Demographic Form

Who is your CPHC Provider:

Last Name:	First Name:	MI:
Sex: M F	Birthdate:	SSN:
Street Address:		
City:	State:	Zip:
Home:	Work:	Cell:
Preferred Contact: ❑ Home ❑ Work ❑ Cell		
Preferred Language:		

Race:
- ❑ American Indian /Alaska Native ❑ Asian
- ❑ Black /African American ❑ Native Hawaiian
- ❑ Other Pacific Islander ❑ More than one race
- ❑ White /Caucasian ❑ Other
- ❑ Unreported/Refuse to Report

Ethnicity:
- ❑ Hispanic or Latino
- ❑ Non-Hispanic
- ❑ Refuse to Report
- ❑ Unreported/Refuse to Report

Marital Status:
- ❑ Single
- ❑ Married
- ❑ Divorced
- ❑ Separated
- ❑ Widowed

OTHER FAMILY MEMBERS SEEN BY OUR PRACTICE

	Relationship	Same Insurance?
1.		Y N
2.		Y N
3.		Y N
4.		Y N

RESPONSIBLE PARTY (*if different from patient*):

Last Name _____ First Name _____ MI _____

Sex M F Birthdate _____ SSN _____

Address _____

City _____ State _____ Zip _____

Home _____ Work _____ Cell _____

PRIMARY INSURANCE INFORMATION

Insurance Company _____ Phone _____

Address _____

Group Number _____ Policy Number _____

POLICY HOLDER (*if different from patient*):

Last Name _____ First Name _____ MI _____

Sex M F Birthdate _____ SSN _____

Employer _____ Phone _____

DO YOU HAVE SECONDARY INSURANCE? ❑ **YES** ❑ **NO**

IF YES, SECONDARY INSURANCE INFORMATION

Insurance Company _____ Phone _____

Address _____

_____

Group Number_____ Policy Number _____

IS YOUR VISIT ACCIDENT RELATED? ❑ **YES** ❑ **NO**

If yes, what type of accident? ❑ Auto ❑ Work ❑ Other _____

Date of Accident _____ Case / Claim Number _____

Adjuster's Name _____ Phone Number _____

If work related, has employer been notified? ❑ Yes ❑ No

If yes, employer contact_____ Phone _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: *I hereby authorize payment directly to Colorado Primary Health Care, LLC., the surgical and/or medical benefits available, if any, and authorize release of any medical information necessary to process this and future claims. I understand that if my insurance fails to make a payment, I am ultimately responsible for payment of services rendered.*

Patient / Guardian Signature: _____ Date: _____

Welcome to Colorado Primary Health Care **Adult New Patient History Form**

Name:_____ Today's Date: _____

Birthdate: _____

Preferred Language: _____

Do you have special communication needs for: ❑ Loss of Hearing ❑ Vision Problems ❑ N/A

Do you have Advance Directives (living will, etc.) in place? ❑ Y ❑ N ❑ I don't know

IMMUNIZATIONS: Have you had the following immunizations and if so, when?

Immunization		Year		
Pneumonia Shot	❑ Y		❑ N	
Flu Shot	❑ Y		❑ N	
Tetanus Shot	❑ Y		❑ N	*Did Tetanus Shot Include Whooping Cough?* ❑Y ❑ N

ALLERGIES: Please list any allergies you have, and your reaction:

Food or Drug Allergy	Reaction

MEDICATIONS: Please list medications you currently take (including over the counter medications): *Please list any additional medications on back of form*

Medication Name	Dose (mg)	How often

MEDICAL PROBLEMS: Please list any significant illnesses you have had.

Problem		Year	Problem		Year
❑ Yes	Allergies		❑ Yes	Scarlet Fever	
❑ Yes	Asthma		❑ Yes	Measles	
❑ Yes	Diabetes		❑ Yes	Mumps	
❑ Yes	Heart problems		❑ Yes	German Measles	
❑ Yes	Kidney problems		**Additional Problems**		
❑ Yes	Liver problems				
❑ Yes	Pneumonia				
❑ Yes	Seizures				
❑ Yes	Chickenpox				
❑ Yes	Rheumatic Fever				

HOSPITALIZATIONS / SURGERIES / SERIOUS INJURIES: Have you ever had a hospitalization, surgery, or serious injury?

Please use the back of this page for additional hospitalizations, surgeries or injuries

Year	Problem	Hospital

SPECIALIST VISITS: Which Specialists have you seen in the past 3 years?

Please use the back of this page for additional specialists you have seen.

