PARKER SQUARE FAMILY PRACTICE

19641 E Parker Square Dr, Suite E

Patient Name (as it appears on insurance card): _____ Date: _____

Date of Birth: _____ Age: _____ SSN: _____ Marital Status: _____ Sex: M F

Race: _____ Ethnicity (circle one): Hispanic Not Hispanic Refused

Mailing Address:_____ Unit #: _____City: _____State:_____Zip:_____

Home Phone: _____ Cell Phone: _____ Email Address: _____

Employer/School:_____ Occupation: _____ Employer/School Ph: _____

Pharmacy: _____ Pharmacy Phone: _____ Pharmacy Address:_____

Emergency Contact: _____ Phone: _____ Relationship to Patient: _____

Mailing Address:_____ Unit #: _____City: _____State:_____Zip:_____

For patients of our Family Practice you must make sure to elect one of our doctors as your PCP if required by your insurance.
(We bill your insurance company as a courtesy. However, if you do not provide your current insurance card at the time of service the visit may be billed as Self Pay)

Primary Insurance: _____ ID #: _____ Group #: _____

Name of Policy Holder: _____ Relationship to Patient: _____ Policy Holder's DOB_____

Policy Holder's SSN: _____ Policy Holder's Phone: _____ Policy Holder's Employer:_____

Policy Holder's Address:_____ Unit #: _____City: _____State:_____Zip:_____

Secondary Insurance: _____ ID #: _____ Group #: _____

Name of Policy Holder: _____ Relationship to Patient: _____ Policy Holder's DOB_____

Policy Holder's SSN: _____ Policy Holder's Phone: _____ Policy Holder's Employer:_____

Policy Holder's Address:_____ Unit #: _____City: _____State:_____Zip:_____

FOR PATIENTS WHO ARE MINORS, Please complete the following information for the parent or legal guardian who is financially responsible:

Name: _____ DOB: _____ SSN: _____

Address: _____ Apt/Unit #: _____

City: _____ State:_____ Zip:_____ Phone: _____

I certify that the information provided is true and correct to the best of my knowledge. I certify that I do not have Medicaid coverage. I will notify you of any changes to the above information. I understand that failure to provide updates on my insurance information will result in my medical bills becoming my sole responsibility.

Sign: _____ ***Date:*** _____

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Parker, CO 80134

Should your provider or a member of our office staff need to contact you we need to know your contact preferences.

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

I wish to be contacted in the following manner:

Home Telephone: (_____)_____
□ Okay to leave message with detailed information
or □ Leave message with call-back number only

Cell Phone: (_____)_____
□ Okay to leave message with detailed information
or □ Leave message with call-back number only

Work Telephone: (_____)_____
□ Okay to leave message with detailed information
or □ Leave message with call-back number only

Best number to contact you:

□ Cell or □ Home

Written Communications:
□ Okay to mail to my home address
□ Okay to mail to my work/office address:
_____
_____
□ Okay to fax to this number:
Fax: (_____)_____

*We require your email address in order to give you access to your patient portal. Your patient portal lets you see lab results, office visit summaries, request refills and much more. By providing your email address you are giving us permission to assign you access to your patient portal.

Email Address: _____

It is important that you list any friends or family with whom we may leave detailed information regarding your health care at the phone numbers listed above. The individuals you list will also be allowed to pick up prescriptions, samples or medical documents on your behalf. (this list of contacts may be updated at your request by completing a new copy of this form for Parker Square Family Practice to maintain in your electronic file)

1._____ 2._____

3._____ 4._____

Patient or Responsible Party Signature:_____

If signed by a Responsible Party please describe your relationship to the patient: _____

Today's Date: _____/_____/_____

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Parker, CO 80134

HIPAA Privacy Consent

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Submit claims to your insurance company to obtain payment and obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions.

RELEASE OF INFORMATION:
I authorize Parker Square Family Practice and my Practitioner(s) to release (verbally or in writing) confidential medical, psychiatric and/or psychological information contained in my medical record to my employer (Worker's Compensation only) and/or to any person or entity which may be liable to me, Parker Square Family Practice or my Practitioner(s) for charges for this treatment, and for quality management/utilization review, discharge planning, transfer and follow-up purposes. I understand that following the release of this information is subject to revocation at any time except to the extent that Parker Square Family Practice or Practitioner(s) have already taken action in reliance on it.

