DTC Family Health

Please complete the **ENTIRE** form

Date of Birth: _____ **SS #**: _____

Patient Name: _____
(Last Name) (First Name) (Middle Name)

Address: _____

City: _____ **State**:_____ **Zip Code**: _____

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

Personal Email (Please Print Clearly): _____

Marital Status: ☐ Single ☐ Married ☐ Divorced **Sex**: ☐ Female ☐ Male

Race: ☐ American Indian ☐ Asian ☐ Hawaiian ☐ African American ☐ White ☐ Latino ☐ Other

Ethnicity: ☐ Latino ☐ Not Latino **Primary Language**: ☐ English ☐ Spanish ☐ Other

Pharmacy Name: _____ **Pharmacy Phone Number**: _____

Pharmacy Address (Cross Streets): _____

Emergency Contacts: _____ _____ _____
(Name) (Relationship to the Patient) (Phone Number)

_____ _____ _____
(Name) (Relationship to the Patient) (Phone Number)

Insurance Information:

Subscriber Name (Person who carries the Insurance): _____

Subscriber's Date of Birth: _____ **Subscriber's SS #**: _____

Subscriber's Relationship to Patient: _____ **Subscriber's Phone Number**: _____

Subscriber's Address: _____

Subscriber's City/State/Zip: _____

Subscriber's Employer: _____

Insurance Company Name: _____

ID #: _____ **Group #**: _____ **Co-Pay Amount**: _____

Financial Responsibility: As a service to you, we will submit your claims to your insurance company. You are responsible for any deductible amount, co-insurance, co-payment or any non-covered services not paid by your insurance company. In order to control billing costs and comply with our insurance contracts, your portion of charges must be paid at the time of service. If you do not have your current insurance card with, you will be required to pay in full at the time of service. I understand that I am financially responsible for all charges whether or not paid by Insurance.

Assignment of Benefits: I authorize payment of medical benefits to DTC Family Health. for these and all future claims. Further, I authorize the release of any medical information necessary to process insurance claims.

Signature: _____ **Date**: _____
(Signature of Patient or Guardian)

Name: _____ **DOB:**_____ **Date:**_____

FAMILY HISTORY

Illness	Family Member (Include mother's or father's side)	Age at Onset	Age at Death	Illness	Family Member (include mother's or father's side)	Age at onset	Age at death
☐ Alcohol/Substance Abuse				☐ COPD/Emphysema			
☐ Alzheimer's Disease				☐ Crohn's/Ulcerative Colitis			
☐ Anemia				☐ Diabetes			
☐ Asthma				☐ Gastrointestinal Problem			
☐ Arthritis				☐ Heart Attack (MI)			
☐ Anxiety/Depression				☐ High Blood Pressure			
☐ Bipolar Disorder				☐ High Cholesterol			
☐ Blood Clots				☐ Immune Problem			
☐ Cancer-Breast				☐ Kidney Disease			
☐ Cancer-Colon				☐ Liver Disease			
☐ Cancer-Lung				☐ Circulation Problem			
☐ Cancer-Ovarian				☐ Stroke			
☐ Cancer-Prostate				☐ Thyroid Problem			
☐ Cancer-Other_____				☐ Other:_____			

