DTC FAMILY HEALTH & WALK-IN

Please complete **ENTIRE** form

SS#_____ Birthdate:_____

Patient Name: _____
Last Name First Name MI

Address: _____

City: _____ State: _____ Zip Code: _____

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

Sex: F M Race:_____Ethnicity:_____LanguagePreference:_____

Pharmacy _____Location_____Pharmacy Phone_____

Personal Email_____ Marital Status: _____

Emergency Contacts:

1. _____ _____
Name/relationship Phone Number
2. _____ _____
Name/relationship Phone Number

INSURANCE: **THIS SECTION MUST BE COMPLETED & SIGNED IN ORDER TO BILL INSURANCE.** If the patient is the responsible party, enter "Self" as Primary Subscriber & skip to "Name of Insurance".

Primary Subscriber: _____ Birthdate: _____

SS#_____ Relationship to Patient:_____ Phone:_____

Address:_____ City/State/Zip:_____

Name of Insurance: _____ Copay: _____

ID # :_____ Group #: _____ Employer:_____

I certify that I have insurance with _____, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize use of my signature on all insurance submissions.

_____ _____
Signature of Beneficiary, Guardian or Personal Representative Date

Name: _____ DOB:_____ Today's Date:_____

PAST MEDICAL HISTORY

☐ Alcohol/Substance Abuse issues	☐ Ear Problem/Hearing Problem	☐ Osteoporosis
☐ Allergies/Immune Problem	☐ Eye or Vision Problem	☐ Arthritis
☐ Anemia	☐ Fibromyalgia	☐ Rheumatologic Problem
☐ Anxiety/Depression/Stress	☐ Gastrointestinal Problem	☐ Sexually Transmitted Disease
☐ Asthma	☐ Headaches/Migraines	☐ Seizures/Epilepsy
☐ Blood Clots	☐ 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	_____

PAST SURGICAL HISTORY

Last Screening Colonoscopy: _____

☐ 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	_____	_____

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? _____

SOCIAL HISTORY

Marital Status: ☐Single ☐Married ☐Life Partner ☐Divorced ☐Widowed	How often do you exercise? ☐< 1x/wk ☐2-3x/wk ☐4-5x/week ☐6-7xwk What time of exercise do you do?_____
Number of Children: _____	Do you drink alcohol: ☐Yes ☐No
Occupation: _____	How often? ☐rarely ☐occasionally ☐frequently
Education: ☐High School ☐ Some College ☐ 4-year College	How many drinks/week? _____
☐ Graduate School/Professional Degree	Do you use recreational drugs? ☐Yes ☐No
Do you smoke? ☐ Yes ☐ No How much? _____	Do you have a smoke alarm at home? ☐Yes ☐No
How many years have you/did you smoked? _____	Do you always use seat belts? ☐Yes ☐No
Do you chew tobacco? ☐Yes ☐No How much? _____	Do you use sunscreen regularly? ☐Yes ☐No

FAMILY HISTORY

Illness	Family Member	Age at Onset/Death	Illness	Family Member	Age at Onset/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:_____		

IMMUNIZATIONS

Vaccine	Date Received	Vaccine	Date Received	Vaccine	Date Received
Hepatitis A		**MMR**		**Other:**	
Hepatitis B		**Pneumonia**			
Influenza		**TDaP/Tetanus**			
Meningitis		**Shingles**			

DTC Family Health

HIPPA Release Form

Name (printed) _____ Date of Birth ____/____/____

Release of Information

I authorize the release of my personal health information including the diagnosis, records, examination rendered to me, payment and claims information to:

( ) Parent(s) _____

( ) Spouse _____

( ) Child(ren) _____/_____

( ) Other _____

This **Release of Information** will remain in effect until terminated by me in writing or until I have filled out a new HIPPA form.

Messages

Please call: ( ) Home ( ) Work ( ) Cell # _____

If unable to reach me:

( ) Leave a detailed message

( ) Please leave a message asking me to return your call

( ) Other _____

Name (signed) _____ Date ____/____/____

AUTHORIZATION OF RELEASE OF PATIENT INFORMATION

DTC Family Health
8301 E Prentice Ave Suite #125
Greenwood Village, CO 80111
P:303-771-3939 F:303-771-4949

NAME: _____ DATE OF BIRTH: _____

RELEASE TO:
DTC FAMILY HEALTH
8301 E PRENTICE AVE SUITE #125
GREENWOOD VILLAGE, CO 80111

FROM: _____
ADDRESS: _____
CITY/STATE: _____ **ZIP:** _____
Phone: _____

Information Requested:

Complete Chart ( )	History/Physical ( )	Diagnostic Studies ( )
X-Rays ( )	Lab Reports ( )	Psychological studies ( )
Pathology Report ( )	Doctor notes ( )	Operative Reports ( )

Other: _____

Treatment date: _____

Purpose of Release: Treatment ( ) Insurance ( ) Legal ( ) Other: _____

I certify that this request has been made voluntarily. This authorization is subject to written revocation at any time, except to the extent that the action has already been taken to comply within. In any event, this authorization expires 90 days from the date of signature. 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.

