



phone: 720.898.1110 | fax: 720.898.1113
www.sfmcolorado.com

NAME OF PATIENT: _____
PATIENT ADDRESS: _____ APT # _____
CITY: _____ STATE: _____ ZIP CODE: _____
HOME PHONE NUMBER: _____ DATE OF BIRTH: _____
CELL PHONE NUMBER: _____ SOCIAL SECURITY NUMBER: _____
SEX: _____ MARITAL STATUS: _____
EMPLOYER NAME: _____ WORK PHONE NUMBER: _____
EMPLOYER ADDRESS: _____
OCCUPATION: _____
EMAIL: _____ HOW DID YOU HEAR ABOUT US? _____
PREFERRED PHARMACY _____ LOCATION _____

RESPONSIBLE PERSON INFORMATION (NAME THE INSURANCE IS UNDER)

NAME: _____ RELATIONSHIP: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
HOME PHONE NUMBER: _____ WORK PHONE NUMBER: _____
DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____
NAME OF EMPLOYER: _____
EMPLOYER ADDRESS: _____

PRIMARY INSURANCE INFORMATION

SECONDARY INSURANCE INFO

INSURANCE NAME: _____	_____
POLICY / ID NUMBER: _____	_____
GROUP NUMBER: _____	_____
POLICY HOLDER NAME: _____	_____
COPAYMENT AMOUNT: _____	_____

EMERGENCY CONTACT INFORMATION

NAME: _____
RELATIONSHIP: _____ PHONE NUMBER: _____

I hereby authorize payment directly to Sports and Family Medicine of Colorado, PC and authorize the release of any medical information to process insurance claims.

I voluntarily consent to examination and treatment for myself and/or my dependent.

I will be responsible for the full amount of the charges except those under Sports and Family Medicine of Colorado PC's contractual arrangements with payors.

SIGNATURE OF RESPONSIBLE PERSON: _____

DATE: _____



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Sports and Family Medicine of Colorado, P.C.

Patient Consent for Use and Disclosure
of Protected Health Information

I hereby give my consent for Sports and Family Medicine of Colorado to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

(The Notice of Privacy Practices provided by Sports and Family Medicine of Colorado describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Sports and Family Medicine of Colorado reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Sports and Family Medicine of Colorado, 6390 Gardenia Street, Suite #140, Arvada, CO 80004.

With this consent, Sports and Family Medicine of Colorado may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Sports and Family Medicine of Colorado may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Sports and Family Medicine of Colorado may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Sports and Family Medicine of Colorado restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Sports and Family Medicine of Colorado to use and disclose my PHI to carry out TPO.

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, Sports and Family Medicine of Colorado may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Print Patient's Name

Date

Print Name of Patient or Legal Guardian, if applicable



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To the patients of Sports and Family Medicine of Colorado

Appointment Scheduling

In order to improve our quality of service, we are looking at ways of reducing waiting time for your appointment.

There are frequently unforeseen complications in medicine that preclude any permanent solution. There are some simple steps that you can take that will help reduce the wait time for all patients.

When you are scheduling appointments, please notify the scheduling staff of all medical issues you would like to discuss. To adequately address these issues, we must allow the right amount of time. This helps us stick to our schedule and see all of our patients in a timely fashion. We may need to schedule more than one office visit for multiple problems. Please notify the office at least *24 hours in advance* if you will need to cancel or reschedule your appointment, for any reason. That way, patients with an unforeseen illness or injury can be seen as soon as possible. Patients that have scheduled an appointment and do not notify the office in advance that they will need to cancel will be assessed a **\$25.00 “no show” fee**.

Please bring a list of all your medications to each visit. This list should include the name of the medication, dose and frequency and should be presented at the beginning of your visit. Better yet, place all your pill bottles in one bag and just bring the bag.

Having additional family members seen during your scheduled visit is generally not possible. Trying to accommodate this request increases the wait time for other scheduled patients.

Financial

You will be asked to provide your insurance card at each visit. Patients are responsible for knowing the benefits of their insurance policies. If you have questions, please call the member services number listed on your card prior to your appointment. You will also be asked on each visit to verify that your address, phone numbers and insurance information is unchanged from your last visit.

Patients without insurance, or who have insurance with a plan that we do not participate with, will be required to pay in full for all charges at the time of service. Please ask about our cash discount. Patients that do not pay their co-pay at the time of their appointment will be assessed a **billing fee of \$15.00**.

If you are covered by an insurance plan that we do participate with, we will bill your insurance as a courtesy to you. Regardless of insurance coverage, you are responsible for all charges incurred during your office visit. Our billing cycle is monthly. Balance is due upon receipt and no later than 90 days. Account balances past 120 days will go to collections and lead to patient dismissal. Please understand that a **monthly billing fee of \$15.00** will be assessed on any unpaid balance.

If lab work is done during your visit, you will receive a separate bill from the laboratory that handles that work. Any billing questions regarding lab bills will need to be dealt with directly with the lab. We have nothing to do with their billing.

Thank you for your assistance. By following these guidelines you will be helping us improve the quality of care our patients receive.

Signature: _____ have read and agree to abide by the preceding policies, terms and conditions of Sports and Family Medicine of Colorado.



