

SOUTH POINTE HEALTHCARE

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST – FIRST—MIDDLE INITIAL)		ADDRESS		CITY,STATE
ZIP	PREFERRED PHONE		SECONDARY PHONE	
PATIENT DATE OF BIRTH	PATIENT SSN	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other	
PATIENT EMPLOYER NAME		ETHNICITY / RACE	EMAIL	

HOW DID YOU HEAR ABOUT SOUTH POINTE HEALTHCARE?

INSURED / RESPONSIBLE PARTY INFORMATION

NAME (FIRST – LAST – MIDDLE INITIAL)	ADDRESS (if different from patient)	RELATION TO PATIENT: <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> GUARDIAN	
PREFERRED PHONE	EMAIL (if different)	SSN	BIRTH DATE

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	ADDRESS (STREET – CITY- STATE – ZIP)	PHONE
GROUP NUMBER	ID NUMBER	EFFECTIVE DATES
SECONDARY INSURANCE NAME	ADDRESS (STREET – CITY- STATE – ZIP)	PHONE
GROUP NUMBER	ID NUMBER	EFFECTIVE DATES

EMERGENCY CONTACT

CONTACT NAME	RELATIONSHIP	PHONE NUMBER
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ASSIGNMENT / RELEASE AND FINANCIAL RESPONSIBILITY: I hereby authorize my insurance benefits to be paid directly to the physician and that I am financially responsible for non-covered services. I authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees associated with my account /s.

If I am an **un-insured, self-pay patient**, I agree to pay the \$100 co-pay along with any services rendered the date of visit at a discounted rate set by South Pointe Healthcare. All services must be paid in **FULL** at the time of visit. If for any reason, services are billed after the initial visit, they will be billed at the full rate mandated by the Medicare Fee Schedule and will have **30 days** to pay the account in full. I will be responsible for obtaining this information and I agree that if I am unable to pay for any services rendered in a timely manner that is agreed upon with South Pointe Healthcare, I will be discharged for non-compliance with payment.

PLEASE READ

PATIENT SIGNATURE	DATE
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HIPPA Policy

SOUTH POINTE HEALTHCARE

150 OLD LARAMIE TRAIL SUITE 210
LAFAYETTE, CO 80026
303-665-8444

Medical Information Release

(PLEASE CHECK ONE)

- I **do not** authorize South Pointe Healthcare to release my Medical Information
- I authorize South Pointe Healthcare to release my Medical Information (e.g. lab results, appointment times) to any of following persons listed below. This will remain in effect until otherwise notified.

Contacts:

Relationship to Patient:

_____	_____
_____	_____
_____	_____

Name of Patient (PLEASE PRINT)

Date

Signature/guardian's signature if patient is a minor

Name of guardian

SOUTH POINTE HEALTHCARE

Cancellation / No Show Policy for Appointments

Effective January 1, 2017

We understand that there are times when you must miss an appointment due to an emergency, or obligations for work or family. However, when you do not call to cancel your appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel or no show and we are unable to schedule you for a visit, due to a seemingly “full” appointment book.

If your appointment is not cancelled at least 24 hours in advance, you will be charged a \$50.00 fee; this will not be covered by your insurance company.

We understand that delays can happen, however we must try to keep the other patients and provider on time. We ask you to please arrive **10-15 minutes** prior to your appointment. Although we will do our best to accommodate you, if you are **one minute** or more past your appointment time, you may be rescheduled for another date. If you are more than 15 minutes past your appointment without prior notice, you will automatically be rescheduled and charged the No-Show fee. **After 3 missed appointments (failure to show or call), you may be discharged from care as a direct result of being “noncompliant to treatment.”**

We value our patient/doctor relationships and will do everything we can to accommodate you. Your communication and compliancy are not only very much appreciated, but will help us to help you and others achieve a positive outcome.

Please sign below acknowledging you have read and understand the above statement.

Print Patient Name

Signature of Patient or Guardian

Date

SOUTH POINT HEALTHCARE

Notice of Privacy Practices

This notice describes how health information about you as a patient may be used and disclosed and how you can gain access to your health information. Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize these laws are complicated but we must provide you with the following important information.

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order, or if required by a law enforcement official
3. When necessary to reduce or prevent a serious threat to your health and safety of you or another individual.
4. If you are a member of U.S. or foreign military forces (including veterans) and if required by authorities
5. To federal officials for intelligence and national security activities authorized by law.
6. To correctional institution or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.
7. For Worker's Compensation and similar programs.

Your rights regarding your health information:

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location.
2. You can request a restriction in our use, or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals in your care or the payment of your care. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records. You must submit your request in writing.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. Your request must be made in writing and include a reason that supports your request for amendment.
5. You are entitled to receive a copy of this Notice of Privacy Practices and may ask for a copy at any time.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing and you will not be penalized for filing a complaint.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. If you have any questions regarding this notice or health information privacy policies, please contact us.

By signing below, you acknowledge and understand the above practices and that you have the right to receive a copy at any time.