SOCIAL HISTORY

Occupation: _____ Education: ☐High School ☐ Some College ☐ 4-year College ☐ Graduate	Do you use marijuana? ☐Yes ☐No Do you use other recreational drugs? ☐Yes ☐No
Marital Status: ☐Single ☐Married ☐Life Partner ☐Divorced ☐Widowed	How much caffeine do you use/day? _____
Number of Children: _____	How high is your stress level? ☐ Low ☐ Medium ☐ High
Do you smoke or use tobacco products? ☐ Yes ☐ No What type? _____How much? _____ How many years: _____ Have you smoked in the past? ☐ Yes ☐ No How many years? _____ When did you quit?_____	How often do you exercise? ☐< 1x/wk ☐2-3x/wk ☐4-5x/week ☐6-7xwk What type of exercise do you do?_____ How many hours/week do you exercise? _____
Do you drink alcohol: ☐Yes ☐No How often? ☐rarely ☐occasionally ☐frequently How many drinks/week? _____ How many days in the past year have you had a heavy drinking consumption (4+ females, 5+ males)? _____ In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food? ☐Yes ☐No Are you worried that in the next 2 months, you may not have stable housing? ☐Yes ☐No	Do you always use seat belts? ☐Yes ☐No Do you use sunscreen regularly? ☐Yes ☐No Do you have a smoke alarm in your home? ☐Yes ☐No Any deafness or hearing problems? ☐Yes ☐No Any blindness or serious vision problems? ☐Yes ☐No Do you ever need help reading patient education material? ☐Yes ☐No Are you afraid you might be hurt in your apartment building or house: ☐Yes ☐No

PAST SURGICAL HISTORY

☐ Angioplasty/Stent Placement	☐ Heart Surgery-other	☐ Prostate Surgery
☐ Appendectomy	☐ Hernia Repair	☐ Thyroid Surgery
☐ Bladder Surgery	☐ Hysterectomy-☐ abdominal	☐ Tonsillectomy
☐ Breast Surgery	☐ vaginal	☐ Other Surgeries:
☐ Cancer Surgery	☐ Joint Surgery_____	_____
☐ C-Section	_____	_____
☐ Coronary Artery Bypass Surgery	☐ Joint Replacement Surgery	_____
☐ Gallbladder Surgery	_____	**Last colonoscopy:** _____

PAST MEDICAL HISTORY

☐ Alcohol/Substance Abuse issues	☐ Ear Problem/Hearing Problem	☐ Osteoporosis
☐ Allergies/Immune Problem	☐ Eye or Vision Problem	☐ Arthritis
☐ Anxiety/Depression/Stress	☐ Fibromyalgia	☐ Rheumatologic Problem
☐ Cancer/Oncology Disorder	☐ Gastrointestinal Problem	☐ Sexually Transmitted Disease
☐ Cardiovascular/Heart Disorder	☐ Headaches/Migraines	☐ Seizures/Epilepsy
☐ Dermatology/Skin Problems	☐ Liver Disease	☐ Stroke
☐ Cancer_____	☐ High Blood Pressure	☐Urinary/Kidney Problem
☐ COPD/Emphysema	☐ High Cholesterol	☐ Other Serious Illness:_____
☐ Colon/Bowel Problems	☐ Insomnia/Sleep Apnea	_____
☐ Dermatology/Skin Problems	☐ Mental Health Problem	_____
☐ Diabetes	☐ Neurologic Problem	☐ Hospitalizations:_____
☐ Dizziness/Vertigo	☐ Orthopedic Problem	_____

GYN HISTORY (females only)

Age at first child:_____	When was your last mammogram? _____
Age at first menstrual period: _____	
Are your periods regular? ☐ Yes ☐ No	If you have gone through menopause,
How often do you get your period? _____	how old were you? _____
When was your last period? _____	Have you had a hysterectomy? ☐ Yes ☐ No
If you are using birth control, what type? _____	What was the date of the hysterectomy? _____
When was your last pap smear?_____	Have you ever had a bone density? ☐ Yes ☐ No
Have you ever had an abnormal pap? ☐ Yes ☐ No When:_____	When was your last bone density? _____

IMMUNIZATIONS

Vaccine	Date Received
Influenza	
TDaP/Tetanus	
Shingles	
Prevnar (13)	
Pneumovax (23)	
Hepatitis A	
Hepatitis B	

DTC Family Health
Acknowledgment of Notice of Privacy Practices/Prescription History
HIPAA Release Form/Consent to Leave Messages/Office and Financial Policies

Patient's Name (Print): _____ Date of Birth:_____

Acknowledgment of Notice of Privacy Practices

By signing this form, I acknowledge receipt of DTC Family Health's Notice of Privacy Practices. I understand that the Notice of Privacy Practice contains information on the uses and disclosures of any personal health information and I have been given the opportunity to review the Notice. I understand that the terms of the Notice may change and that I will be given a revised notice if changes occur.

