CEDAR POINT HEALTH

Welcome to Cedar Point Health!

Dear Patient,

I would like to welcome you to our practice and express my confidence that your experience with us will be exceptional. Our care team is made up of the most professional, capable, and compassionate health care professionals around. In addition, our patient services team and support staff will strive to make all interactions simple, efficient, and positive.

It is our mission to be courteous, kind, and caring as we deliver high quality health care in a clean, safe, comfortable environment. We strive to be on time and accessible for our patients. However, we know that we are not yet perfect, and we would like to hear how we can do better. Please, reach out to me if you feel any experience, you have here is below our standards. We will make it right.

Please familiarize yourself with this packet. The materials contained herein are for collecting some information from you, clarifying patient expectations, and making some legal agreements. I believe that a few minutes reading through these pages will prevent confusion and will benefit you greatly.

We are determined to deliver the best possible care for all of our patients. Our care model is continually evolving to meet the needs of the community and our patients. Please communicate your needs and concerns and we will strive to meet them. Again, welcome to Cedar Point Health.

Sincerely,

Cory Phillips, CEO

INSTRUCTION SHEET

Please follow the instructions below to help you complete the new patient packet. Failure to complete in its entirety will cause a delay in scheduling your first appointment. If you are signing on behalf of the patient, you will also need to include legal documentation to authorize your signature.

- **Pages 3 and 4** - Please read our **Practice Policies** then print and sign your name, acknowledging that you understand them.
- **Pages 5 and 6 –** Fill out the **New Patient Personal History** in its entirety, making certain to add contact and insurance information. You will also need to supply copies of your insurance card and identification. If you need more space for your medications, please attach it in a separate sheet.
- **Pages 7-9 -** We will need the **Authorization for Release of Protected Health Information** filled out to get copies of your records from previous providers. One per provider/facility. If you need more than three copies, we are happy to provide extra. Or you can print them from our website. If only one is needed, the rest can be left blank.
- **Page 10 -** Please read the **Cedar Point Health Financial Policy,** select which applies to you and sign at the bottom.
- **Page 11 –** Fill out the **Authorization to Discuss Protected Health Information** with the contact information of those whom you authorize us to discuss your medical care.
- **Page 12 –** Sign the **PBM Consent Form** and select whether you give consent or not.

Thank you for taking the time to fill this out completely. It is our goal to contact you within three business days to complete the process.

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 your medical records on file before your first visit.** 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 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 Care Teams as our care delivery method.** Your Primary Care Provider (PCP) will oversee the delivery and coordination of your care. Other providers in your care team will work closely with your PCP to ensure that your medical care is timely and personal. Although most visits will be with your PCP, you will see other providers within your care team. A care team consists of three or four providers, two medical assistants, and a scheduler. Care teams allow us to balance the needs of hospitalized patients with those in our clinic. If your PCP is caring for critically ill patients in the hospital, you can still be seen by a member of your care team who is familiar with your medical history. The goal is to provide better access through coordinated team-based care without sacrificing the intimate patient-provider relationship.
- **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.

- **Allow three business days for prescription refills.** Calling in advance will ensure that it is filled before you run out.
- **Understand that narcotics will not be filled early or on weekends.**
- **Allow up to five business days for the return of labs.** If your lab results are non-urgent, it may take a few days for your results to be returned. If the results are urgent, they will be returned more quickly.
- **We ask you to use our Patient Portal.** This tool helps us to provide more timely responses, and allows you to send secure messages, ask your doctor or nurse questions, request and cancel appointments, view chart documents and visit summaries, and more. To set up your Patient Portal account, provide us with your current email address and ask us to send you an invitation. See the Portal Login page for step-by-step instructions on using the Patient Portal.
- **Know what your insurance benefits are.** Be prepared to pay any co-pays and co-insurance.

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

NEW PATIENT PERSONAL HISTORY

DATE:_____

DEMOGRAPHIC AND INSURANCE INFORMATION

* means 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) HISPANIC/LATINO NON-HISPANIC UNKNOWN DECLINED	PRIMARY LANGUAGE

MARITAL STATUS	DRIVER'S LICENSE	

ADDRESS*	ZIP CODE*	CITY*	STATE*

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

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

EMPLOYER NAME	EMPLOYER ADDRESS

EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER

REASON FOR CURRENT VISIT	

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

PERSONAL HEALTH HISTORY

PAST AND CURRENT MEDICAL CONDITIONS	**SURGERY OR PROCEDURES –** List dates when able

NEW PATIENT PERSONAL HISTORY (Cont.)

DATE: _____

ALLERGIES – LIST ALL MEDICATION, FOOD, AND ENVIRONMENTAL ALLERGIES WITH ALLERGIC REACTION

MEDICATIONS – List all medications, birth control, vitamins, herbs, or supplements you take with or without a prescription	
MEDICATION	DOSE AND FREQUENCY

VACCINATIONS – Indicate when you most recently received each vaccination if applicable.			
FLU	PNEUMONIA	TETANUS	SHINGLES

SOCIAL HISTORY				
	NEVER	FORMER	CURRENT	IF CURRENT, AMOUNT & TYPE
SMOKING STATUS:	☐	☐	☐	
ALCOHOL STATUS:	☐	☐	☐	
RECREATIONAL DRUG USE:	☐	☐	☐	
EXERCISE	☐	☐	☐	
HAVE YOU FALLEN IN THE LAST YEAR? (CIRCLE ONE)	YES	NO		

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
INFORMATION MAY BE RELEASED **FROM**:	Organization: _____ Address: _____ Phone Number: _____ Fax Number: _____
INFORMATION MAY BE RELEASED **TO**:	Organization: **Cedar Point Health** Address: 2303 S. Townsend Ave., Suite A; Montrose, CO 81401 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 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
INFORMATION MAY BE RELEASED **FROM**:	Organization: _____ Address: _____ Phone Number: _____ Fax Number: _____
INFORMATION MAY BE RELEASED **TO**:	Organization: **Cedar Point Health** Address: 2303 S. Townsend Ave., Suite A; Montrose, CO 81401 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 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
INFORMATION MAY BE RELEASED **FROM**:	Organization: _____ Address: _____ Phone Number: _____ Fax Number: _____
INFORMATION MAY BE RELEASED **TO**:	Organization: **Cedar Point Health** Address: 2303 S. Townsend Ave., Suite A; Montrose, CO 81401 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

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

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.

<table>
<tr><td>PATIENT INFORMATION:</td><td>Patient Name: _____
Date of Birth: _____ Phone Number: _____</td></tr>
<tr><td>INFORMATION MAY BE DISCUSSED WITH:</td><td>Name: _____
Relationship: _____
Phone Number: _____</td></tr>
<tr><td rowspan="2">INFORMATION TO BE RELEASED:</td><td>☐ All health information ☐ Radiology
☐ Office Notes ☐ Labs
☐ Pathology Reports ☐ Other: _____
☐ Immunization Records</td></tr>
<tr><td>Optional
☐ Health information between the following dates: _____ to _____
☐ Include psychotherapy notes. To authorize, initial here _____
☐ Exclude:</td></tr>
<tr><td>AUTHORIZATION ENDS:</td><td>☐ On (date): _____ ☐ When the following occurs: _____
If no date is provided, authorization ends one year from signing.</td></tr>
</table>

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

PBM CONSENT FORM

Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM.) PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

By signing this consent form you are agreeing that Cedar Point Health can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

☐ CONSENT GIVEN

☐ CONSENT DENIED

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