NORTH VISTA
MEDICAL CENTER

Patient Information

Legal Name (Last, First, M.I.): _____ Prefers to be called: _____

Date of Birth: _____/_____/_____ Marital Status: _____

Preferred Language: _____ Race: _____ Ethnicity: _____

Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Cell Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

****THIS IS A REQUIRED RESPONSE: Do you have Medicaid**? YES ☐ NO ☐

Insurance Information

Subscriber Name: _____ DOB: _____

Insurance Company: _____ Member ID #: _____

Group #: _____ Effective Date: _____ Copay: _____

Claims Address: _____

Employer Name: _____

Secondary Insurance

Subscriber Name: _____ DOB: _____

Insurance Company: _____ Member ID #: _____

Group #: _____ Effective Date: _____

Claims Address: _____

Employer Name: _____

Emergency Contact

Emergency Contact Name: _____Relationship to Patient: _____

Cell Phone: _____ Work Phone: _____

Deductibles, co-payments or co-insurance and payments for services are required at the time of service. Our office will only file a claim with an insurance company with whom we have a contract with.

I authorize my insurance benefits to be paid directly to the treating physician, realizing I am responsible to pay non-covered and unauthorized services, and hereby authorize the release of pertinent medical information to the insurance carrier.

****By signing this document, I acknowledge that I do not have any other insurance than what is listed on this form <u>INCLUDING</u> Medicaid. If I do obtain any new insurance, it is my responsibility to inform the practice**

_____ _____

SIGNATURE OF PATIENT OR AUTHORIZED GUARDIAN **DATE**

NORTH VISTA MEDICAL CENTER

Personal Information

Name: _____ Date: _____DOB: _____Sex: M F T

Preferred Pharmacy:_____

YOUR MEDICAL HISTORY (Please circle which medical conditions you have had):

High Blood Pressure	Liver Disease	Kidney Problems	Other Conditions:
Heart Problems	Stomach Ulcers	Back Pain	
High Cholesterol	Diverticulitis	Arthritis	
Diabetes	Gallstones	Neurologic Problems	
Stroke	Pancreatitis	Mental Illness	
Lung Problems	Blood Clots	Depression/Anxiety	
Asthma	Anemia	Cancer (what Kind):	
Allergies	Thyroid		

Your Surgeries/Operations:_____

Current Medications (include doses):_____

_____

Medication Allergies:_____

Tobacco use?	Occupation:	Marital Status:
How much do you drink?	Recreational Drug use?	Hobbies:
Ages of Children:	Pets:	Do you exercise?:

Your Family History (Do you have any blood relatives with these problems?):

Heart Attack (who and what age): _____

Cancer (who and what age): _____

Other: _____

Have you or anyone in your family ever been threatened, injured, or abused by someone you know? _____

Vaccines/Immunizations

Pneumonia Shot (pneumovax): _____Hepatitis B: _____Tetanus: _____

Shingles: _____HPV: _____

Preventative Health Maintenance (Please indicate year of last screening- if applicable):

Mammogram/PSA: _____ Colonoscopy: _____

PAP: _____ Skin Cancer: _____

Please tell us if you have any specific goals for your health, wellness, and medical care?

_____

Are there any other important things we should know about you? _____

How did you hear about North Vista Medical Center? _____

NORTH VISTA
MEDICAL CENTER

Our focus at North Vista Medical Center is whole person care with an emphasis on prevention as well as treatment of chronic diseases. Please answer the following questions:

The Patient Health Questionnaire (PHQ-(9)

Patient Name: _____ Date of Visit: _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than Half the Days	Nearly Every Day
1.Little interest or pleasure in doing things	0	1	2	3
2.Feeling down, depresses, or hopeless	0	1	2	3

If you have answered 'not at all' to Questions 1 & 2 please stop. You do NOT have to answer Questions 3-10.

If you have responded to Questions 1 & 2 any other way than 'not at all,' please CONTINUE and answer Questions 3-10.

3.Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4.Feeling tired or having little energy	0	1	2	3
5.Poor appetite or overeating	0	1	2	3
6.Feeling bad about yourself- or that you're a failure or have let yourself or your family down	0	1	2	3
7.Trouble concentration on things, such as reading the newspaper or watching television	0	1	2	3
8.Moving or speaking so slowly that other people could have noticed. Or, the opposite- being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9.Thoughts that you would be better off dead or hurting yourself in some way	0	1	2	3

10. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

ACKNOWLEDGEMENT

OF PRIVACY PRACTICES (HIPAA)

NORTH VISTA
MEDICAL CENTER

We want to inform you of the rights you have as a patient under the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

Under HIPAA, I understand that my personal information may be used to:

- Provide and coordinate my treatment among a number of healthcare providers who may be involved in my treatment directly or indirectly.
- Obtain payment from third-party payers for my healthcare services.
- Conduct normal healthcare operations such as quality assessment and improvement activities.