Documentation of Good Faith Efforts

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

☐ Patient refused to sign.
☐ Patient was unable to sign or initial because: _____.
☐ Patient had a medical emergency. An attempt to obtain acknowledgement will be made at the next visit.
☐ Other: _____.

Prescription History Consent

By signing this form, I authorize DTC Family Health to obtain my prescription history from external sources to aid in medical history and treatment.

Release of Information

By signing this form, DTC Family Health has permission to release my personal health information regarding my medical care and/or account information to:

1) Name: _____ Relationship to Patient _____
2) Name: _____ Relationship to Patient _____
3) Name: _____ Relationship to Patient _____

This Release of Information will remain in effect until revoked by me in writing or until I have completed a new HIPAA Release Form.

Consent to Leave Messages

Please call phone number: _____ which is my (☐) Home (☐) Work (☐) Cell

If unable to reach me: (☐) Leave a detailed message (☐) Please leave a message asking me to return your call.
(☐) Other_____

My signature below indicates that I have read and agree to following:
DTC Family Health's Notice of Privacy Practices
DTC Family Health to obtain my prescription history
DTC Family Health has permission to release my personal health information as stated above
DTC Family Health has consent to leave messages as stated above
DTC Family Health Office and Financial Policies

Signature: _____ Date:_____
(Signature of Patient or Guardian)

DTC Family Health Office and Financial Policies

Thank you for choosing DTC Family Health as your health care provider. We are committed to providing you with quality, affordable healthcare, and building a successful physician-patient relationship with you and your family.

Office Policies

Emergencies: Our Practice has full-time coverage for patient emergencies; if a problem arises during a time when the office is closed, call the office **303-771-3939** and the answering service will contact the provider on-call. Your call will be returned in a timely manner. **Please note that prescription refills and referrals are not considered emergencies and will not be done after hours.** Our office may charge for after-hours consultations initiated by the patient or patient's guardian.

Prescriptions: All prescription refill requests should be called into your pharmacy or processed on our "Patient Portal". Your pharmacy will call the office if authorization is needed. Your refill requests will be handled within 48 hours after your request is received.

Referrals and Pre-Certification: Patients are required to notify us at least 72 hours in advance of an appointment requiring a referral/pre-certification.

Patient Portal: A patient portal is a secure online website that gives patients convenient 24-hour access to personal health information from anywhere in the U.S. with an internet connection. Using a secure username and password, patients can view health information such as recent provider visits, medications and immunization. You can also exchange secure portal messages with your provider, request refills, schedule non-urgent appointments, update contact information, make payments, download patient forms and view educational material.

Test Results: If you have any laboratory work or other diagnostic testing done through our Practice, you will be notified of the results as soon as they are available (usually within 5 working days from the test date). All results will be available on the patient portal as soon as they are reviewed by the ordering provider. If you request a phone call or copy via mail, these may take longer.

Financial Policies

As a service to you, we will submit your claims to your insurance company. You are responsible for any deductible amount, co-insurance, co-payment, or any non-covered services not paid by your insurance company. In order to control billing costs and comply with our insurance contracts, your portion of charges must be paid at the time of service. Medical services are provided to a person, not an insurance company thus, the insurance company is responsible to the patient, and the patient is responsible to DTC Family Health. Your insurance coverage is a contract between you and your insurance company. Therefore, knowing your insurance benefits is your responsibility. In order to properly bill your insurance, **you must present a current insurance care at each visit** and verify that all contact and billing information is up to date. If you have a dispute with your insurance company about their payment on your claim, it is your responsibility to negotiate with them for payment or reprocessing.

