PATIENT INFORMATION FORM

(PLEASE PRINT)

PATIENT NAME: _____ DATE OF BIRTH: _____

SEX: Female / Male / Unknown PATIENT'S SS #: _____
RACE: ___White/Caucasian ___Native American ___Hawaiian Native/Pacific Islander ___Black/African American ___Asian
OTHER: _____
ETHNICITY: ___Hispanic ___Non-Hispanic

Preferred Language: _____

PARENT #1 PHONE: _____
PARENT #2 PHONE: _____

ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____ COUNTY: _____

RESPONSIBLE PARTY (Guarantor): _____
Insurance Holder name if Different: _____
INSURANCE COMPANY: _____NUMBER: _____
DOB Of Insured: _____RELATIONSHIP: ___Mother __Father OTHER: _____

PARENT #1: _____ MOTHER / FATHER / GUARDIAN
Email: _____
DOB: _____ SS#: _____
ADDRESS if different:_____
CITY: _____ STATE: _____ ZIP: _____
Place of Employment: _____ PHONE # _____

PARENT #2: _____ MOTHER / FATHER / GUARDIAN
Email: _____
DOB: _____ SS#: _____
ADDRESS if different:_____
CITY: _____ STATE: _____ ZIP: _____
Place of Employment: _____ PHONE # _____

Will we be your PRIMARY CARE PROVIDER or is this a WALK-IN ONLY visit?

Who may we contact other than a Parent/Guardian, In case of Emergency:
_____ Phone #: _____
Relationship to Patient: _____

Additional Family Members Seen In Our Office: _____

HOW DID YOU HEAR ABOUT US? _____

CONSENT FOR TREATMENT/FINANCIAL POLICY

CONSENT: I hereby request and consent to routine and medical care for the patient including all routine examinations, tests, photographs and other procedures. Any tissue removed may be disposed of in the Clinic's customary manner. I acknowledge that no guarantees have been made as to the results of such medical care. I understand a patient has the right to refuse treatment and that my signature below is not consent to any special medical or surgical procedure. In the event that such procedures are recommended, it is the physician's responsibility to explain the nature of the procedure, the reason it is recommended and the risks associated with the procedure. The physician and/or a member of the nursing staff may ask the patient to sign a form confirming consent to the recommended procedure and alternatives to the procedure. Patients are encouraged to insist on any additional information necessary to make an informed decision to consent to or refuse treatment. No patient will be involved in any research or experimental procedure without his or her full knowledge and consent. Patients may receive behavioral health support services and can decline such services at any time.

ASSIGNMENT OF BENEFITS: I hereby assign to Thompson River Pediatrics, for services provided by Thompson River Pediatrics, all coverage or other benefits available under any government program, insurance policy or plan, and other benefit program, and I direct that all benefits be paid directly to Thompson River Pediatrics.

FINANCIAL AGREEMENT: **Patients WITH Health Insurance:** Due to the many new options in Health Insurance plans it is **patients' responsibility to call their insurance company** to verify that we are in network with your plan before being seen in our office. Although we can accept most major insurance plans, there are now several new options under those plans that have restricted networks. If your insurance won't cover a visit due to changes in their plan coverage, **it is patient responsibility to pay for services.** Many health insurance plans require you to pay a copay and we are contractually required to collect this copayment at the time of service. The remaining balance of the charges for your services will be billed to your insurance plan. If you are unable to pay your copayment at the time of service, you may be asked to reschedule your appointment for a future time. If you have an existing balance, you are required to either pay this balance or make financial arrangements with us to pay the balance before your child can be seen (except in a medical emergency). Financial arrangements can be made by calling the Billing Specialist at (970) 619-8139. If your account is more than 120 days overdue, you may be referred to collections. I understand that should my account become delinquent and turned over to an attorney and/or collection agency, I will be responsible for all costs of collection, legal fees, and attorney fees incurred as a result. **Patients who DO NOT have Health Insurance:** For those who do not have health insurance, payment for services rendered is required at the time of service. If you are unable to pay at the time of service, please ask to speak to our Billing Specialist.

MEDICAL RECORD RELEASE: I authorize release of all or any part of the patient 's medical record to any person or entity which may be responsible to pay for any portion of the charges incurred . This release to third-party payers may not be revoked as to records of services provided. I authorize release at any time of medical records from Thompson River Pediatrics to any physicians or other health care professionals (and their staff) who may require health information in connection with the patient's current or subsequent health care. This release to health care professionals may be revoked in writing to Thompson River Pediatrics at any time.

COMMUNICATION: I authorize Thompson River Pediatrics and its Affiliates to use an automated system to communicate with me now or later. By providing the information below, I consent to receiving communications. The callers may leave the name of the company making the call or reference whom the caller is representing. These methods may be used to contact me about my dependents' health care or costs related to healthcare. **Please Choose Your Preferred Method Below!**

☐ Email Reminder – E-mail address: _____
☐ Voice Reminder – Phone number: _____
☐ Text Reminder – Phone number: _____

This form has been fully explained to me, I understand its content, l have had a full opportunity to ask questions concerning this form and any questions I 've asked have been answered to my satisfaction.

Patient Name: _____ **Date of Birth**: ____/____/____

Parent/Guarantor Name: _____

Signature: _____

Relationship to Patient: _____ **Date**: ____/____/____

TRpeds Representative Witness:_____

4435 Ronald Reagan Boulevard, Johnstown, CO 80534
Phone: (970) 619-8139 Fax: (970) 612-8013

HIPAA/AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS, FRIENDS, AND/OR LEGAL REPRESENTATIVE

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we must obtain your authorization in order for healthcare providers or staff to release to your designee any information about your child's medical condition or medical needs. For our office, this release may also serve as authorization for these family members or designees to accompany your child to the clinic for care in the event that you are not able to bring them. Thompson River Pediatrics 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.

- ☐ I **DO NOT** authorize Thompson River Pediatrics and Urgent Care to release any information concerning my or my child's medical care to any individual except as set forth above or in the HIPAA Privacy Notice.
- ☐ I authorize Thompson River Pediatrics to verbally release relevant medical information concerning my or my child's medical care to the following individuals.
- ☐ I further authorize the following individuals to accompany my child to the office of Thompson River Pediatrics and Urgent Care in the event that I am unable to do so.

Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient

☐ I have received the HIPAA Notice of Privacy Practices for Thompson River Pediatrics and Urgent Care.

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

Parent/Legal Guardian Name: _____

Signature: _____ **Date**: _____

Relationship to Patient: _____

Witness Signature: _____ **Date**: _____

Employee Documentation of Good Faith Effort. Give a reason if signed acknowledgment is not obtained:

- ☐ Attempted to distribute the Notice of Privacy Practices to the patient/parent/legal guardian, but the patient/parent/legal guardian declined to acknowledge the receipt of the Notice of Privacy Practices.
- ☐ Patient/parent/legal guardian stated they had already received the Notice of Privacy Practices.
- ☐ The Notice of Privacy Practices was mailed to the patient/parent/legal guardian.
- ☐ Other: _____