Colorado Springs Family Practice

Please print all requested information.

PATIENT INFORMATION

Name:_____ Date of Birth: ____/____/____ SSN:____-____-____

Gender: M or F Marital Status: Single Married Divorced Widowed Legally Separated

Address:_____ State:_____ Zip Code:_____

Home Phone:(____)_____ Employer:_____

Work Phone:(____)_____ Occupation:_____

Cell Phone:(____)_____ Work Address:_____

E-Mail Address:_____ State:_____ Zip Code:_____

Race(optional): Asian Native Hawaiian Other Polynesian Black Native American White Unknown

Ethnicity: Hispanic All Others Language Preferred:_____

SPOUSE/PARENT INFORMATION (if applicable)

Name:_____ Date of Birth:____/____/____ SSN:____-____-____

Address:_____ State:_____ Zip Code:_____

Home Phone:(____)_____ Employer:_____

Work Phone:(____)_____ Occupation:_____

Cell Phone:(____)_____ Work Address:_____

Relationship to Patient:_____ State:_____ Zip Code:_____

INSURANCE INFORMATION (if applicable)

Payments including co-payments are due and collected at your scheduled appointment

Primary Insurance:_____ Secondary Insurance:_____

Policy/Id #:_____ Group#:_____ Policy/Id #:_____ Group #:_____

Policy Holder's Name:_____ Policy Holder's Name:_____

Policy Holder's DOB:_____ Policy Holder's DOB:_____

Policy Holder's SSN:_____ Policy Holder's SSN:_____

Relationship to Patient:_____ Relationship to Patient:_____

EMERGENCY CONTACT (nearest relative not living with you)

Name:_____ Relationship:_____

Address:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Financial Agreement, Authorization for Treatment, Release of Medical Information and Appointment Policy

I authorize treatment of the person(s) named above and agree to pay all fees and charges for such treatment. I understand this is payable prior to the time of service. As a courtesy, you will bill my insurance company, but will collect any co-pay or deductible due at the time of service. I authorize payment of insurance benefits directly to Colorado Springs Family Practice. I hereby authorize release of medical information needed to complete insurance claim inquiries. I am also aware that if insurance does not cover services within 45 days, interest will be assessed at the rate of 1.5% per month on the unpaid balance. I am responsible for all charges including costs for collection, attorney fees and court costs. Insurance benefits are a matter between you and your insurance company. You are ultimately responsible for payment on your account. A 24 hour notice is requested for changing or cancelling an appointment. "No Show" missed appointments are subject to a $40.00 fee, as the appointment was a specific time set aside specially for you.

Signature:_____ Date:_____

COLORADO SPRINGS FAMILY PRACTICE, P.C.

OUR PRACTICE FINANCIAL POLICY

We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.

YOUR INSURANCE

We have made prior arrangements with many insurance health plans. We will bill those plans with which we have an agreement and will collect any required co-payment at the time of your arrival. If you come unprepared to pay your co-pay, we may have to reschedule your appointment.

It is your responsibility to determine what is or is not covered per your insurance plan benefits so that you can make sound decisions regarding your treatment. You will be responsible for the full amount of the visit or procedure if your insurance indicates that it is not a "covered expense". Any charges applied to your deductible become due and payable. Insurance benefits are a matter between you and your insurance company. You are ultimately responsible for payment on your account.

MISCELLANEOUS FORMS CHARGES

Physicians will complete various health questionnaire forms on your behalf, and HIPAA law requires that we first obtain your authorizing signature on a Medical Release. There will be a charge of $25.00 per form that is due at the time the Medical Release is signed in order for us to cover our expenses for staff time and copying of the records.

MINOR PATIENTS

For all services rendered to minor patients, parents or guardians shall be responsible for the consent for treatment and payment for service. An authorization to treat will be signed by the responsible party.

BILLING POLICY

The financial guarantor agrees to pay costs, including attorney fees and court costs incurred in collection efforts.

Checks returned by your bank for insufficient funds will be subject to a $40.00 administrative fee and if not received in five working days will be transferred to the Collection Service for collection.

APPOINTMENT POLICY

In order to provide the best possible service and availability to all our patients, it is our policy to charge $40.00 for missed appointments not canceled at least 24 hours prior. Please call us as early as possible if you know you will need to reschedule your appointment.

AUTHORIZATION

I have read and understand the financial policy, of the practice, and I agree to be bound by its terms. I further authorize Colorado Springs Family Practice to furnish any information necessary to my insurance carrier concerning my visit in order to receive reimbursement for services rendered, and such reimbursement is assigned to Colorado Springs Family Practice, PC.

Print Patient Name _____ DOB:_____

_____ \ Relation _____

Signature of Patient or Responsible Party if a Minor

_____

DATE

COLORADO SPRINGS FAMILY PRACTICE, P.C.

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I received Colorado Springs Family Practice's Notice of Privacy Practices.

_____ _____

Name of Patient (please print) **Date of Birth**

_____ _____

Signature of Patient/Guardian Date

Documentation of Good Faith Efforts

(For use when acknowledgment cannot be obtained from the patient.)

The patient presented to the office on _____ and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

☐ Patient refused to sign

☐ Patient had a medical emergency. An attempt to obtain signed acknowledgement will be made at the next opportunity.

☐ Other reason:

_____

_____

_____ _____

Signature of Employee Completing Form Date

COLORADO SPRINGS FAMILY PRACTICE

HIPAA RELEASE FORM

Patient name:_____ Date Of Birth:_____

Release of information

I Authorize CSFP the release of information including the diagnosis, records; examination rendered to me, claims information, insurance, test results, lab results, prescriptions and any other information regarding my health care. I authorize these person(s) to receive messages regarding information from CSFP. These person(s) must know the last four digits of your social security number in order to allow us to speak to them.

This information may be released to:

Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____

o CHECK IF YOU DO NOT WANT INFORMATION RELEASED

This Release of information will remain in effect until terminated by me in writing.

Messages

It is ok to leave a message on:
Home phone:_____ Work phone:_____
Cell phone:_____ Email:_____

o CHECK IF YOU DO NOT WANT MESSAGES LEFT

Patient signature:_____ Date:_____