Pavilion Family Medicine
1804 E Pavilion Place, Montrose, CO 81401
Phone 970-249-6670 Fax 855-780-5041

New Patient Application

Date: _____

Name: _____ Date of Birth: _____
Address: _____City: _____Zip: _____
Phone Number: _____ Work Phone: _____
Cell Number: _____ Which number do you prefer: _____
Sex: _____ Marital Status: ___ Single ____ Married ____ Divorced ____ Widowed ____ Separated
Social Security Number: _____ Email: _____
Race: _____Ethnicity: _____Language(s): _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____
Phone Number: _____Work Number: _____ Cell Number: _____

Insurance Information

Responsible Party: _____Date of Birth: _____
Relationship: _____Social Security Number: _____
Address: _____City: _____ Zip: _____
Phone Number: _____
Primary Insurance: _____ Phone: _____
Primary Insured Name: _____ Birthdate: _____
Policy: _____ Group: _____
Secondary Insurance: _____ Phone: _____
Secondary Insured Name: _____Birthdate: _____
Policy: _____ Group: _____

Medications

Preferred Pharmacy:_____
Address:_____ Phone:_____

PFM Providers Will Not Provide Chronic Pain Medication Such As Prescription Opiate

If you are seeing a specialist for your pain, please list:

Specialist Name: _____
Medical issue/s being treated: _____

Current Pain Medications

Pain Medication	Dose	Frequency

Other Current Medications

Medication	Dose	Frequency

Allergies to Medications

Medication	Reaction

Medical History

Problem	**Y/N**	**When**	**Problem**	**Y/N**	**When**
ADD or ADHD			GERD		
Allergies			GI problems		
Anemia			Gout		
Anesthesia problems			Headaches/Migraine		
Anxiety			Heart problems		
Asthma			Hepatitis		
Bed Wetting			High Blood Pressure		
Bladder problem			High Cholesterol		
Blood diseases			Hypothyroidism		
Breast Cancer			Hyperthyroidism		
Breast Problems			Kidney problem		
Cancer			Kidney Stones		
Chicken Pox			Liver Disease		
Chronic Pain			Lung Disease		
Colon Cancer			Muscle/Joint/Bone problem		
Congenital anomalies			Osteoarthritis		
Constipation			Osteopenia/Osteoporosis		
COPD			Psychiatric illness		
Coronary Artery Disease			Pulmonary Embolism/blood clot		
Depression			Rheumatoid Arthritis		
Developmental/Behavioral problems			Scoliosis		
Diabetes			Seizure/Epilepsy		
Diverticulitis			Serious injuries		
Ear/Hearing problems			Stroke		
Eczema/Hives/Skin problem			Tuberculosis		
Endometriosis			Frequent Urinary Tract Infections		
Fibromyalgia			Varicose Veins		

Past Surgical History

Procedure	Date	Surgeon/Hospital

Family History

Relative	Problem	Died at Age
Paternal Grandfather Paternal Grandmother		
Maternal Grandfather Maternal Grandmother		
Father		
Mother		
Sibling		
Children		
Other		

Health Maintenance

Females:

Are you still getting pap smears: Y/N Date of last pap smear: _____
Have you ever had an abnormal one: Y/N If so, what was done: _____
Are you getting mammograms: Y/N Date of mammogram: _____
Have you ever had an abnormal one: Y/N If so, what was done about it: _____
Have you had a bone density screening done? Y/N When and what was the result: _____
Have you ever had a colonoscopy: Y/N When and what was the result: _____

Males:

Have you had a colonoscopy: Y/N When and what was the result: _____
Have you ever had a PSA (prostate) screening done: Y/N When and what was the result: _____

***Social History*:** (We recognize that these questions are sensitive. However, completing this section will help us better care for you.)