Physical Exam Information

What does a physical exam typically entail?

- The complete physical, or periodic health examination, should answer one or more of the following questions: (1) “Am I in the early stages of a disease that, if detected, can be cured or forestalled?” (2) “Are there lifestyle changes I can make that will improve my health and well-being?” (3) “Can I get information about my specific health concerns?” *
- The above will often be accomplished with a *comprehensive history and physical exam*
- Labwork may be indicated based upon the above
- Multiple medical problems may be *identified and often a follow up office visit* will be required to go into more detail and focus in these areas

Why can't the health care provider address every problem at the time of the physical?

- Many times the health care provider *would like to* do this because it is *more efficient* for you and for us. However, schedule constraints and **insurance limitations** often prevent this.
- Often times the health care provider will try to accommodate additional concerns at the time of the physical, but this *may result in an additional co-payment fee or charges that get applied to a deductible.*

As always, we try to do our best to effectively and efficiently manage your healthcare. If you have questions or concerns regarding the above, please review with your health care provider.

I have read and understand the above.

Signature of Patient or Legal Guardian

Printed Name

Date

* American Academy of Family Practice

Consent Form for Preauthorization to Treat Minors

For families who are ongoing patients of (facility):

it may be more convenient to have prior authorization for medical care delivered directly to minors without a parent having to be present prior to treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatment in advance.

AUTHORIZATION

I (we) request and authorize (facility):

and its personnel to deliver medical care to my (our) child(ren) listed below:

PLEASE PRINT

Name: _____

DOB: _____

Name: _____

DOB: _____

Name: _____

DOB: _____

Please try to contact me (us) regarding health care of my (our) child(ren) at the following phone number(s):

Parent's name: _____

Phone (office/home): _____

Parent's name: _____

Phone (office/home): _____

Other (relationship): _____

Phone (office/home): _____

(Signature): _____

Date: _____

PRINT name and relationship:

NOTE: If there are any special parental or custodial relationships (such as custody with one parent only, legal custody/guardianship with non-parent, etc.), please explain in the space below with your signature, printed name, and phone number at which you can be contacted.



PEDIATRIC HEALTH HISTORY

CHILD'S Name : _____ Date: _____

Date of Birth: _____ Parents Name(s): _____

ALLERGIES AND ADVERSE REACTIONS

(Please state "NONE" if none known)

MEDICATIONS

What medications are you taking? (including Birth Control Pills, Herbs, Vitamins, Dietary Supplements and Over the Counter)

(Please state "NONE" if not taking any medications)

YES	NO	CHRONIC HEALTH CONDITIONS		YES	NO	SURGERIES
		Irregular Heart Beat				Tonsils Removed
		Congestive Heart Failure				Appendix Removed
		Heart Murmur				Hernia Surgery
		Asthma /RAD				Heart Surgery
		Chronic Bronchitis				Gallbladder Removed
		Epilepsy / Seizures				Abdominal Surgery
		Juvenile Diabetes				Broken Bone Repair
		Thyroid Problems- High or Low				Arthroscopic Surgery
		Kidney Disease				
		Skin Disease				
		Anemia/ Low Blood Count				
		Bleeding Problems				
		Blood Transfusions				
		Cancer- Leukemia, etc				
		ADHD				
		Other:				Other:

FAMILY HISTORY

YES	NO	DISEASE	RELATIONSHIP TO PATIENT		YES	NO	DISEASE	RELATIONSHIP TO PATIENT
		Heart Attack					Bleeding Problems	
		High Blood Pressure					Sickle Cell Anemia	
		High Cholesterol					Diabetes/High Blood Sugar	
		Asthma					Thyroid Problems	
		Tuberculosis					Glaucoma	
		Liver Disease					Cancer, Type:	

	Kidney Disease				Alcohol Abuse	
	Gout / Arthritis					
	Osteoporosis					
	Stroke					
	Epilepsy / Seizures					
	Anxiety / Depression				Other:	

OTHER HISTORY

Is your child involved in Sports? _____ What kind of sports? _____

Are child's immunizations up to date? _____ Do you have a copy of their immunization records? _____

Does your child have a job? _____ How many hours per week? _____

Birth weight _____ Apgar Scores _____ Any complications with birth? _____

SOCIAL HISTORY AND HABITS

The following questions are very important and strictly confidential. Please answer them accurately.

Smoking /Alcohol

Have you ever smoked? Yes No Do you use smokeless tobacco? Yes No

Do you drink? Yes No How much? _____ How often? _____

FEMALE PATIENTS ONLY

Number of Pregnancies _____ Number of Deliveries _____ Number of Abortions _____ Number of Miscarriages _____

When was your last period? _____ How long was it? _____ Any problems? _____

Have you ever had a PAP smear? _____ Date: _____ Have you ever had an **abnormal PAP smear**? Yes No

If "Yes", when was the abnormal PAP smear? _____ What was the abnormality? _____

What kind of treatment did you have? _____

The above information is current and correct to the best of my / our knowledge.

I have reviewed the above history with the Patient/Parent

Patient / Parent Signature

Date

Physician/Provider's Initial

Date