_____ _____
Signature of patient/Guardian/Personal Representative Date

_____ _____
Witness (required if patient is unable to sign) Relationship

UNDERSTANDING MEDICAL BILLING

Thank you for choosing DTC Family Health PLLC to serve the health care needs for you and your family. We look forward to establishing a lasting relationship as your health care provider. We recognize the need for our patients to have a better understanding regarding payment for medical services and the insurance companies. As part of that relationship, we have set forth some financial information for you:

As a courtesy, we will bill your primary and secondary insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. Please remember that your health insurance policy is a contract between you and your Health Insurance Company, not between the Provider and the insurance company. In order to be able to properly bill your insurance company, **YOU MUST PRESENT A CURRENT INSURANCE CARD AT EACH VISIT**. If your insurance company requires you to pick a Primary Care Physician (PCP) and we are not the primary care physician (PCP) on your card, we will be unable to accept your insurance card. We will try to send the claim to your insurance for processing, but it will be your responsibility to present to us a card with one of our physicians listed as your primary care physician (PCP).

As a patient, it is in your best interest to know and understand your responsibility for any co-payment, deductible and/or co-insurance as determined by your contract with your insurance carrier prior to your visit. Copayments are due at the time of service. Your insurance company requires that we collect the co- payment at the time of service. This is part of your contract with the insurance company.

Not all services are covered in all insurance contracts. If your insurance plan does not cover a service or procedure, you may be liable for full payment of the bill. Any questions or complaints regarding your coverage should be directed to your insurance carrier.

There are no “free” visits. Any time you are seen by one of our providers there will be a charge for their services. There are limited exceptions to this rule (additional immunizations in a series, or suture removal, for example). If you are here for suture removal or additional immunizations, and only have the sutures removed or the immunization given, there will not be a charge for the visit. If you ask the doctor additional questions related to anything other than the suture removal or immunization (that you have a cough, or chest pain, for example) you will be charged for an office visit and the applicable co-payment, co-insurance or deductible will apply.

Your insurance company should provide an Explanation of Benefits (EOB) which shows the amount you are responsible for. Your insurance benefits determine this amount. We only bill you for what your insurance benefits do not cover.

If you do not have insurance, we will still be able to see you as a self-pay patient. At the time of your office visit, a $100.00 deposit is required. If there are any additional fees, we will send you a statement.

We are more than willing to work with you toward payment of your statement through a payment plan. In order to initiate a payment plan, we require a credit card on file for which we will charge the monthly payment that you have designated us to do so on the designated date. We have a form to fill out for keeping your credit card information. This information is kept in a secure safe until needed.

If you have any questions regarding problems with your insurance, or questions regarding your account with DTC Family Health PLLC, please call (303) 771-3939.

GLOSSARY OF TERMS

Co-insurance: The part of your bill, in addition to co-pay, that you must pay. Co-insurance is usually a percentage of the total medical bill – for example, 20 percent.

Co-payment: The cost-sharing part of your bill that is a fixed dollar amount designated by your insurance company that is your responsibility to pay at each visit (also known as “co-pay”). Co-payments can range anywhere from $5 to $50 per visit. Please be aware that there may be different co-payments for Primary Care Physicians (PCP) and Specialists.

Deductible: The amount of cost sharing that you must pay for medical services BEFORE your health insurance company starts to pay.

Responsible Party: Any patient over the age of 18, or an emancipated minor, who will be held financially responsible for all charges incurred; in short, the person who will be receiving the statements.

Subscriber: This is the person who holds the insurance. This can be different from the responsible party.

Initial Office Visit vs. Established Office Visit: We are required to follow the AMA and CMS guidelines for billing. There are two sets of codes for office visit billing – one set for new patients and one set for established patients. A new patient is defined as someone who has not received services from any provider in the practice within three years. An established patient is defined as someone who has received services from a provider in the practice within the past 3 years. If it is your first visit to our practice within 3 years, you are charged an initial office visit. This ensures that we comply with billing guidelines. During an initial office visit, we are required to perform several “behind the scenes” services, for example reviewing and updating your medical history. After your initial office visit, all subsequent visits will be billed as established office visits, as long as it has been less than 3 years since your last visit to our office.

DTC Family Health Office Information and Acknowledgement

Thank you for choosing **DTC Family Health** as your health care provider. We are committed to providing you with quality and affordable health care and to building a successful physician-patient relationship with you and your family. Below is some important information regarding our office policies. **We ask that you read this carefully**. Please ask us any questions you may have and sign in the space provided. A copy will be provided to you upon request.

