Eastern Plains Medical Clinic of Calhan
560 Crystola Street * P.O. Box 275
Calhan, CO 80808
(719)347-0100 (p) (719)347-0851 (f)

(Please print and fill out *COMPLETELY* using *LEGAL NAME* as it appears on your insurance card or ID.)

Today's date: **Primary Provider:**

PATIENT INFORMATION

Last Name: **First:** **Middle:** **How would you like to be addressed:**

Mailing Address: **City:** **State:** **Zip:**

Physical Address:

Home Number: **Cell Number:** **Work Number:**

Date of Birth: **Age:** **Sex**: ❑M ❑F ❑T ❑Other **Marital Status**: **Social Security Number:**

E-Mail Address: **Employer:** **Employer phone #:**

Person Responsible for Bill (if other than patient): **Home/Cell #:**

Address:

Preferred Pharmacy: **Referred to clinic by:**

Ethnicity: ❑Hispanic ❑Non-Hispanic ❑Decline to answer

Race: ❑White ❑African American ❑American Indian or Alaska Native ❑Asian ❑Hispanic or Latino ❑Decline to answer

Preferred Language: ❑English ❑Spanish ❑Other

INSURANCE INFORMATION

(Please give your insurance card(s) to the receptionist.)

Please Indicate Primary Insurance

Subscriber's name: **DOB:** **ID/Policy#:** **Group#** **Co-Pay: $**

Patient's relationship to subscriber: ❑ **Self** ❑ **Spouse** ❑ **Child** ❑ **Other**

Name of secondary insurance (if applicable): **Subscriber's name:** **DOB:** **ID/Policy #:** **Group #:**

Patient's relationship to subscriber: ❑ **Self** ❑ **Spouse** ❑ **Child** ❑ **Other**

IN CASE OF EMERGENCY

Name of friend or relative: **Relationship to Patient:**

Home/Cell #: **Work #:**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Eastern Plains Medical Clinic of Calhan or insurance company to release any information required to process my claims.

Patient/Guardian Signature *Date*

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FINANCIAL POLICY

Patient Name: _____ Date of Birth: _____

Basic Policy: Pay for service is due in full at the time that service is provided in our office. The office accepts cash, personal checks, debit, and credit cards.

Non-covered Services: Any care not covered by your existing insurance coverage will require payment in full at the time services are rendered or upon notice of insurance claim denial.

For Patients with Insurance: We will bill most insurance carriers (primary and/or secondary) for you if proper paperwork is provided to us. Co-payments, co-insurances, and deductibles are due at the time of service.

Insurance Deductible: I have paid my insurance deductible for the current calendar year. Yes _____ No_____ Unknown _____

Medicare Patients: We will bill Medicare for you. We will also bill secondary insurance carriers for you.

For patients without insurance, or if insurance will not cover your services at EPMCC, payments are expected to be paid in full at the time of service or arrangements must be made prior to services.

Refunds: For credits that are $40.00 and under, a credit will be left on the account to be applied towards future copays/deductibles/coinsurance and other balances. If you wish to receive the amount as a refund, please submit your request, in writing. For approved refund requests, and balances greater than $40.00, a refund check will be mailed within 60 days. Unclaimed credits, left on the account for greater than three years, will be turned over to the State of Colorado, per the Unclaimed Property Laws.

Laboratory/Radiology Fees: You may be referred to an outside laboratory or radiology facility for tests. These fees will be billed to your insurance or you by the independent facility. It is your responsibility to use the laboratory or radiology facility contracted by your insurance.

Signature on File: For the convenience of our patients and to expedite billing of services on your behalf, EPMCC will maintain your signature on file, which will be updated annually.

Assignment of Insurance Benefits and Authorization for Payment: I authorize payment of medical benefits as determined by my insurance carrier directly to EPMCC. As the responsible party, I agree to pay all charges incurred including those for services not covered by my insurance policy.

Authorization for Release of Medical Records: I authorize the release of medical records and information necessary to process the insurance claims for medical benefits.