Specialist Name	Reason	When

When was your last…

Screening	Year	Screening	Year
Physical Exam		Mammogram	
Colonoscopy		PAP Test	

Family History	Mother		Father		Brother / Sister		Brother / Sister		Brother / Sister		Brother / Sister		Other		Other	
Still Living?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
If not, cause of death?																
Age at death?																
Diabetes																
Heart Disease																
Cancer (include type)																
Mental Illness																
Depression																

SOCIAL MEDICAL HISTORY

Do you Use Tobacco? ❑ Y ❑ N *Formerly?* ❑ *Y* ❑ *N* *Year Quit* _____	Smoke? ❑ Y ❑ N Amount Per Day_____ Chew ? ❑ Y ❑ N Amount Per Day_____
Do you Drink Alcohol? ❑ Y ❑ N *Formerly?* ❑ *Y* ❑ *N* *Year Quit* _____	Beer ❑ Y ❑ N Amount Per Week_____ Wine ❑ Y ❑ N Amount Per Week_____ Liquor ❑ Y ❑ N Amount Per Week_____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Occupation: _____

Do you Exercise? ❑ Y ❑ N What type?_____Times per week?_____

Do you have a religious affiliation? ❑ Y ❑ N *If yes, what religion?* _____

Are there animals in the home? ❑ Y ❑ N *If yes, what type?* _____

Are you currently using recreational drugs? ❑ Y ❑ N ❑ Decline

Please List Persons Living in your home:

Name	Relationship to you	Age

Signature: _____ Date:_____

Colorado Primary Health Care **Patient's Authorized Contacts**

Patient's Name (please print) _____ Today's Date _____

Patient's Birthdate _____

Who Can CPHC Contact Regarding Your Care and Billing?

Contact persons with whom we may discuss your care, give test results and account and billing information:

Name_____ Relationship_____ Phone #_____

Name_____ Relationship_____ Phone #_____

Name_____ Relationship_____ Phone #_____

Name _____Relationship _____ Phone #_____

Name _____Relationship _____ Phone #_____

May we leave confidential information on voicemail or answering machines listed below?

Home Phone_____ ❑ Yes ❑ No

Work Phone _____ ❑ Yes ❑ No

Cell Phone _____ ❑ Yes ❑ No

Patient Signature: _____ Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with a copy of the Practice's Notice of Privacy Practices.

_____ ____/____/____

Print Name Date of Birth

_____ ____/____/____

Patient (or Patient Representative*) Signature Today's Date

For Practice Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining
- ☐ acknowledgement Other (Please Specify)

_____

*If Patient Representative is signing, legal documentation must be included designating authority to sign or receive information. This form must be maintained for 6 years.

Notice of Privacy Practices for Protected Health Information (PHI)

Colorado Primary Health Care

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY!

Effective date: MARCH 1, 2016

The Practice of Colorado Primary Health Care is required by applicable federal and state laws to maintain the privacy of your health information. Protected health information (PHI) is the information we create and maintain in the course of providing our services to you. Such information may include documentation of your symptoms, examination and test results, diagnoses and treatment protocols. It also may include billing documents for those services. We are permitted by federal privacy law (the Health Insurance Portability & Accountability Act of 1996 (HIPAA)), to use and disclose your PHI, without your written authorization, for purposes of treatment, payment, and health care operations.

Examples of Using Your Health Information for Treatment Purposes:

- Our nurse obtains treatment information about you and records it in your medical record.
- During the course of your treatment, the physician determines he will need to consult with a specialist. He will share the information with the specialist and obtain his/her input.
- We may contact you by phone, at your home, if we need to speak to you about a medical condition or to remind you of medical appointments.

Example of Using Your Health Information for Payment Purposes:

- We submit requests for payment to your health insurance company. We will respond to health insurance company requests for information from about the medical care we provided to you.

Example of a Using Your Information for Health Care Operations:

- We may use or disclose your PHI in order to conduct certain business and operational activities, such as quality assessments, employee reviews, or student training. We may share information about you with our Business Associates, third

parties who perform these functions on our behalf, as necessary to obtain their services.

Your Health Information Rights

The health and billing records we maintain are the physical property of the Practice. The information in them, however, belongs to you. You have a right to:

