Patient Name___________________________ **Date of Birth**________**Todays Date**__________

Consent for Medical Care
I hereby consent to medical care for myself or as the guardian of the above named patient at Peak Health Family Medicine. I authorize my medical provider to provide the treatment deemed necessary for the benefit of the patient including but not limited to diagnostic testing, medications, and/or other therapeutic modalities. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of treatments or examinations. I have read this consent and voluntarily certify that I understand and agree to its content.

Authorization to Release Medical Information and Assign Insurance Benefits
I hereby give authorization for payment of insurance benefits to be made directly to Peak Health Family Medicine, and any assisting medical providers for services rendered. Peak Health Family Medicine and its medical providers are authorized to release any medical information required in the processing of applications for financial coverage. I permit a copy of this authorization to be used in place of the original. I certify that the information given by me in applying for payment is correct. I authorize benefits be made in my behalf.

I guarantee payment of all charges on this patient/guarantor account and assign to the medical providers any and all benefits relating to this patient/guarantor account whether insured or self-funded. I further assign the proceeds of all claims, resulting from or relating to the financial liability of this account made by a third party: any person, employer or insurance company on behalf of this account, unless the account is paid in full upon discharge. If eligible for Medicare, I request Medicare services and benefits. I understand I am responsible for any charges not covered by insurance or other form of health benefit.

<u>It is my responsibility, and not Peak Health Family Medicine, to be knowledgeable of my medical insurance benefits, deductibles, copays and coinsurance.</u>

Personal Medical Records requested for by patients for personal use will be charged a fee. Medical Records requested by another healthcare facility or provider are released free of charge once release consent is signed.

No Show Fee/Showing up Late
Please give us 24 hours advanced notice if you cannot make it to your scheduled appointment. If you do not inform us of your inability to come to your scheduled appointment, we will charge a $50.00 no-show fee for a 20 minute scheduled appointment and a $100.00 no-show fee for a 40 minute scheduled appointment. In addition, I understand that if I show up late to my appointment, I may have to reschedule to the next available appointment because we value your time as well as the rest of our patients' time.

Prescription Medications
I will give Peak Health Family Medicine a minimum of 48 business hours to refill Rx medication. I understand I should call my pharmacy for all refill request. I recognize it is my responsibility to call my pharmacy to discontinue auto re-fill and it is not the responsibility of Peak Health Family Medicine.

Phone Calls
We encourage patients to call with questions, but please understand we do not treat medical conditions over the phone since this is medically inappropriate and can result in misdiagnosis and/or inadequate care. Therefore, we prefer you schedule an appointment with a medical provider for proper care and treatment. For after-hours medical emergencies, we do have an on call medical provider who can determine whether or not you need to go to Emergency Department or wait to be seen in clinic.

Personal Liability
I understand that I am personally responsible for the charges resulting from care and treatment. Any payment received by Peak Health Family Medicine as a result of the above Authorization for Release of Medical Information and Assignment of Insurance Benefits will be credited toward my patient/guarantor account and I will be personally liable for any and all remaining balances on the account.

I further understand that if the third party payor denies benefits or fails to make payment within 30 days of submission, I will be personally responsible for the entire balance on the account.

Privacy Notice
I have been provided the opportunity to receive a copy of the “Notice of Privacy Practices” that explains when, where, and why my confidential health information may be used or shared.

I agree that a photocopy or digital image of this agreement shall be as valid as the original.

Print Name:________________________________ **Date of Birth:**____________

Signature: _________________________________ **Date:** ______________

Email Address:____________________________________
Preferred Pharmacy: ___________________________
Pharmacy Address:_____________________________
Pharmacy Phone: ______________________________

Medical Information Release Form
(HIPAA Release Form)

Patient Name: ________________________________ DOB ______________

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:
[ ] Spouse____ Phone:________________________
[ ] Child(ren)______________________________________Phone:________________________
[ ] Other____Phone:_______________________
[ ] Information is not to be released to anyone.
This Release of Information will remain in effect until terminated by me in writing.

Notice of Privacy Practices

A copy of Peak Health Family Medicine's (PHFM) Notice of Privacy Practices (NPP) is available to you if requested.

Please check one of the following boxes below:
[ ]I have been provided a copy of PHFM's NPP today, upon my request (please see our receptionist and he/she will promptly provide you with a copy)
[ ]I will not take a copy of PHFM's NPP today but am aware that it is posted clearly at the front desk and online for review, and is available to me if I request a copy in the future.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:__________________
If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] ____
It is best to reach me: (day)___________________ between (time)_________

Is it okay to email or send a text message as a reminder for any future appointments?
Yes:____
No: ____

Email: _____________________________________

Signature: _________________________________ Date: ______________

Patient Medical History Form

NAME: ________________________________Date_________ **AGE:** ______ **DATE OF BIRTH:** _______
RACE: ______________________ **ETHNICITY:** ___________ **PREFERRED LANGUAGE:** ______________
REASON FOR TODAY'S VISIT:

____

ALLERGIES and/or REACTIONS TO MEDICINES:

____

CURRENT MEDICATIONS: Prescription, non-prescription medicines, and vitamins.
Medication Dose (e.g. mg/pill) how many times/day when started? Please check the Aspirin.

