practice is determined to prevent prescription drug abuse and dependency. As a result, no refills or new prescriptions for narcotic pain medications will be given to a new patient in our practice without meeting with you and reviewing your history/records. Continuation of narcotics is not likely, but may occur in rare circumstances, such as cancer-related pain, at discretion of your new provider. Furthermore, we reserve the right to dismiss patients who fail to adhere to guidelines laid out in pain medication agreements.
- **We have adopted a collaborative care model.** You will be assigned to one provider who will oversee the coordination of your care and act as your primary care provider. However, sick, urgent care, inpatient, or other circumstances may require you to be seen by any available or "on call" providers, including nurse practitioners. This model ensures that your needs are met promptly.
- **Communicating changes to your insurance is your responsibility.** If you fail to communicate changes in insurance, you may be responsible for paying your medical bill out of pocket. Insurance companies often have particular requirements for documentation and billing and failure to meet these requirements may result in your claim being denied. If we don't meet requirements because you failed to communicate a change in benefits, you will be required to pay that bill.
- **Failure to show for an appointment may result in fees.** We strive to be accessible and on-time for our patients. We ask that you are respectful of our time by arriving early for your appointment and by informing us if you are unable to come. Failure to show for appointments without prior notification *may* result in fees and, eventually, termination from the practice.
- **You may be billed for items that fall outside the scope of 'preventive' during a wellness visit.** Many insurance plans now cover an annual 'preventive care' or 'wellness' visit that is different than a traditional 'physical.' Our practice is preventive and wellness focused and we do these visits regularly. We discourage use of the wellness visits to discuss acute illnesses or chronic concerns as such items fall outside of what insurers define as preventative and may result in additional charges that your insurance may not cover. If you have non-preventative items you wish to discuss, please notify the scheduler and they can set up a separate appointment dedicated to these concerns.

PATIENT NAME (PRINT)	SIGNATURE	DATE
PERSON SIGNING ON BEHALF OF PATIENT	RELATIONSHIP TO PATIENT	

NEW PATIENT PERSONAL HISTORY

DATE: _____

PROVIDER YOU ARE REQUESTING: _____

DEMOGRAPHIC AND INSURANCE INFORMATION

* INDICATES REQUIRED FIELD

LAST NAME	FIRST NAME	MIDDLE NAME

NICKNAME	BIRTHDATE	SEX	*SOCIAL SECURITY NUMBER

*RACE (CIRCLE)

AFRICAN AMERICAN/BLACK AMER INDIAN/ALASKAN NATIVE ASIAN CAUCASIAN/WHITE NATIVE HAWAIIAN/PACIFIC ISLANDER DECLINED UNKNOWN OTHER: _____

*ETHNICITY (CIRCLE)	PRIMARY LANGUAGE
HISPANIC/LATINO NON-HISPANIC UNKNOWN DECLINED	

MARITAL STATUS	DRIVERS LICENSE	RELIGION

ADDRESS	ZIP CODE	CITY	STATE

PRIMARY PHONE	OTHER PHONE	EMAIL
☐ CELL ☐ HOME ☐ WORK	☐ CELL ☐ HOME ☐ WORK	

FINANCIALLY RESPONSIBLE PARTY (IF OTHER THAN PATIENT)	RELATIONSHIP TO PATIENT	PHONE (IF DIFFERENT)	ADDRESS (IF DIFFERENT)

PRIMARY INSURANCE	INSURANCE ID OF POLICY NUMBER	GROUP NUMBER

OTHER INSURANCE/SUPPLEMENT	INSURANCE ID OR POLICY NUMBER	GROUP NUMBER

PERSONAL INFORMATION

LAST SCHOOL GRADE COMPLETED	OCCUPATION	START DATE (MONTH/YEAR)	RETIRED?

EMPLOYER NAME	EMPLOYER ADDRESS

EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER

REASON FOR CURRENT VISIT	HOBBIES/INTERESTS

DATE OF LAST PHYSICAL EXAMINATION	PREVIOUS DOCTOR/REFERRING DOCTOR	PREFERRED PHARMACY

HEALTH OF FAMILY

	GOOD	POOR	DEAD	COMMENTS (Note Medical Conditions plus age and cause of death if applicable.)
FATHER (NATURAL, BIOLOGICAL)	❑	❑	❑	
MOTHER (NATURAL, BIOLOGICAL)	❑	❑	❑	
BROTHERS/SISTERS	❑	❑	❑	
	❑	❑	❑	
	❑	❑	❑	
	❑	❑	❑	
	❑	❑	❑	
CHILDREN (NATURAL, BIOLOGICAL)	❑	❑	❑	
	❑	❑	❑	
	❑	❑	❑	
	❑	❑	❑	
	❑	❑	❑	
	❑	❑	❑	
	❑	❑	❑	

NEW PATIENT PERSONAL HISTORY

PATIENT NAME:_____

PERSONAL HEALTH HISTORY

MEDICAL ILLNESSES	SURGICAL PROCEDURES – List dates when able
REASONS FOR HOSPITALIZATION	
ARE YOU SEEKING TO BECOME AN OB PATIENT? ☐ YES ☐ NO	**(IF YES) DATE OF LAST MENSTRUAL PERIOD:** _____/_____/_____

MEDICATIONS AND ALLERGIES

ALLERGIES – List all allergies to medications and what reaction occurred.

MEDICATIONS – List all medications, birth control, vitamins, herbs, or supplements you take with or without a prescription; include dose and frequency.

VACCINATIONS – Indicate when you most recently received each vaccination if applicable.

FLU	PNEUMONIA	TETANUS	SHINGLES

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Please complete this form to authorize Cedar Point Health (CPH) to request your personal health information on your behalf. You may revoke this authorization in writing or by contacting medical records at CPH. Once health information is disclosed, the organization that receives it may re-disclose it. Privacy laws may no longer protect it.