- Obtain a paper copy of our current Notice of Privacy Practices for PHI ("the Notice");
- Receive Notification of a breach of your unsecured PHI;
- Request restrictions on certain uses and disclosures of your health information. We are not required to grant most requests, but we will comply with any request with which we agree. We will, however, agree to your request to refrain from sending your PHI to your health plan for payment or operations purposes if at the time an item or service is provided to you, you pay in full and out-of-pocket;
- Request that you be allowed to inspect and copy the information about you that we maintain in the Practice's designated record set. You may exercise this right by delivering your request, in writing, to our Practice;
- Appeal a denial of access to your PHI, except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our Practice. We may deny your request if you ask us to amend information that (a) was not created by us (unless the person or entity that created the information is no longer available to make the amendment), (b) is not part of the health information kept by the Practice, (c) is not part of the information that you would be permitted to inspect and copy, or (d) is accurate and complete. If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be placed in your record;
- Request that communication of your health information be made by alternative means or at alternative locations by delivering a written request to our Practice;
- If we engage in fundraising activities and contact you to raise funds for our Practice, you will have the right to opt-out of any future fundraising communications;
- Obtain a list of instances in which we have shared your health information with outside parties, as required by the HIPAA Rules.
- Revoke any of your prior authorizations to use or disclose information by delivering a written revocation to our Practice (except to the extent action has already been taken based on a prior authorization).

Our Responsibilities

The Practice is required to:

- Maintain the privacy of your health information as required by law;
- Notify you following a breach of your unsecured PHI;
- Provide you with a notice ('Notice') describing our duties and privacy practices with respect to the information we collect and maintain about you and abide by the terms of the Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods for communicating with you about your health information and comply with your written request to refrain from disclosing your PHI to your health plan if you pay for an item or service we provide you in full and out-of-pocket at the time of service.

We reserve the right to amend, change, or eliminate provisions of our privacy practices and to enact new provisions regarding the PHI we maintain about you. If our information practices change, we will amend our Notice. You are entitled to receive a copy of the revised Notice upon request by phone or by visiting our website or Practice.

Other Uses and Disclosures of your PHI

Communication with Family

· Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment for care, if you do not object or in an emergency. We may also do this after your death, unless you tell us before you die that you do not wish us to communicate with certain individuals.

Notification

· Unless you object, we may use or disclose your PHI to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care about your location, your general condition, or your death.

Research

· We may disclose information to researchers if an institutional review board has reviewed the research proposal and established protocols to ensure the privacy of your PHI. We may also disclose your information if the researchers require only a limited portion of your information.

Disaster Relief

- We may use and disclose your PHI to assist in disaster relief efforts.

Organ Procurement Organizations

- Consistent with applicable law, we may disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation/transplant.

CORHIO Health Information Exchange

Colorado Primary Health Care endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the <CORHIO> HIE, or cancel an opt-out choice, at any time. Opt-Out forms are available at all our locations, or may be obtained by calling your primary care provider.

Food and Drug Administration (FDA)

- We may disclose to the FDA your PHI relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers' Compensation

- If you are seeking compensation from Workers Compensation, we may disclose your PHI to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

· We may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; or to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

As Required by Law

· We may disclose your PHI as required by law, or to appropriate public authorities as allowed by law to report abuse or neglect.

Employers

· We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services

are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of the release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of information to your employer.

Law Enforcement

· We may disclose your PHI to law enforcement officials (a) in response to a court order, court subpoena, warrant or similar judicial process; (b) to identify or locate a suspect, fugitive, material witness, or missing person; (c) if you are a victim of a crime and we are unable to obtain your agreement; (d) about criminal conduct on our premises; and (e) in other limited emergency circumstances where we need to report a crime.

Health Oversight

· Federal law allows us to release your PHI to appropriate health oversight agencies or for health oversight activities such as state and federal auditors.

Judicial/Administrative Proceedings

· We may disclose your PHI in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

For Specialized Governmental Functions or Serious Threat

· We may disclose your PHI for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, to public assistance program personnel, or to avert a serious threat to health or safety. We may disclose your PHI consistent with applicable law to prevent or diminish a serious, imminent threat to the health or safety of a person or the public.

Correctional Institutions

· If you are an inmate of a correctional institution, we may disclose to the institution or its agents the PHI necessary for your health and the health and safety of other individuals.

Coroners, Medical Examiners, and Funeral Directors

· We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about our Patients to funeral directors as necessary for them to carry out their duties.

Website

· You may access a copy of this Notice electronically on our website.

Other uses and disclosures of your PHI not described in this Notice will only be made with your authorization, unless otherwise permitted or required by law. Most uses and disclosure of psychotherapy notes, uses and disclosures of your PHI for marketing

purposes, and disclosures of your PHI that constitute a sale of PHI will require your authorization. You may revoke any authorization at any time by submitting a written revocation request to the Practice (as previously provided in this Notice under "Your Health Information Rights.")

