Heritage Hills Addiction Medicine & Mental Health

Patient Registration Form

Whom may we thank for referring you? _____ Date _____

Patient Information

Patient Name _____**Social Security No.** _____
First MI last

Nickname _____ **Date Of Birth** __/___/___ **Gender:** Male/Female **Marital Status:** S M W D

Patient Address

_____

_____

Home Phone _____**Cell Phone (NOT PARENTS)** _____

Employment Status FT PT Retired N/A **Occupation** _____

Patient Employer Name _____ **Work Phone** _____

Employer Address _____

Patient Email _____ **Spouse's Name** _____

Pharmacy Name: _____ **What Cross Streets?** _____

IF MINOR: BILLING PARTY INFORMATION (ie the person to whom correspondence should be sent)

Name _____ Phone _____

Billing Address (if Different) _____

DEMOGRAPHIC INFORMATION

(REQUIRED BY THE FEDERAL GOVERNMENT)

Please circle the correct answers below and fill in the blanks as necessary:

NAME:_____**DOB:**____/____/____

RACE: White Black Asian Other: _____

ETHNICITY: Non-Hispanic / Hispanic

PREFERRED LANGUAGE: English / Spanish Other:_____

COMMUNICATION PREFERENCE: Home phone Cell US Mail

SMOKING STATUS: Never Quit Current Occasional Smoker Current Daily Smoker

MARITAL STATUS: Married / Never Married / Legally Separated / Divorced / Widowed / Domestic Partner / Annulled

_____ _____

SIGNATURE DATE

EMAIL CONSENT FORM
FOR HERITAGE HILLS FAMILY MEDICINE

Sign here to state that you will actually READ all of the below before signing. Do NOT just sign without reading. You must be over 18 years old to sign this form or have your parents co-sign.

_____ SIGNATURE

PATIENT NAME: _____ DOB:____/____/_____

Introduction: E-mail is one of several options available for doctor/staff/patient communication. We prefer to use the HALE app for all communications but will allow you to use the email medquestion@hhfmamilymedicine.com for purposes of only transmitting PDF documents. All medically related information must be transmitted on the HALE app.

Policies: Patients of HERITAGE HILLS FAMILY MEDICINE have the option of communicating with the medical assistants, receptionist, and billing by email. Prior to doing this, you need to read through this policy sheet carefully and sign it below. First of all, you must always include your full name in any email messages. Many email programs don't automatically include your name so you must be sure to include it.

Occasionally, emails get lost while traveling between the sender and the recipient. YOU are hereby reminded that it is your responsibility to follow up on emails and to never send anything that is time sensitive or of a medical nature. Further you are reminded never to email anything medical and especially any emergent/urgent issues.

Confidentiality: We are the only ones who will read emails received at the email address. This includes Dr. Edrich, our receptionist, any medical assistants, and our office manager/billing. Please be aware that email is not considered hipaa compliant and any information you decide to send via email may not remain secure.

If you have any questions about these policies, please ask us or one of the other office staff. If you feel that you understand all of these policies and you would like to add email to the ways you communicate with the doctor, then sign and date below and return this form to one of the office staff.

Name Printed:_____

Signed: _____ date:_____

guardian (if needed):_____

Email that you authorize us to use:_____

WRITE LEGIBLE PLEASE

Voice Recording Consent Form

Sign here to state that you will actually READ all of the below before signing. Do NOT just sign without reading. You must be over 18 years old to sign this form or have your parents co-sign.

PATIENT NAME: _____ DOB:_____

Introduction: This is to notify you that we may or may not choose to audio record any and or all office visits and phone conversations between myself, my staff, and you, the patient. We will be guarding these audio files in the same secure manner that we store all other sensitive medical information.

Confidentiality: We (staff at HERITAGE HILLS) are the only ones who will access these voice recordings when they exist. This includes Dr. Edrich, any medical assistants and our office manager.

Signed: _____ Date: _____

Guardian (if needed):_____

Emergency Contact Information:

Name of Nearest Relative or Close Friend NOT Living With the Patients

_____

Relationship:_____PhoneNumber_____

Name of Relative or Friend to Contact In Case of Emergency_____Relation:_____Phone_____

Consent for Treatment I, the undersigned, voluntarily agree to the tests, procedures, and/or treatments which the physician has deemed necessary and which are administered to or performed on me under the direction of the physician or his designee.

Consent for Treatment for Minors I, the undersigned, understand that a minor child (17 and under) must have my consent to be treated. I understand that I must be present at each appointment for any child aged 14 and under. If the child is between the ages of 15 and 17, I understand that I must send a note with the child to the appointment consenting for the child to be treated. The note must contain the date, a statement of consent, and my signature. Further, I understand that consent for treatment does not alter the legal requirement for confidentiality. I also understand that Colorado Law provides for minors to seek care without parental consent for some issues.

Consent to Copy Medical Records I understand that it may be necessary for other healthcare providers to review information in my medical record in order to render medical care for me. I authorize HERITAGE HILLS FAMILY MEDICINE to copy part or all of my medical records in the event that it is needed by another healthcare provider in order to receive/provide additional medical treatment or hospitalization. Further, I understand that medical records from either healthcare providers/hospitals may be requested to assist in rendering care for me. I agree to release such records.