CONSENTS AND DISCLOSURES:
I hereby voluntarily agree to diagnostic procedures and medical and surgical treatment which may be administered to or performed on me under the general or special instructions of the attending Practitioner's care and service or the Practitioner's designee(s). I further understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks. No guarantees have been made to me as to the results of my treatment at Parker Square Family Practice. I understand Parker Square Family Practice encourages me to ask questions and voice concerns about medical care or services and that asking questions or voicing concerns will not compromise my care.
NOTE: A copy of this agreement may be used with the same effectiveness as an original.

BY SIGNING BELOW I CERTIFY THAT I HAVE READ THIS AGREEMENT AND/OR THAT IT HAS BEEN FULLY EXPLAINED TO ME, THAT I UNDERSTAND ITS CONTENT AND THAT I AM THE PATIENT, OR A PERSON DULY AUTHORIZED TO EXECUTE THIS AGREEMENT, AND ACCEPT ITS TERMS.

_____	_____
Print Patient Name	Patient Date of Birth
_____	_____
Signature of Patient or Guardian	Date

PARKER SQUARE FAMILY PRACTICE

PATIENT FINANCIAL POLICY

INSURED PATIENTS:

- I understand that I am financially responsible and agree to pay all of Parker Square Family Practice charges and any related charges that are not paid by insurance or any other third party Payer.
- I authorize payment directly to Parker Square Family Practice for all benefits**.**
- Co-payments are due at the time of service. Waiver of co-payments may constitute fraud under the state and federal law.
- If your insurance company requires you to select a PCP, one of our physicians must be the PCP listed on your insurance card. If we are not the PCP listed on your card you may be responsible for payment for all services provided.
- If you are not insured by a health insurance plan we are contracted with, payment in full is expected at the time of service. If you are insured with a health insurance plan that we are contracted with, but do not have a current insurance card, payment in full for each visit is required until we can verify your coverage.
- **I understand that if I do not provide all of the requested/necessary information, I will be billed directly for all charges. I understand it is my responsibility to provide the most current and accurate information regarding my health insurance, and will update Parker Square Family Practice & Urgent Care with any changes on my health insurance including new insurance cards.**
- I will disclose all insurance coverage to Parker Square Family Practice.
- Your health insurance contract is between you and your insurance company. It is the patient's responsibility to know their benefits and coverage. Any questions regarding your benefits and coverage must be directed to your insurance company.
- Payment plans are available to assist with your account balance. We require 50% of the balance be paid up front and can offer up to 3 months to pay the remaining balance. To create a payment plan we require a credit card be kept on file to run on the agreed upon dates. Any failure for payments to go through may result in your account being turned over to our collection agency.

SELF PAY PATIENTS:

- We provide a 30% discount to self-pay patients. However, if you are unable to pay in full at the time of service, you will not receive this discount.
- We collect a minimum fee of $120.00 for established patients, and a minimum fee of $155.00 for new patients before your visit. If you are unable to pay this amount at the time of service you will be asked to reschedule. Once your visit is complete, we will inform you of any additional charges above and beyond the office visit that we will need to collect at the time of check-out.
- Payment plans are available to assist with the balance beyond the initial fee. A credit card must remain on file to be run at agreed upon dates, up to 3 months from the date of service, to create a payment plan. Any failure for payments to go through may result in your account being turned over to our collection agency.

PATIENT BALANCES:

- Balances are due upon receipt. We collect any balance due on your account prior to your next appointment, or at the time of your next appointment if your account is still in good standing.

AFTER HOURS PHONE CONSULTATIONS:

- Our office may charge a minimum of $35 for telephone consultations initiated by the patient or by the patient's guardian after regular business hours of 8:00 am - 5:00 pm., Monday - Friday. These charges will not be processed through your insurance, they will be billed directly to the patient.

FORMS COMPLETION:

- We recommend scheduling an appointment for most paperwork/forms needs. This allows the provider to ask questions to the patient while completing the forms. However, if no appointment is deemed necessary, our office charges $25 for the completion of disability, adoption, and FMLA paperwork/forms. These charges will not be billed to your insurance company, they will be billed directly to the patient.

MISSED APPOINTMENTS:

- We require a 24 hour notice of cancellation prior to your scheduled appointment. Failure to provide this notice will result in a $45 fee. If you show up more than 15 minutes late for your scheduled appointment you will be asked to reschedule. This will also be considered a missed appointment and include a $45 fee. These charges will not be billed to you insurance company, they will be billed directly to the patient.

COLLECTIONS FEE:

- A collection fee of 50% will be assessed to accounts that go to our collection agency.

Authorization

I have read, understood and agree to the financial policies stated above. I accept responsibility for payment of all fees/charges incurred at Parker Square Family Practice.

_____ _____

Print Patient Name Patient Date of birth

_____ _____

Patient/Responsible Party Signature Date