Missed Appointments: Your appointment time is reserved especially for you. Out of respect for all patients waiting for appointments, EPMCC has a 24-hour, one business day cancellation/no show policy. After three (3) same day cancellation/no show appointments, patients will only be seen on a walk-in basis. Walk-ins will be taken daily based on appointment availability. You will need to call in the morning for a same day appointment if available. Patients will be seen in the following order: Urgent/emergent, scheduled appointments and walk-in. Please note that an appointment for Monday at 10:00 a.m. for example will need to be cancelled before 10:00 a.m. the preceding Friday. This same principle applies to holidays.

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Collections: Account balances not paid within 30 days are considered overdue. Delinquent accounts may be turned over to a collection agency. I understand that I will be charged for and herby agree to pay, all costs and expenses incurred in collecting any past due fees and interest by law. Your signature below signifies your understanding and willingness to comply with this policy.

Patient Portal: EPMCC offers patients easy and private access to their health information online. The patient portal is a secure online website that gives patients 24-hour access to personal health information from anywhere with an internet connection, using a secure username and password. EPMCC will automatically enroll you with the patient portal when a valid e-mail address is provided.

Consent to Treat

I/we do herby consent to and authorize the performance of treatments, immunizations, minor procedures, and medical services deemed advisable by the providers and staff of Eastern Plains Medical Clinic to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage, excluding only authorized services provided under a valid prepaid HMO contract. I furthermore agree to pay legal interest, collection expenses and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize Eastern Plains Medical Clinic to release information requested by my insurance company and/or its representatives. I fully understand this agreement and consent will continue until cancelled by me in writing.

I have read, understand, and agree to the above Financial Policy and Procedures.

_____ _____

Signature Date

_____

Relationship to Patient

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Consent to Share

At Eastern Plains Medical Clinic of Calhan, we are committed to safeguarding the privacy and confidentiality of your medical records including the personal information you share with us. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

To assist us in protecting your privacy, please complete the following ***(please print)***:

Patient Name _____ Date of Birth: _____

Preferred Contact number(s): May we leave a **detailed** message? Y N ***(circle one)***
Home: _____ Cell: _____ Work: _____

Please list the people who we have your permission to discuss your health and/or medical records with:

Name of person(s)	Relationship	Date of Birth	Phone Number (if available)

This authorization applies to the following information

PLEASE INITIAL:

All Information _____ Labs _____ Imaging _____ Immunizations _____ Medication _____

Referrals _____ Billing _____

I have been made aware and have had the opportunity to review the privacy policies of Eastern Plains Medical Clinic of Calhan.

Patient/Guardian Signature: _____ Date: _____

Print Name: _____

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HIPAA ACKNOWLEDGEMENT NOTICE

PLEASE DO NOT SIGN THIS NOTICE UNTIL YOU HAVE COMPLETELY READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES.

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to my Protected Health Information and how it is used. I understand that this information can and will be used by Eastern Plains Medical Clinic of Calhan and staff to carry out treatment, payment or healthcare operations.

I understand that I may refer to the Notice of Privacy Practices for a more complete description of these uses and disclosures. I acknowledge that I have been informed and read the Notice of Privacy Practices in its entirety prior to signing this consent.

I understand that I may request in writing that you restrict how my private information is used and disclosed. I also understand that the office of Eastern Plains Medical Clinic of Calhan are not required to agree to my requested restrictions, but if they do agree then they are bound to abide by such restrictions. I understand that if this request is granted and information needed to carry out payment for treatment is restricted, this office exercises its right to collect payment for those services in full prior to services being rendered. I also understand that it will be my responsibility to seek reimbursement for those services from my insurance company.

I understand that Eastern Plains Medical Clinic of Calhan reserve the right to amend the Notice of Privacy Practices from time to time and that I many at any point request a copy of the current Notice at the address listed above.

I understand that I may revoke this consent in writing at any time, except to the extent that the covered entity has taken action in reliance of poor consent and authorization. I understand the consent must be signed in person with the Privacy Officer or in written form and sent via certified return receipt mail to the attention of the Privacy Officer.

_____ _____

Signature of Patient/Personal Representative Date

_____

Printed Name