Consent to Communicate Medical Records to Other Individuals I, the undersigned, understand that medical results will be communicated directly to me unless I specifically identify individuals to whom information may be communicated*. In the event that I am not able to receive medical results when called upon, I authorize HERITAGE HILLS FAMILY MEDICINE to leave medical information with any of the names identified below. It is my responsibility to notify these persons that such information may be left with them and I agree not to hold HERITAGE HILLS FAMILY MEDICINE responsible for information not conveyed to me through these persons.

Name (First, MI Last) Male Female Date of Birth Relation OK to receive results No YES

Name (First, MI Last) Male Female Date of Birth Relation OK to receive results No YES

Name (First, MI Last) Male Female Date of Birth Relation OK to receive results No YES

Name (First, MI Last) Male Female Date of Birth Relation OK to receive results No YES

Signature_____Date:_____

Patient Billing Agreement

Medical Services Billing: If we are in-network with your insurance company, we will submit the charges directly to your primary insurance. After your insurance(s) complete(s) payment to us you are responsible for payment of any allowable remaining patient balance.

Co-Pays – Are ALWAYS collected at check-in. The amount is usually listed on your insurance card. **Deductibles –** If your plan has a deductible, you are required to pay a portion of it at check-in. After insurance processes the claim, you will be billed for the remaining balance. Please see the deductible page and sign. **Self-Pay Patients –** If you are "self-pay" then payment is expected at the time of service.

Billing Process – Once we have received the final payment statement from your insurance, we will submit to you a statement requesting the remaining allowable patient amount. If you are unable to make a payment in full before 30 days, you may call our office manager and make installment payment arrangements to avoid having your account go to the collection agency. If your account is not paid 30 days after we send you the statement, your account will be turned over to our collection agency without further notice from us. After your account has been turned over to our collection agency, you will be responsible for the outstanding balance you have with us as well as any agency fees, legal/attorney fees, and court costs. This could be placed on your credit record and may affect your ability to make any credit purchases.

Other Billing Policies: Cancellations / No Shows – If you do not call us to cancel or reschedule at least 24 hours in advance of your scheduled appointment, this may be considered a "no-show". A fee of $50.00-$100.00 will be billed to the patient, not the insurance company and this fee is required to be paid prior to scheduling the next appointment.

Routine Physicals and Preventative Services – It is your responsibility to know the benefits covered by your insurance. Please find out in advance if your insurance will pay for preventative services.

Payment Methods Accepted – For your convenience, we accept VISA, MasterCard, money orders, cash, or personal checks with proper ID.

Insufficient Funds – If your check is returned due to insufficient funds, you will be charged a $50.00 fee by us. You will receive a statement for amounts due in this case. Also, you will not be allowed to pay us by check for any visits following the returned check.

Patients in Collections – Patients with unpaid balances in collections will not be scheduled for appointments unless approved by the billing department. Generally, "collections" balances must be paid in full. .

I hereby assign HHFM the right to bill and receive payment from my health insurances and authorize HHFM to release information to them for payment and audit purposes and provide access to my records to the necessary parties to accomplish this task and acknowledge understanding of the above policies and procedures as a patient of HERITAGE HILLS FAMILY MEDICINE (HHFM).

_____ _____ _____ Printed Patient Name Patient/Guardian Signature Date

If you have a High Deductible Plan please read below and sign:

DEDUCTIBLE

Your health insurance deductible is the amount that you will have to pay annually for your healthcare (such as specialist office visits, physical therapy, surgical procedures, blood tests, or hospitalizations) *before* the health insurance pays anything.

You are responsible for payment of the amount applied to your deductible. We may request payment towards your deductible.

I understand my deductible plan and agree to pay my medical bills according to my plan.

SIGNED: _____

Date: _____

If you have any questions about our billing policies or a statement that you have received, please contact our billing manager at (303) 792-3333.

Telemedicine Patient Consent/Refusal Form

Patient Name:_____DOB:_____

1. PURPOSE: The purpose of this form is to obtain your consent to participate in telemedicine consultation in connection with the following procedure (s) and/or service(s)

_____

_____

2. NATURE OF TELEMEDICINE CONSULT: During the telemedicine consultation:

a. Details of your medical history, examinations, x-rays, and tests will be discussed with other health professionals through the use of interactive video, audio, and telecommunications technology. b. A physical examination of you may take place. c. A non-medical technician may be present in the telemedicine studio to aid in the video transmission. d. Video, audio and/or photo recordings may be taken of you during the service. 3.MEDICAL INFORMATION & RECORDS: All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable image or information for this telemedicine interaction to researchers or other entities shall not occur without your consent. 4.CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and CO state law apply to information disclosed during this telemedicine consultation. 5.RIGHTS: You may withhold or withdraw consent to telemedicine consultation at any time without affecting your right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. 6. DISPUTES: You agree that any dispute arriving from the telemedicine consult will be resolved in CO, and the CO law shall apply to all disputes. 7. RISKS, CONSEQUENCES & BENEFITS: you have been advised of all the potential risks, consequences and benefits of telemedicine. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All of your questions have been answered, and you understand the written information provided above. I agree to participate in telemedicine consultations for the service described above

SIGNATURE:_____

If signed by someone other than the patient, indicate relationship_____

REFUSAL/OPT OUT: if you sign to refuse you will not be able to participate in our telemedicine/texting program.

I refuse to participate in a telemedicine consultation for the service described above.

SIGNATURE:_____

if signed by someone other than the patient, indicate relationship_____

DATE:_____

WITNESS:_____