PHONES: Telephones are answered **Monday through Friday from 9:00 AM to 5:00 PM**

OFFICE HOURS: Office hours are **Monday – Friday 7:30 AM – 5:00 PM and Saturday 8:00 AM – 11:00 AM**

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

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 by this practice within 48 hours after your request is received. Prescriptions will not be called in after hours or on weekends.

REFERRALS AND PRE-CERTIFICATION: Referrals and pre-certifications will not be done after hours or on weekends. Patients are required to notify us at least 72 hours in advance of an appointment requiring a referral or pre-certification to and from insurance.

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 doctor visits, medications and immunizations. 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 education material.

TEST RESULTS: Should 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 must first be reviewed by the ordering provider. These will be available on the patient portal as soon as they are reviewed. If you requested a phone call or a copy via mail, these may take longer.

RECORDS RELEASE: Records will be released to any physician upon your written request and authorization as a courtesy. **There is a charge of $10 for personal records release**.

PRIVACY PRACTICES: DTC Family Health "Notice of Privacy Practices" is available for all patients upon request. In accordance with the HIPPA Privacy Rule, all patients are required to acknowledge receipt of the Notice of Privacy Practices.

By signing this form, I acknowledge receipt of DTC Family Health's Office Policies and Notice of Privacy Practices. I understand that the Notice of Privacy Practices 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. I understand that I may request restrictions on the uses and disclosure of information for the purpose of treatment, payment or healthcare operations. I also understand that DTC Family Health is not required to agree to such requests, but that if it does agree, those restrictions are binding on DTC Family Health.

_____ _____

Patient Name Date of Birth

_____ _____

Signature Date

DTC Family Health

Acknowledgement of Financial Policies

Thank you for choosing DTC Family Health as your primary health care provider. The following financial policies are in place to help keep your account with us current and in good standing:

All co-payments are due at the time of your scheduled appointment as well as any payments for services not covered by your insurance. **It is your responsibility to make sure that all contact, billing and insurance information is up to date with us.** If we do not have the correct insurance and/or contact information we cannot bill your insurance company accurately and you will be responsible for any balance owed.

Please be advised that is it your responsibility to know your insurance benefits. If, for any reason, your insurance company does not pay for a visit, full payment is due to our office. If you have a dispute or appeal with your insurance company about their payment to us, it is you responsibility to negotiate with them for payment or reprocessing. We are glad to assist you with this dispute with documentation if needed.

If you have a balance due and our billing department does not receive payment within 90 days from the date of the first statement sent, the balance will be sent to an outside collections agency. If the balance is sent to a collection agency, you are no longer allowed to schedule appointments, request prescription refills, or receive refills and you are at risk of being permanently dismissed from our practice.

If you are uninsured, full payment is due at the time of service. **All uninsured patients must put down a $100 deposit prior to being seen for any type of appointment.** If there is a balance due after the charges for your visit have been entered, they need to be paid before you leave. You will be reimbursed in the case that your appointment does not require the full $100 charge. Any charges not available at the time that you check out will be billed to you later.

For your convenience, we accept cash, check and credit/debit cards for payment. We also accept payments on the Patient Portal. A $20 charge will be issued for all returned checks. If a check is returned to us for non-sufficient funds, we will no longer be able to accept checks for payment. You will need to pay all balances via cash or credit card going forward.

A **no show** is any failed appointment whether it is confirmed or not. This includes any wellness or routine appointment not cancelled 24 hours in advance. The same applies for any same day appointment not cancelled at least 4 hours in advance. This also includes situations where a patient shows up too late for their appointment to be seen (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 NO SHOW: A charge of $45 will be assessed for any failed appointment
- 2ND NO SHOW: The patient will receive a second $45 fee
- 3RD NO SHOW: The patient will receive a third $45 fee and will be dismissed from the practice

I, (Print Name)_____ acknowledge receipt of the above financial policies and I agree to abide by them.

_____ _____

Signature Date

DTC FAMILY HEALTH AND WALK-IN

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 and Walk-In 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 and Walk-In, 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 and Walk-in 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 and Walk-in 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 and Walk-in 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 and Walk-in 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 and Walk-in 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 and Walk-In 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 and Walk-In 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 and Walk-In 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 and Walk-In 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 and Walk-In 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 and Walk-In 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 and Walk-In 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 and Walk-In 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 and Walk-In 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 and Walk-In are the property of DTC Family Health and Walk-In, 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 Office Manager at (303) 771-3939.

IF YOU BELIEVE THAT YOUR RIGHTS HAVE BEEN VIOLATED: You may file a complaint with DTC Family Health and Walk-In or with the U.S. Secretary of Health and Human Services. To file a complaint with DTC Family Health and Walk-In, please contact the Office Manager 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.