Printed Name: _____

Signature: _____ Date: _____

*******PREFERRED PHARMACY AND LOCATION**

MEDICATIONS: List any medications you are currently taking (including OTC meds) PLEASE PRINT LEGIBLY

MEDICATION	DOSAGE	TIMES PER DAY

ALLERGIES

REACTIONS

FAMILY HISTORY (circle all that apply)

MOTHER	Arthritis	Cancer	Diabetes	Heart Disease	Hypertension	Stroke	Thyroid Disorder
FATHER	Arthritis	Cancer	Diabetes	Heart Disease	Hypertension	Stroke	Thyroid Disorder
SIBLINGS	Arthritis	Cancer	Diabetes	Heart Disease	Hypertension	Stroke	Thyroid Disorder

SOCIAL HISTORY

MARITAL STATUS: Single Married Divorced

Do you drink alcohol? NO YES (X's _____ a day, week, month, year)

Do you drink Caffeine? NO YES (X's _____ a day, week, month, year)

Do you use illicit drugs? NO YES (Type _____, How often _____)

Do you use tobacco? NO YES (Smoke or Chew X's _____ a day, week, month, year)

Past Surgical History: Please list any hospitalizations, pregnancy, surgeries, fractures or major illnesses you have had.

TYPE	DATE AND YEAR

MEDICAL HISTORY / ONGOING CONDITIONS: Do you currently have or ever had any of the following?

- | | | | |
|--------------------------------------------------|---------------------------------------------------|---------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> No issues | <input type="checkbox"/> chest pain | <input type="checkbox"/> hypertension | <input type="checkbox"/> organ injury |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> congestive heart failure | <input type="checkbox"/> hypogonadism male | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> chronic fatigue syndrome | <input type="checkbox"/> hypothyroidism | <input type="checkbox"/> pulmonary embolism |
| <input type="checkbox"/> arthritis conditions | <input type="checkbox"/> depression | <input type="checkbox"/> infection problems | <input type="checkbox"/> blood clots |
| <input type="checkbox"/> asthma | <input type="checkbox"/> diabetes | <input type="checkbox"/> insomnia | <input type="checkbox"/> seizure disorders |
| <input type="checkbox"/> arterial fibrillation | <input type="checkbox"/> drug/alcohol abuse | <input type="checkbox"/> irritable bowel syndrome | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> bleeding problems | <input type="checkbox"/> erectile dysfunction | <input type="checkbox"/> kidney problems | <input type="checkbox"/> sinus conditions |
| <input type="checkbox"/> coronary artery disease | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> menopause | <input type="checkbox"/> stroke |
| <input type="checkbox"/> cancer | <input type="checkbox"/> Gerd | <input type="checkbox"/> migraines/headaches | <input type="checkbox"/> tremors |
| <input type="checkbox"/> cardiac arrest | <input type="checkbox"/> heart disease | <input type="checkbox"/> neuropathy | <input type="checkbox"/> wheat allergy |
| <input type="checkbox"/> celiac disease | <input type="checkbox"/> high cholesterol | <input type="checkbox"/> onychomycosis | <input type="checkbox"/> other _____ |

Preventative Services Please list dates of last:

Annual Physical _____	Colonoscopy _____	Cardiac Testing _____
Mammogram _____	Sigmoidoscopy _____	Flu Shot _____
Pap _____	Dexa Scan _____	
PSA _____	EKG _____	

SYMPTOMS: check symptoms you currently have or have had in the past year. Leave blank if not.

Your health care provider will review this form with you

Constitutional

- Chills
- Fever
- Feeling poorly
- Feeling tired
- Weight gain
- Weight loss

Respiratory

- Cough
- Wheezing
- Shortness of breath
- Trouble breathing
- w/exercise
- Trouble breathing
- w/laying flat
- Snoring

Skin

- Skin lesions
- Rash
- Itching
- Change in a mole
- Dry skin
- Unusual growth

Heme/Lymph

- Easy bleeding
- Easy bruising
- Swollen glands

Eyes

- Eye pain
- Red eyes
- Eyesight problems
- Discharge from eyes
- Dry eyes
- Eyes itch

Gastrointestinal

- Abdominal pain
- Nausea/Vomiting
- Constipation
- Diarrhea
- Heartburn
- Blood in stool

Neurological

- Numbness
- Weakness
- Dizziness
- Fainting
- Confusion
- Headache

ENT

- Ear ache
- Loss of hearing
- Nosebleeds
- Nasal discharge
- Sore throat
- Hoarseness

Genitourinary

- Pain w/urination
- Incontinence
- Urination at night
- Genital lesions

Psychiatric

- Suicidal
- Sleep Disturbances
- Anxiety
- Depression
- Change in personality
- Emotional problems

Cardiovascular

- Chest pain
- Palpitations
- Fast pulse
- Slow pulse
- Leg pain w/exercise
- Leg swelling

Musculoskeletal

- Pains in joints
- Neck pain
- Joint swelling
- Joint stiffness
- Muscle aches
- Limb swelling Endocrine
- Droopy eyelids
- Hot flashes
- Muscle weakness
- Change in the voice
- Weakness

WOMEN Only

- Breast lump
- Abnormal pap smear
- Irregular bleeding
- Severe cramps
- Pelvic pain
- Painful intercourse
- Vaginal discharge
- Nipple discharge

MEN Only

- Erection difficulties
- Lump in testicle
- Sore on penis
- Discharge from penis