____

____

ASPIRIN USAGE: Daily_____Dosage: 81mg or 325mg?________Occasional______Never____
PERSONAL MEDICAL HISTORY: Do you or have you had any of these problems?

Yes	Date	MEDICAL PROBLEM	Yes	Date	MEDICAL PROBLEM
		High Blood Pressure			Kidney Stones
		High Cholesterol			Urinary Tract Infection (recurrent)
		Diabetes Type 1			Fracture which bones? _____________________
		Diabetes Type 2			Arthritis Rheumatoid? Yes/No
		Irregular Heartbeat			Gout
		Heart Attack			Breast Disease (non-cancerous)
		Heart Murmur			Thyroid Disease type?__________________
		Congestive Heart Failure			STDs type? _____________________________
		Stroke			HIV
		Asthma			Blood Clot/Pulmonary Embolus
		Emphysema/COPD			Blood Transfusion
		Pneumonia			Anemia
		Sleep Apnea (date of last sleep study____________) CPAP / BiPAP / O2 (circle)			Bleeding Disorder type? ________________
		Stomach Ulcer			Allergies Seasonal/Year-Round
		Gall Stones			Skin Disease type?______________________
		Liver Disease/Hepatitis Type?___			Cancer, Type ________________________
		Hemorrhoids			Dementia
		Ulcerative Colitis/Crohn's			Depression/Anxiety (circle applicable)
		GERD/Heartburn			Insomnia
		Chronic Pain location_____________			Other______________________________

Specialists: Please list any specialists and their office information

____

____

____

NAME: ____**DATE OF BIRTH:** __________

FAMILY MEDICAL HISTORY (List Medical Conditions ex: diabetes, high blood pressure, etc.):

Father: ___________________________________ Mother: ____________________________________

Paternal Grandfather: _______________________ Maternal Grandfather: ________________________

Paternal Grandmother: ______________________ Maternal Grandmother: _______________________

Brother: __________________________________ Sister: _____________________________________

LIST ANY SURGERIES: (reason and date)

____

____

____

LIST ANY HOSPITALIZATIONS: (reason and date):

____

____

Do you have advanced directives ("living will")? Yes / No (circle)

WOMEN'S GYNECOLOGICAL HISTORY:

Contraceptive Method:_____________________ Age of first period:_____________

# of Pregnancies _____ # of Deliveries ______ # of Abortions _____ # of Miscarriages______

Menopausal: No / Yes . If yes, what age? ________________

Last PAP smear __________ History of Abnormal PAP smear? Yes / No

Last mammogram __________ History of Abnormal mammogram? Yes / No

HEALTH MAINTENANCE: When were your most recent screening tests?

PSA (Prostate cancer screen) (date) _____________ Results? _________________

Colonoscopy (date) ________ Results? ________

CIMT (Carotid Ultrasound) (date) ____________ Results? ______________

AAA (Abdominal Aorta Aneurysm ultra sound) (date) ____________ Results? ______________

IMMUNIZATIONS: Please indicate the date of your most recent:

Tetanus(date) ___________ Influenza(date) ___________ Zostavax (date) __________

Pneumovax (Pneumonia) (date) __________ Prevnar13 (Pneumonia) (date) __________

SOCIAL HISTORY: Tobacco Use (please circle one): Never Cigarettes Quit Date __________

Current Smoker: packs/day ______ # of years:______ Interested in quitting? Yes / No

Other Tobacco: *Pipe* *Cigar* *Chew*

Alcohol Use: Do you drink alcohol? No / Yes, # of drinks/week ______

Is alcohol use a concern for you or others? No / Yes

Illicit Drug use? No / Yes, Name/s of Drugs____

SOCIOECONOMICS:

Occupation: _________________________ Employer: ____________________________________

Marital Status: S M D W Other: _________________Spouse/Partner's name: _________________

Children(s) Name(s):____

EXERCISE: Do you exercise regularly? No / Yes, What kind of Exercise?

____

How long? (minutes) __________ How often? ______________________________

Patient Name (First, Middle, Last):	DOB:
Address:	Phone:

This Authorization applies to the following Information:

[ ] **All Information**; I understand that the information may contain psychiatric/psychological, alcohol/drug abuse, and/or AIDS/HIV information and I expressly consent to the release of the information.

[ ] **Only** the following records or types of Information:

[ ] Office Visits	[ ] Labs	[ ] ETOH/substance abuse record
[ ] HIV/STD records	[ ] Radiology	[ ] Other (Please specify)
[ ] Mental Health record	[ ] EKG, Spirometry	_________________________

Treatment Dates: from (month/date/year): ____/____/_____ to _____/____/_____

Previous Medical Provider and Address:	Phone: Fax:
Disclose Information to:	
Peak Health Family Medicine **10901 W. Toller Drive Ste 100** **Littleton, CO 80127**	Phone: 303-973-3529 Fax: 303-973-3549

Purpose of the release:

[ ] Change of Primary Care Provider [ ] **Other** *(Please specify):*__________________________

This authorization ends: [ ] on (date) __________ If no date is specified, this authorization will end after 180 days from date of signature.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, or treatment for alcohol and drug abuse. I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or obtain copies of the information to be used or disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact Peak Health Family Medicine.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by Peak Health Family Medicine based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

______________________________ ________________________________ _______

Signature of Patient/Legal Guardian **Printed Name** of Patient/Legal Guardian Date