How far did you go in school: _____ Do you have any children/how many: _____
What is your sexual orientation: _____ Are you currently sexually active: _____
Are you using any type of birth control: _____ Are you safe in current relationship: _____

Do you have difficulty doing any of the following:

Concentrating, remembering, or making decisions Y/N Doing errands alone Y/N
Dressing or bathing Y/ N Driving at night Y/N Walking or climbing stairs Y/N
Is it difficult to pay heat, water, or electricity bills: Y/N Do you have a consistent place to live: Y/N
Do you go hungry because you do not have enough food: Y/N Do you feel safe in your current living situation: Y/N
Do you have problems with transportation? Y/N

How often do you exercise: ___ Never ___Occasionally ___ Moderate___ Heavy

Stress Level: ___ Low ___ Moderate ___ High

Over the past 2 weeks, how often have you been bothered by any of the following:

	Not at all	Several	More than half	Nearly everyday
Little interest or pleasure in doing things	0	1	2	3
Feeling down depressed or hopeless	0	1	2	3

Do you currently consume alcohol: Y/N

Frequency/Amount: _____

Do you currently use tobacco products:

Smoking: Y/N Chewing tobacco: Y/N
Frequency/Amount: _____
If you previously used tobacco, how much did you use and when did you quit: _____

Do you use any other recreational drugs: Y/N How often: _____

Caffeine intake:
____ None ____ 1-2/day ____ 3-4/day ____ 5+/day

Do you use your seatbelt on a routine basis: Y/N

Do you regularly use sunscreen: Y/N

Do you have carbon monoxide and smoke detectors in your home: Y/N

Do you have an Advanced Directive: Y/N If yes, please bring copy for your chart

Who referred you to Pavilion Family Medicine: _____

Previous Doctor: _____
Reason for leaving: _____

Your Medical Records will be retrieved from your previous provider once you have been accepted as a patient.

By signing below, I agree that the above information is true and correct. I authorize Pavilion Family Medicine to leave a voice mail on the phone number(s) above unless otherwise noted. Should there be any missing information, Pavilion Family Medicine may refuse service. By signing this, I also acknowledge receipt of Pavilion Family Medicine HIPAA Privacy Act Policy. This indicates Pavilion Family Medicine participates with Colorado Prescription Monitoring Program and Quality Health Network which is a centralized data base for healthcare professional and authorize prescription history consent. I hereby give a lifetime authorization for payment for insurance benefits to be made directly to Pavilion Family Medicine. I understand I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections, and reasonable attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

_____ _____

Signature Date

Name of Patient: _____ Date of Birth: _____

Notice of Privacy Practices

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certification.

I understand that this organization has the right to change the Notice of Privacy Practices from time to time and that I may contact this organization at any time 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 health care operations. I understand you are not required to agree to my requested restrictions, but if you do agree, you are bound to abide by such restrictions.

_____ _____
Patient Signature Date

Authorization for Protected Communication

I, _____, prefer to be contacted in the following manner.

Patient portal – Preferred E-mail Address: _____
Telephone – Preferred Phone Number: _____
Written Communication – Home Address: _____
Other: _____

Access to Information

Pavilion Family Medicine may share or access medical information about me from/with the following person(s):

Name	Relationship	Telephone #	Is this person also an emergency contact? Yes/No

_____ _____
Patient Signature Date

Agreement of Financial Responsibility

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider and are the designated Primary Care Provider (PCP), if applicable.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ _____

Signature of Patient /Responsible Party Date

_____ _____

Print Name of Patient/Responsible Party Relationship to Patient

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Full Name_____

DOB _____ Phone number _____

1. **Provider <u>authorized to release</u> Patient's information:**

   Name _____Fax _____Phone _____

   Address _____

2. **Provider <u>authorized to receive</u> Patient's information:**

   Pavilion Family Medicine
   1804 E Pavilion Place
   Montrose, CO 81401

   Phone: 970-249-6670
   Fax: 855-780-5041

3. The specific information that should be disclosed:

   _____ ALL OFFICE NOTES/LABS/X-RAYS _____ LAST 24 MONTHS OFFICE NOTES/LABS/X-RAYS

   OTHER *(BE SPECIFIC)*:

   _____

   Pick up_____ Faxed_____ Mailed_____

4. **The purpose for the disclosure is: _____**

5. **This authorization will expire on the following date or event: _____**

   If no expiration date or event is listed, the authorization will expire one year after the date of the authorization.

   IF A PATIENT WANTS ARCHIVED RECORDS SENT TO THEMSELVES, RECORDS WILL BE COPIED ON DISC AT A FEE OF $22.00. PRE-PAYMENT REQUIRED

   Signed

   _____ _____
   Patient Date

   _____
   Parent/Legal Guardian/POA