

PATIENT REGISTRATION FORM

PATIENT INFORMATION (Please print)

Patient's Legal Name: (Last) _____ (First) _____ (MI) _____

Preferred Full Name (if different from above): _____ Patient Social Security Number: _____ - _____ - _____

Address: _____

City, State, Zip: _____

Home Phone Number (landline): _____ Cell: _____ Work: _____

E-Mail Address: _____ Date of Birth: _____

Gender Identity: Female Male Transgender Female to Male Transgender Male to Female Genderqueer Choose not to disclose Additional Gender category not listed _____

Race: American Indian/Alaska Native Asian Native Hawaiian/Pacific Islander Black/African American White
 Hispanic Chose not to disclose Other not listed _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Choose not to disclose

Preferred Language: English Spanish ASL Japanese Mandarin Korean French Indian: Hindi, Tamil, Gujarati etc
 Swahili Russian Arabic Vietnamese Haitian Creole Bosnian/Croatian/Serbian/Serbo-Croatian
 Albanian Burmese Tagalog Farsi-Iranian/Persian Portuguese Cambodian Other

RESPONSIBLE PARTY INFORMATION (If not self)

(Information used for patient balance statements)

Responsible party: Another patient Guarantor Self Check here if address and telephone information is same as patient

Responsible party name: (Last) _____ (First) _____ (MI) _____

Relationship to patient: _____

Date of birth: MM /DD /YYYY Sex: Female Male

Responsible Party Social Security Number: = = Phone number: _____

Address: _____

City, State: _____ ZIP: _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last) _____ (First) _____

Phone number: _____ Do you have a living will? Yes No Guardian

Emergency contact relationship to patient: _____

Address _____

City, State: _____ ZIP: _____

Home phone: _____ Work phone: _____ Ext. _____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment, recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative: _____

Date: _____

Printed name of patient or personal representative: _____

Relationship to patient: _____

Last Updated: 8/20/2020



Patient Responsibility Policy

Thank you for choosing Colorado Gynecologic Oncology Specialist for your medical needs.

In order to achieve our goal in providing and maintaining a good physician-patient relationship we believe it is important to have solid policies in place. The policy below is designed to help provide our patients with high quality, cost-effective and timely health care. We ask that you carefully read and sign the following expectations prior to your visit.

- A 24 hour notice is expected for all appointment cancellations and reschedules.
 - o If you **fail** to notify us of a cancellation or reschedule your appointment will results in a “No-Show/ No-Call”.
- Patients with repeat “No-show/ No-Call’s” are subject to review with possible discharge from the practice.
- Patients are expected to arrive **10 min. prior to their scheduled appointment time** to accommodate the check-in process.
 - o *If you **fail** to arrive 10 min. prior to your appointment you may be asked to reschedule.*
- Upon arrival, please sign in at the front desk and present complete insurance information.
 - o Which includes: current health insurance cards and proper picture ID.
 - o You will be asked to present both of these items at each visit for proper identification.
 - o *If you **fail** to provide complete or current insurance information we may not be able to accurately file your claim(s) and you will be responsible for full payment until accurate information is submitted to our office.*
- Co-payments are expected to be paid at each visit if required by your insurance plan.
- It is the patient’s responsibility to know their Healthcare benefits and coverage limitations.
 - o Any services determined NOT covered by your insurance plan will be the patient’s responsibility to pay.
- A 35 % discount is provided to patients without health care coverage or if we do not participate with their health plan.

I, the undersigned, have read and understand Colorado Gynecologic Oncology Specialist Patient Responsibility Policy above. I agree to comply and accept the terms and responsibility to the policy as outlined above. I agree to pay for all services rendered NOT covered by my insurance plan and to notify the office should there be any changes to my health insurance coverage.

Patient Name (print)

Patient Signature (or Responsible Party)

Date

Patient Privacy Policy

In an effort to protect your privacy, our practice standard does not allow sharing of medical information with anyone except the patient or legal guardian or for messages to be left on voice mail unless permission is given.

If you would like to grant permission please indicate below.

Approved phone numbers for detailed voice mail messages:

My home phone: _____

OTHER: _____

My cell phone: _____

My Spouses phone: _____

My work phone: _____

My Spouses Name: _____

I, the undersigned, give permission to the office of Colorado Gynecologic Oncology Specialist to leave a phone message regarding my medical care on the numbers listed above, including the voice mail associated with that number.

Patient Signature (or Responsible Party)

Date



Patient HIPAA Acknowledgment and Consent Form

Patient Name (Printed): _____ Date of Birth: _____

Our practice is now on EMR and would like to web-enable you to our patient portal. You would be able to obtain your records online, see your labs or test results and send or receive secure messages to and from your provider.

Do you consent to be web-enabled? YES NO _____

EMAIL ADDRESS _____

Notice of Privacy Practice/clinics.

_____ (Patient/Representative initials) I acknowledge that I have received the practice/clinic's Notice of Privacy Practice/clinics, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice/clinic's Notice of Privacy Practice/clinics.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?"

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent _____ (Patient/Representative Initials) to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

-OR-

I do not consent _____ (Patient/Representative Initials) to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice/clinic's health care operations purposes (e.g., quality improvement activities).

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications:

We want to stay connected with our patients. Patients in our practice/clinic may be contacted via email, calls to your cellular telephone (including prerecorded/artificial voice messages and/or calls from an automatic dialing device), and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. If at any time, you provide an email, cellular telephone number, address or text number below, you understand that you may get these communications from the Practice/clinic. You may opt out of these communications at any time (see next page). The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

I authorize to receive text messages and/or cellular telephone calls for appointment reminders, feedback, and general health reminders/information and **the cell phone number is** _____.

I authorize to receive email messages for appointment reminders and general health reminders/feedback/information and the email that is _____.

-OR-

I decline _____ (Patient/ Representative Initials) to receive communication via text.

I decline _____ (Patient/ Representative Initials) to receive communication via cellular telephone call.

I decline _____ (Patient/ Representative Initials) to receive communication via email

Note: This clinic uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- **I do want** _____ (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:
 - o Name: _____ Date: _____
 - o Name: _____ Date: _____
- **I do not want** _____ (Patient/ Representative Initials) to designate anyone to pick-up my prescription order.

Patient/Parent/Guardian/Patient Representative Signature _____ Date: _____

Patient/Parent/Guardian/Patient Representative Name (Printed) _____

Patient Name (Printed): _____ Date of Birth: _____



Only If you have previously consented to receive communication via text/cellular telephone call/email and wish to remove the consent/Opt Out/Revocation of communications via email and/or text or cellular telephone call. In other words, I do not want my email address or cell number to be used any longer for the above mentioned communications.

- ___ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **text**.
- ___ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **cellular telephone call**.
- ___ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **email**.

Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____ Time: _____