To Request Information, Exercise a Patient Right, or File a Complaint

If you have questions, would like additional information, want to exercise a Patient Right described above, or believe your (or someone else's) privacy rights have been violated, you may contact the Practice's Privacy Officer at (303) 703-8583, or in writing to us at:

Paul Patterson
Colorado Primary Health Care
7720 S Broadway, #500
Littleton, CO 80122

Please note that all complaints must be submitted in writing to the Privacy Officer at the above address. You may also file a complaint with the Secretary of Health and Human Services (HHS), Office for Civil Rights (OCR). Your complaint must be filed in writing, either on paper or electronically, by mail, fax, or e-mail. The address for the Colorado regional office is: Office for Civil Rights, U.S. Department of Health and Human Services, 999 18th Street, Suite 417, Denver, CO 80202; or call (800) 368-1019. More information regarding the steps to file a complaint can be found at: www.hhs.gov/ocr/privacy/hipaa/complaints.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of HHS as a condition of receiving treatment from the Practice.

- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of HHS.

Colorado Primary Health Care — Medical Records Release

PLEASE COMPLETE THIS FORM IF: ❑ We do not have records from your previous provider(s)
❑ You wish to have CPHC release your records to someone else

Authorization for Release of Personal Health Information (PHI)

Must Be Completed For All Authorizations:

I hereby authorize the use and disclosure of my personal health information as described below. I understand that this authorization is voluntary, and will in no way affect treatment, payment, enrollment or benefit eligibility. I further understand that I may inspect and copy any information disclosed pursuant to this authorization. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____ **Date of Birth:** _____ **SSN:** _____

Person/organization providing the information:	**Person/organization receiving the information:**
_____	_____
_____	_____
_____	_____

The purpose for this authorized release of information is: _____

❑ At the request of the individual

I authorize the health care provider to release the information specified below to the organization, agency or individual named on this request. I specifically authorize the release of information regarding the following condition(s). If these are not marked they cannot be released.

❑ Drug Abuse ❑ Substance Abuse ❑ Psychological or Psychiatric conditions ❑ AIDS/HIV

Please release the following records:

❑ All records generated in your office

❑ Other: _____

(Specific dates of treatment or specific description or information requested)

Are you leaving our practice? ❑ Yes ❑ No

If yes, please explain: _____

Must be Completed For All Authorizations:

1. I understand that this authorization will expire 90 days from the date of signature.
2. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider or other entity considered a covered entity under HIPAA, the released information may no longer be protected by federal privacy regulations, and that the information may be re-disclosed by the parties listed, and no longer protected.
3. I understand that Federal and State Regulations allow for a reasonable fee to be charged for the duplication of Protected Health Information, and that I may be charged a fee to copy and mail the records I am requesting.

_____ _____ _____

Signature of Patient or Patient's Representative **Date** **Printed Name of Patient or Patient's Representative**

Revocation of Authorization:

I understand that authorization is voluntary and may be revoked at any time by signing below and returning to the Practice. I further understand that any such revocation does not apply to the extent that persons authorized to use and/or disclose my health information have already acted upon my previous authorization(s). I hereby revoke this authorization, effective____/____/____

_____ _____ _____

Patient Signature (Representative) **Date** **Printed Name**

DIRECT PAYMENT AUTHORIZATION AND CONSENT FORM
ANDY FINE, M.D.
7720 S. BROADWAY, SUITE G30
LITTLETON, CO 80122

Name of Patient (Print)
Last:_____First:_____MI:_____

AUTHORIZATION FOR MEDICAL EVALUATION:
I hereby authorize Andy Fine, MD to evaluate my medical condition at my initial consultation appointment and any treatment or follow up appointments as deemed necessary.

AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION:
I consent that information contained in my medical record may be furnished to any insurance carrier, hospital service corporation or medical expense indemnity company, which may be liable for my medical expenses under a specific contract. Such information shall be confidential. I also consent to communication between Andy Fine, MD and my other healthcare providers.

AUTHORIZATION TO PAY INSURANCE BENEFITS:
I hereby authorize payment directly to Andy Fine, MD of any Insurance Benefits payable to me but not to exceed the regular and customary charges for the services. I hereby assign, transfer, and set over sufficient monies and/or benefits to cover the cost of care rendered to me or my dependents and authorize payment to the physician directly. I understand that I am financially responsible for any amounts not covered by my plan or this authorization.

MEDICARE BENEFITS:
I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information to release to the Social Security Administration, or its carriers, any information required to process my Medicare claim. I request that payment under the Medical Insurance Program be made to Andy Fine, MD for services provided to me.

FINANCIAL AGREEMENT:
I, the undersigned, agree that in consideration for the services rendered to me, that I am fully responsible for the full amount of the bill (charges). Should my account be turned over for collection, I agree to pay all attorney fees including any fee over and above that of the bill. Interest may be charged at the IRS legal rate should my account become delinquent.

I, the undersigned, certify that I have read the foregoing, understand, and accept its terms.

Signed:_____Date:_____

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