Co-Payments/Account Balances: Copayments and services not covered by your insurance company are due at the time of service. If you have a balance due on your account and our billing department does not receive payment within 90 days, from the date the first statement was sent, your account will be sent to an outside collection agency. If our account is sent to the collection agency, you will not be able to schedule appointments or receive prescription refills and you are at risk of being dismissed from our Practice.

Uninsured Patients (Self-Pay): If you do not have health insurance, payment in full is expected at the time of service. You will be required to pay $100.00 deposit prior to being seen for your appointment. If there are additional charges for your visit, the balance due will need to be paid before you leave the office. Any charges not available, at the time you check out, will be billed to you later. You will be reimbursed if your appointment did not require the full $100.00 charge.

Service Charges: $20.00 will be charged for checks returned from the bank for NSF (nonsufficient funds), closed account, etc. If a check is returned from the bank, we will no longer be able to accept checks for payment; you will need to pay with cash or credit card.

Cancellation/Missed Appointment (No Show): We require 24 hours-notice if you need to cancel and/or reschedule your appointment; for a same day appointment we require 4 hours-notice. Failure to provide such notice will result in a $45.00 charge. This fee also applies if you miss a scheduled appointment (No Show) or arrive too late to be seen for your appointment. Patients have a 10-minute window to arrive for their scheduled appointment. Patients will be permanently dismissed from our practice after 3 no shows in a three-year period. The following protocols will be followed:

- New Patient No Show: If you fail to arrive for your first appointment, you will not be able to reschedule with our office.
- 1st and 2nd No Show: A $45 charged will be assessed.
- 3rd No Show: A $45 fee will be assessed, and you will be dismissed from the Practice.

Thank you for your cooperation!

DTC Family Health

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

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

DTC Family Health is required to maintain the privacy of your health information and to provide you with a notice of its legal duties and privacy practices. We will not use or disclose your health information except as described in this Notice. This Notice applies to all of the medical records generated by DTC Family Health, as well as records we receive from other providers.

USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION IN TREATMENT, PAYMENT & HEALTH CARE OPERATIONS

Treatment: DTC Family Health may use and disclose your protected health information in the course of providing or managing your health care as well as any related services. For the purpose of treatment, we may coordinate your health care with a third party. For example, we may disclose your protected health information to a pharmacy to fulfill a prescription for medication, to a radiology facility to order an X-ray, or to another physician who is assisting in your health care. In addition, we may disclose protected health information to other health care providers related to the treatment provided by those other providers.

Payment: When needed, DTC Family Health will use or disclose your protected health information to obtain payment for its services. Such uses or disclosures may include disclosures to your health insurer to get approval for a recommended procedure or to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. When obtaining payment for your health care, we may also disclose your protected health information to your insurance company to demonstrate the medical necessity of the care or for utilization review when required to do so by your insurance company. Finally, we may also disclose your protected health information to another provider where that provider is involved in your care and requires the information to obtain payment.

Operations: DTC Family Health may use or disclose your protected health information when needed for the practice's health care operations for the purposes of management or administration of the practice and for offering quality health care services. Health care operations may include: (1) quality evaluations and improvement activities; (2) employee review activities and training programs; (3) accreditation, certification, licensing, or credentialing activities; (4) reviews and audits such as compliance reviews, medical reviews, legal services, and maintaining compliance programs; and (5) business management and general administrative activities. For instance, we may use, as needed, protected health information of patients to review their treatment course when making quality assessments regarding ophthalmologic care or treatment. In addition, we may disclose your protected health information to another provider or health plan for their health care operations.

Other Uses and Disclosures: As part of treatment, payment, and health care operations, DTC Family Health may also use or disclose your protected health information to: (1) remind you of an appointment; (2) inform you of potential treatment alternatives or options; or (3) inform you of health-related benefits or services that may be of interest to you.

