Heritage Family Medicine
1006 Robertson St
Fort Collins, CO 80524

New Patient Information

Last Name(Legal): First: Middle

Nickname: DOB: Gender: SSN:

Marital Status: Language: Race: Ethnicity:

Phone (H): (Cell) (w) (w) ext

Address:

City: State: Zip:

(Billing address if different from above):

City: State: Zip:

Heritage Family Medicine believes in the practice of preventative medicine i.e. regular check-ups, promoting healthy habits and a focus on disease prevention. We do send clinical reminders such as, but not limited to; annual physical, A1C, blood pressure checks etc., based on your current health care needs.

***Would you like to receive our E-newsletter? Yes/No Email address (we will not give out to any third parties):**

This E-Newsletter includes seasonal health news and tips to help keep you informed of the most current health care topics. This E-Newsletter is sent out Monthly.

How did you hear about us? Please circle one:

Website/ Dex-online/ Driving by/ Friend/ Family/ Insurance Company/
Referral Doctor, who_____ Medical organization, who_____

Other (please specify)_____

Emergency Contact:

Last Name(legal): First: Middle:

Emergency phone (1): Emergency Phone (2):

Relationship: Address:

City: State: Zip code:

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Employment/Billing/Insurance

Patient Employer Name: _____ Full time/ Part time _____ Job Title: _____

College Student: Yes/ No

School Name: _____ Full time/ Part time _____

Primary Insurance company name: _____

ID#: _____ Group# _____

Guarantor: (The person who holds the insurance policy)
Last Name:_____ First:_____ Middle:_____

DOB:_____ Gender_____

Employer:_____Phone # (H)_____ (C)_____

Address_____

City_____ State_____ Zip Code_____

Relationship to policy holder (circle one): Self/ Spouse/ Parent and-or Guardian

other (specify)_____

Secondary Insurance company name (if any): _____

ID# _____ Group# _____

Guarantor: (The person who holds the insurance policy)
Last Name:_____ First:_____ Middle:_____

DOB:_____ Gender_____

Employer:_____Phone # (H)_____ (C)_____

Address_____

City_____ State_____ Zip Code_____

Relationship to policy holder (circle one): Self/ Spouse/ Parent and-or Guardian

other (specify)_____

If this is work or auto related injury please notify Receptionist.

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Insurance Information/ Billing Authorization

Our billing process for every visit is as follows:

- **Please provide your most current insurance card at each visit**, If your insurance is an HMO this requires a designated PCP (Primary Care Physician) it is your responsibility to provide this information to your insurance carrier before seeing the care provider. If the claim is denied due to wrong PCP information, you will be responsible for any charges.

- Your visit is coded using a standard coding procedure. If you are being seen for preventative care, your insurance will be billed as such unless we are informed of any special circumstances with your insurance coverage or the visit warrants special coding.

- **Copayments and Deductible** payments are required at the time of service. Financial arrangements for self pay accounts must be made in advance.

- **Insurance claims** are billed twice a week and take approximately four weeks to receive payment or denial. Any secondary insurance coverage will be billed at that time.

- **Any remaining balance** will be billed to the patient or guardian. The remaining balance is due upon receipt of the statement. Please understand we bill the insurance company as a service to our patients. The financial responsibility ultimately lies with the patient or guarantor.

- **Any balance carried over** thirty days may be subject to late fees and or collection fees.

- **Please be aware** that many diagnostic tests (labs, etc.) are sent to outside entities and will be billed separately. If you have questions regarding which test(s) are done in house or which are sent out, it is your responsibility to ask.

- **No Show Policy/Cancellation –** We require 24 hours notice for any canceled appointment, if proper notice is not received, responsible party will be assessed a $50.00 charge; HFM understands that emergencies do arise and will waive the No Show fee on the first occurrence; however, on the second incident our No Show fee will be assessed.

- **Insurance Billing Authorization (Medicare- LIFETIME AUTHORIZATION):** I authorize that payment of all medical benefits be made either to me or on my behalf to physician and or provider of Heritage Family Medicine for any service furnished to me by that physician or provider. I authorize release to the Above Said Insurance Company Services and its agents any medical information about me needed to determine the payments for related services. **Medicare Authorization period**: (enter **Today's date**) _____ to 12-31-2034.

- **AUTHORIZATION OF FINANCIAL RESPONSIBILITY:** By signing, I verify the above statements are true and accurate. I agree to pay all medical charges incurred by the above listed patient. I further understand that these charges are my responsibility regardless of insurance coverage.

I have read and understand the insurance billing policies and procedures for Heritage Family Medicine.