PATIENT INFORMATION:	Patient Name: _____ Date of Birth: _____ Phone Number: _____
AUTHORIZATION TO:	☐ Send Information ☐ Request Information
INFORMATION MAY BE RELEASED **FROM**:	Organization: _____ City/State: _____ Phone Number: _____ Fax Number: _____
INFORMATION MAY BE RELEASED **TO**:	Organization: Cedar Point Health City/State: Montrose, CO Phone Number: 970-249-7751 Fax Number: 970-249-5029
INFORMATION TO BE RELEASED:	☐ All health information ☐ Radiology ☐ Office Notes ☐ Labs ☐ Pathology Reports ☐ Other: _____ ☐ Immunization Records
	Optional ☐ Health information between the following dates: _____ to _____ ☐ Include psychotherapy notes. To authorize, initial here _____ ☐ Exclude:
AUTHORIZATION ENDS:	☐ On (date): _____ ☐ When the following occurs: _____ *If no date provided, authorization ends one year from signing.
PURPOSE:	☐ Transfer to New Provider ☐ Consult/Referral ☐ Other: _____

_____ _____ _____

PATIENT NAME (PRINT) SIGNATURE DATE

_____ _____

PERSON SIGNING ON BEHALF OF PATIENT RELATIONSHIP TO PATIENT

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

Please complete this form to authorize Cedar Point Health (CPH) to discuss your health information with specified persons. This does not authorize those listed herein to make medical decision on your behalf. Medical Power of Attorney forms are available upon request. You may revoke this authorization in writing or by contacting medical records at CPH. Once health information is disclosed, the person that receives it may re-disclose it. Privacy laws may no longer protect it.

PATIENT INFORMATION:	Patient Name: _____ Date of Birth: _____ Phone Number: _____
INFORMATION MAY BE DISCUSSED WITH:	Name: _____ Relationship: _____ Phone Number: _____
INFORMATION TO BE RELEASED:	☐ All health information ☐ Radiology ☐ Office Notes ☐ Labs ☐ Pathology Reports ☐ Other: _____ ☐ Immunization Records
	Optional ☐ Health information between the following dates: _____ to _____ ☐ Include psychotherapy notes. To authorize, initial here _____ ☐ Exclude:
AUTHORIZATION ENDS:	☐ On (date): _____ ☐ When the following occurs: _____ If no date is provided, authorization ends one year from signing.

_____ _____ _____

PATIENT NAME (PRINT) SIGNATURE DATE

_____ _____

PERSON SIGNING ON BEHALF OF PATIENT RELATIONSHIP TO PATIENT

CEDAR POINT HEALTH FINANCIAL POLICY

Please review and check the section below that is applicable to you.

- ☐ **Patient With Insurance – MUST PRESENT CURRENT INSURANCE CARDS AT EACH VISIT.** You are responsible for deductibles, copays, non-covered services, coinsurance and items considered "not medically necessary" by your insurance company. Please pay co-payments and coinsurance amounts as services are rendered. The remaining balance should be taken care of within one (1) month of notice from insurance company. If you or your insurance carrier makes payment exceeding your balance, reimbursement will be remitted.
- ☐ **Medicare and/or Medicaid – MUST PRESENT CURRENT MEDICARE/MEDICAID CARD AT EACH VISIT.** Our office will submit your Medicare/Medicaid charges to Medicare/Medicaid and your secondary insurance if appropriate. You are responsible for deductibles, copays, and any non-covered services.
- ☐ **Insurance and Non-Insurance (faith based sharing ministries) That We Do Not Participate With.** Payment is expected in full at the time of service. We will submit claims on your behalf and not accept assignment. Cash discount may be available.
- ☐ **Patient Without Insurance** Payment is expected in full at the time of service. Cash discount may be available.
- ☐ **Worker's Compensation Patient.** As a Worker's Compensation patient, you may be covered by insurance if your injury is reported at work and verified with your employer. Be sure to inform the office personnel that your injury resulted during employment. Patient is ultimately responsible for balance.
- ☐ **Personal Injury (Accident).** If you are a personal-injury patient, our office will bill the appropriate insurance companies. If we are unable to obtain payment, the charges for the services rendered will be your responsibility. Please give all information needed for billing. If an attorney is involved and asks you not to submit insurance claims, a doctor's lien must be signed by you and your attorney.

If, sixty (60) days after billing, you fail to pay any balance due on your account or fail to honor your established financial agreement, your account is subject to a five dollar ($5.00) per month rebilling fee and/or may be sent to a collection agency. If your account is sent to collection, you are responsible for all amounts due plus costs of collection including:

- Handling charge up to fifty percent (50%) of your account balance if it must be sent to collection.
- All collection expenses charged by the collection agency
- Court costs and attorneys' fees

Also, be aware that failure to show for appointments without prior notification may result in fees.

RELEASE OF INFORMATION

I authorize Cedar Point Health to release to my insurance carrier(s) and/or CMS and its agents and/or my secondary insurer any information needed to determine benefits or benefits payable for related services. I hereby authorize health providers at Cedar Point Health to release any information regarding services rendered by him/her and allow a photocopy of my signature to be used to file insurance.
Any claims filed by Cedar Point Health I hereby authorize and direct my insurer to issue payment check(s) for benefits due me for the services rendered by health providers at Cedar Point Health with payment made directly to my provider. Regardless of my insurance benefits, if any, I understand I am financially responsible for the fees for services rendered.

I have read and agree to the Financial Policy and Release of Information paragraphs stated above that apply to me.

PATIENT NAME (PRINT)	SIGNATURE	DATE

PERSON SIGNING ON BEHALF OF PATIENT	RELATIONSHIP TO PATIENT