USES & DISCLOSURES TO WHICH YOU MAY OBJECT

Family/Friends: DTC Family Health may disclose your protected health information to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose protected health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. If you have any objection to the use and disclosure of your protected health information in this manner, please tell us.

USES & DISCLOSURES THAT ARE REQUIRED OR PERMITTED WITHOUT YOUR AUTHORIZATION

Research: Under certain circumstances, DTC Family Health may use and disclose your protected health information to approved clinical research studies. While most clinical research studies require specific patient consent, there are some instances where a retrospective record review with no patient contact may be conducted by such researchers. For example, the research project may involve comparing the health and recovery of patients who received one medication for their medical condition to those who received a different medication for that same condition.

Regulatory Agencies: DTC Family Health may disclose your protected health information to government and certain private health oversight agencies, e.g., the Department of Public Health and Environment or the Board of Medical Examiners, for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary to monitor compliance with the requirements of government programs.

Law Enforcement/Litigation: DTC Family Health may disclose your protected health information for law enforcement purposes as required by law or in response to a court order or other process in litigation.

Public Health: As required by law, DTC Family Health may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury or disability. For example, we are required to report the existence of a communicable disease, such as acquired immune deficiency syndrome ("AIDS"), to the Department of Public Health and Environment to protect the health and well-being of the general public.

Workers' Compensation: DTC Family Health may release protected health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Military/Veterans: DTC Family Health may disclose your protected health information as required by military command authorities, if you are a member of the armed forces.

Organ Procurement Organizations: To the extent allowed by law, DTC Family Health may disclose your protected health information to organ procurement organizations and other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

As Otherwise Required or Permitted By Law: DTC Family Health will disclose your protected health information in any situation in which such disclosure is required by law (e.g., child abuse, domestic abuse) or any other use permitted under HIPAA, its amendments or regulations.

USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION:

Other than the circumstances described above, DTC Family Health will not disclose your protected health information unless you provide written authorization. An authorization is specifically required in most situations involving uses or disclosures of protected health information for marketing purpose, for the sale of protected health information, or for psychotherapy purposes. You may revoke your authorization in writing at any time except to the extent that we have already taken action in reliance upon the authorization.

YOUR RIGHTS RELATED TO YOUR HEALTH INFORMATION:

Although all records concerning your treatment obtained at DTC Family Health are the property of DTC Family Health**,** you have the following rights concerning your protected health information:

- ***Right to Confidential Communications:*** You have the right to receive confidential communications of your protected health information by alternative means or at alternative locations. For example, you may request that we contact you at work or by mail.
- ***Right to Inspect and Copy:*** You generally have the right to inspect and copy your protected health information, except as restricted by your physician or by law. Further, if we maintain your health records on an electronic health records system, you have the right to request an electronic copy of your health records.
- ***Right to Amend:*** You have the right to request an amendment or correction to your protected health information. If we agree that an amendment or correction is appropriate, we will ensure that the amendment or correction is attached to your medical record.
- ***Right to an Accounting:*** You have the right to obtain a statement of the disclosures that have been made of your protected health information other than by your authorization, other than to you and other than for the purpose of treatment, payment or routine operational purposes.
- ***Right to Request Restrictions:*** You have the right to request restrictions on certain uses and disclosures of your protected health information. If we agree, we will abide by the restrictions. Additionally, if you (or anyone on your behalf besides a health plan) pay for the care or services at issue in full out of your own pocket, we are required to comply with your request not to disclose your protected health information to a health plan, unless required by law to do so.
- ***Right to Receive a Copy of this Notice:*** You have the right to receive a paper copy of this Notice, upon request, if this Notice has been provided to you electronically.
- ***Right to Revoke Authorization:*** You have the right to revoke your authorization to use or disclose your protected health information, except to the extent that action has already been taken in reliance on your authorization.
- ***Right to Notice of Breach of Security:*** You have the right to be notified in the event of a breach of unsecured protected health information occurs.
- ***Right to Opt Out:*** You may be contacted for certain fund-raising purposes and you have the right to opt out of receiving such communications.