Patient/Guardian Signature: _____

Print Name: _____ Date _____

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Privacy (HIPAA)
Patient Consent for Use and Disclosure of Protected Health Information.

I hereby give consent for Heritage Family Medicine to use and disclose protected health information (PHI) about me to carry out treatment, payment and health operations (TPO). The Notice of Privacy Practices provided by Heritage Family Medicine describes such uses and disclosures more completely. Heritage Family Medicine endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. However, you may choose to opt-out of participation in the <CORHIO> HIE, or cancel an opt-out choice, at any time. Please see page 5 of this packet, or speak to our receptionist with any questions.

I have the right to review the Notice of Privacy Practice prior to signing this consent; Heritage Family Medicine reserves the right to revise its Notice of Privacy at any time. A revised Notice of Privacy Practices may be obtained by written request to our Privacy Officer, and is posted in our reception area.

With this consent Heritage Family Medicine may contact my home or alternative location (listed on the medical information and sharing form, page 4) in reference to any items that may assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory test results, among others.

With this consent Heritage Family Medicine may mail to my home or other alternative location any items that assist the practice in carrying out TPO. With this consent E-Mail or faxes may be sent to my home or other alternative location containing any item that assists the practice in carrying out TPO. I have the right to request that Heritage Family Medicine restrict how it uses and discloses my PHI to carry out TPO. The practice is not required to agree to my request, but if it does, it is bound by this agreement.

I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent, if I do not sign this consent, or later revoke it; Heritage Family Medicine may decline to provide treatment for me.

By signing this form, I am consenting to allow Heritage Family Medicine to use and disclose my PHI to carry out TPO and participate in participation in the <CORHIO> HIE (Health Information Exchange).

Printed Name of Patient/ Legal Guardian _____

I have been given an opportunity to Review Heritage Family Medicine's Privacy Practices.

Signature _____ Date _____

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HIPAA/Medical Information Sharing

We will call you for appointment reminders and any other pertinent health information. Please list appropriate numbers to call and leave messages on if necessary.

Telephone

- Home_____
- Work_____
- Cell_____

Per Privacy Regulations I authorize Heritage Family Medicine to share any and all medical information concerning my medical care with those individuals listed below (Checked Boxes only).

- ☐ Detailed message on answering machine
- ☐ Spouse_____
- ☐ Both Parents (Names)_____
- ☐ One Parent only (Name)_____
- ☐ Other (list full name) _____

Any requested limitations or exclusions on sharing your medical information?_____

_____

_____

Patient Name: _____

Signature _____ Date _____

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Heritage Family Medicine Health History

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

Patient Name: _____ Birth date: _____

Past Medical History: Have you ever had the following? (Circle "yes " or "no", leave blank if uncertain.)

Measles	no	yes	Anemia	no	yes	High blood pressure	no	yes
Mumps	no	yes	Bladder infections	no	yes	Low blood pressure	no	yes
Chickenpox	no	yes	Epilepsy	no	yes	Hemorrhoids	no	yes
Whooping cough	no	yes	Migraines	no	yes	Date of last chest x-ray		
Scarlet fever	no	yes	Tuberculosis	no	yes	Asthma	no	yes
Diphtheria	no	yes	Diabetes	no	yes	Hives/eczema	no	yes
Smallpox	no	yes	Cancer	no	yes	AIDS or HIV +	no	yes
Pneumonia	no	yes	Polio	no	yes	Infectious Mono	no	yes
Rheumatic fever	no	yes	Glaucoma	no	yes	Bronchitis	no	yes
Heart disease	no	yes	Hernia	no	yes	Mitral Valve Prolapse	no	yes
Arthritis	no	yes	Blood/plasma	no	yes	Stroke	no	yes
Venereal disease	no	yes	Back trouble	no	yes	Hepatitis	no	yes
Ulcer	no	Yes	Kidney Disease	no	yes	Thyroid Disease	no	yes
Bleeding	no	no	Any other disease? (please list)					

Previous Surgeries/hospitalizations/serious illness? When where

_____ _____ _____

_____ _____ _____

Medications (Include non-prescription)**:** _____

_____

_____

ALLERGIES: _____

Patient Social History (please circle answer)**:**

Marital Status: single married separated divorced widowed

Use of Alcohol: never rarely moderate daily

Use of Tobacco: never previously but quit:(date) current packs/day:

Use of Drugs: never If so, type and frequency

Family History:

	Age	Diseases	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Brother	_____	_____	_____
Brother	_____	_____	_____
Sister	_____	_____	_____
Sister	_____	_____	_____
Child	_____	_____	_____
Child	_____	_____	_____