I have been informed of North Vista Medical Center Notice of Privacy Practices and understand that I may request a copy of this Notice for my own use. I understand that North Vista Medical Center has the right to change the Notice of Privacy Practices and that I may contact this office 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 further understand that North Vista Medical center is not required to accept my requested restrictions, but if they are accepted then I understand that North Vista Medical Center will honor my request unless it is an emergency. I further understand that I have the right to not sign this acknowledgement in order to receive treatment at North Vista Medical Center.

Authorization to Communicate Protected Health Information- Check all the Apply:

☐ North Vista Medical Center may leave a detailed message at (phone #) _____

☐ North Vista Medical Center may speak with another person (spouse, family member) about my medical condition ☐ including / ☐ excluding information related to mental/behavioral health, substance abuse, sexually transmitted disease, HIV status, and reproductive medicine:

Name/Relation: _____ Phone #: _____

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the instructions above will be honored until revoked by me in writing. It is my responsibility to notify North Vista Medical Center should I change my phone number and/or party authorized to receive my medical information.

_____/_____ _____/_____

Signature Today's Date Patient Name DOB

_____ _____

Representative Name Relation to Patient

For administrative use only: We are unable to obtain the patient's written acknowledge of our Notice of Privacy Practices due to the following reasons:

☐ Patient declined to sign ☐ Emergency Situation ☐ Communication Barriers ☐ Other: _____

Financial Agreement

NORTH VISTA
MEDICAL CENTER

Payment in full for all charges is required at time of visit.

Insurance Filing

The patient is ultimately responsible for payment in full of their account, not the insurance company. We do, however, file medical insurance claims as a courtesy to our patients. In the event your insurance company does not pay as much as expected, the remaining balance is due and payable immediately by you, the patient.

Assignment of Insurance Benefits

I/we hereby assign directly to North Vista Medical Center insurance benefits otherwise payable to me/us. I/we hereby authorize the release of any information relating to any claims. I/we understand I/we are financially responsible for charges not paid by this assignment.

Delinquent Accounts

All delinquent accounts (30 days or older) are subjected to reasonable service charges and/or legal interest rates. North Vista Medical Center requires that you have a credit card on file with us so that if your account is 60 days past due, we will process your credit card for the outstanding balance.

Collection Proceedings

In the event your account is turned over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any collection costs and/or attorney fees, in addition to the balanced owed. Any account turned over to a collection agency forfeits any past special fees and/or discounts. Such special fees and/or discounts will be reversed and you will be responsible for payment of regular fee for procedures at the time of service.

Failed Appointments

Failed appointments (less than 24 hours' notice) are a significant contributor to raising health care costs. Individuals who fail to show for a confirmed appointment will be assessed a fee.

I have completely read and understand the contents of this agreement. I agree to comply with all policies.

X_____ **X**_____

Name (Print) **Date**

X_____

Signature of Patient or Responsible Party

Credit Card AuthorizationREQUIRED**

NORTH VISTA
MEDICAL CENTER

I authorize North Vista Medical Center to keep my credit/debit card on file. I understand the card will be used if my account has been delinquent for more than 60 days and a payment arrangement has not been set up.

Patient's Name		
Cardholder's Name		Phone Number
City	State	Zip Code
____ Visa ____MC ____Discover ____American Express		
Credit Card Number	Expiration Date	Security Code

_____ _____

Cardholder's Signature Date

NORTH VISTA
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Same Day/No-Show Policy

Patient's Name: _____ DOB: _____

If you need to cancel an appointment, you must give us at least 24 hours' notice. If you cancel on the same day as your appointment or you do not appear at all for your appointment, the charges are as follows:

1st time- $50

2nd time- $100

3rd time- $150

4th time- $200 and termination from practice

**Please note: if you are more than 5 minutes late for your appointment you will need to reschedule, and above charges will apply.

By signing this, you acknowledge that you fully understand the same day/no-show policy and that you are financially responsible for all fees incurred.

Signature: _____ Date: _____

NORTH VISTA
MEDICAL CENTER

Patient Name: _____ Date of Birth: _____

Organization to release information:

_____

_____

_____

_____

Organization to receive information:

North Vista Medical Center

4943 CO Hwy 52 Ste 240

Dacono, CO 80514

PH: 303-501-2600; FX: 877-764-4622

*CD or thumb drives of medical records will not be accepted

*Per Colorado Law, C.R.S. 25-1-801, your provider will charge the following fees for sending medical records: For the first 10 pages: $18.53, for the next 30 pages (pages 11-40): $0.85 per page, each additional page after 40: $0.57 per page, plus any actual postage costs if copies are mailed to you.

Records to be released

☐ Last 3 years

☐ Other _____

Reason copies are being requested

☐ Moving

☐ Changing Doctors

☐ Consultation

☐ Other _____

_____ _____

Signature of Patient (Guardian) **Date**

I hereby authorize North Vista Medical Center to use or disclose my personal health information as detailed above. I understand this authorization is voluntary.