FOR MORE INFORMATION REGARDING HOW TO EXERCISE THESE RIGHTS: If you have questions or would like more information regarding any of the rights listed above, please contact the Compliance Officer at 303-771-3939.

IF YOU BELIEVE THAT YOUR RIGHTS HAVE BEEN VIOLATED: You may file a complaint with DTC Family Health or with the U.S. Secretary of Health and Human Services. To file a complaint with DTC Family Health, please contact the Compliance Officer at 303-771-3939. All complaints must be submitted in writing. There will be no retaliation for filing a complaint.

NOTICE EFFECTIVE DATE: This Notice is effective for all protected health information created on or after September 23, 2013.

DTC Family Health
8301 E Prentice Ave Suite 125
Greenwood Village, CO 80111
(303) 771-3939 Fax (303) 771-4949

Patient Name: _____ Date of Birth: _____ Phone #: _____

AUTHORIZATION TO RELEASE AND/OR OBTAIN PATIENT INFORMATION

I authorize the following facility: (Releasing facility)

DTC Family Health
8301 E Prentice Ave Suite 125
Greenwood Village CO 80111
(303) 771-3939 Fax (303) 771-4949

To release information to: (Receiving facility)

_____
(Facility/Provider Name)

_____
(Complete Address, City, State, Zip)

_____
(Phone #) (Fax #)

Information requested (check all that apply):

Date of service range (month/year): From:_____ To: _____

(☐) Complete Chart (☐) History and Physical (☐) Diagnostic Studies (☐) Laboratory Reports
(☐) Radiology Reports (☐) Pathology Reports (☐) Progress Notes (☐) Operative Reports
(☐) Mental Health Treatment _____ (Initial) (☐) Drug/Alcohol Treatment _____(Initial) (☐)HIV/AIDS Info_____(Initial)
(☐)Other (must specify): _____

Purpose of Release: (☐)Treatment/Diagnosis (☐)Insurance (☐)Legal (☐)Other: _____

Authorization: I herby give the releasing facility permission to disclose my protected health information as listed above. I understand that once this information is disclosed, it may no longer be protected. I understand that this authorization is voluntary. I understand that this authorization expires 90 days from the date of my signature. I understand that I can revoke this authorization in writing at any time, except to the extent that action has already been taken to comply with it. I release the above named, from liability and claims, of any nature, pertaining to the disclosure of the requested information contained in my medical records. A copy, fax or scan of this form is to be considered as valid as the original. I acknowledge that incomplete forms can not be processed and there may be a cost to copy the records.

_____ _____ _____
Signature of Patient/Guardian/Personal Representative Relationship Date

_____ (*If patient is unable to sign document for any reason*) _____
Witness Signature Date

Note: The process may take up to 30 days to provide this information. According to Colorado State Statutes, there may be a fee associated with your request, which may be required in advance. The charge is $16.50 for the first ten or fewer pages, $0.75 per page for pages 11-40, and $0.50 per page for every additional page. Actual postage or shipping costs and applicable sales tax, if any, may also be charged.

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Patient Name: _____ Date of Birth: _____ Phone #: _____

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8301 E Prentice Ave Suite 125
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Information requested (check all that apply):

Date of service range (month/year): From:_____ To: _____

(☐) Complete Chart (☐) History and Physical (☐) Diagnostic Studies (☐) Laboratory Reports
(☐) Radiology Reports (☐) Pathology Reports (☐) Progress Notes (☐) Operative Reports
(☐) Mental Health Treatment _____ (Initial) (☐) Drug/Alcohol Treatment _____(Initial) (☐)HIV/AIDS Info_____(Initial)
(☐)Other (must specify): _____

Purpose of Release: (☐)Treatment/Diagnosis (☐)Insurance (☐)Legal (☐)Other: _____

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