Health ONE Denver Internal Medicine
Physician Care℠

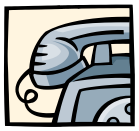
4545 East 9th Ave, Suite 400
Denver, CO 80220
Phone: 303.320.2929 / Fax: 303.320.2767

Welcome To Our Practice!

Welcome

You, the patient, are the most important person in our office. We are committed to providing you with the best possible medical care. Excellence is our goal. We have worked to provide a full range of services and have highly trained and knowledgeable staff. Please do not hesitate to ask us any questions about your health plan or medical care.

Office Hours



Phones: Telephones are answered **Monday – Friday: 8:30am 12pm; 1:00pm– 4pm**

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday
7:30a.m.– 4p.m	**7:30a.m.- 4p.m.**	**7:30 a.m.- 4p.m**	**7:30a.m.- 4 p.m**	**7:30 a.m.- 4p.m**

Emergencies: For life-threatening situations, call 911. If you have an urgent problem, please call our office for instructions. After hours, our answering service will inform you of how to reach a physician on call.

Test Results: Depending on the type of test ordered, it can take up to **5 days** to receive your results. After your provider reviews the results, they will be posted to the Patient Portal or you can call **303.320.2929** to speak with a Medical Assistant.

Prescriptions: Please call your pharmacy to request refills for renewal of medication. If prior authorization is required for your medications, please allow up to 2 weeks depending on your insurance carrier.

Appointments

Appointments can be made by calling our office at 303.320.2929.
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- Please check in *15 minutes* early for your appointment to accommodate our registration process and avoid taking up your appointment time with the provider.
- Please call in advance for routine office visits and we do ask you to make follow-up appointments as you leave the office to ensure appropriate availability. We make every effort to stay on schedule, although emergencies arise.
- As a courtesy to other patients and staff, please call the office as soon as possible if you are unable to keep your appointment or are going to be late.

Financial Policy

- Unless arrangements have been made in advance, **co-payments, co-insurance, and any outstanding balances are expected at the time of service**. Patients may be financially responsible for payment of all services even if their insurance company does not pay.
- If your insurance carrier has not responded to a claim within 90 days, we reserve the right to formally transfer all associated liability for the claim to the patient/guarantor.
- Failure to promptly resolve this balance may result in third party collection and/or legal procedures be taken.
- Account representative can be contacted at **1.888.422.7710.**
- We realize that emergencies do arise that may affect timely payment of your account. If such extreme cases do occur, please contact a patient accounts representative at **1.888.422.7710.**
- Please always notify our office of any change in name, address, phone or insurance information.

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Insurance

- Prior to your appointment, please check your insurance information so you will be informed about referrals, co-payments, and any deductible required at the time of the visit. We also accept: ***Visa, MasterCard, Discover and American Express*.**
- For your first visit, please bring your insurance card and arrive early to complete the necessary patient information forms.
- Your health insurance contract is between you and your insurance company. Any complaints regarding your coverage should be directed to your carrier.
- Referrals: Please allow 2-4 days for referral processing.

What Do We Need From You?

- To inform the Medical Practice staff of any pertinent changes in insurance, employment, demographic information or relationships with other care/service givers.
- To arrive on time for scheduled appointments and cancel, when necessary, with a phone call.
- To provide payment for services requested and delivered by the Medical Practice not covered by insurance within 90 days.
- To notify the Medical Practice of any change in his/her health status.
- To follow the recommended treatment plan and inform the Medical Practice of any physical or mental impairment requiring special accommodation.
- To ask questions if directions and procedures are not understood.

What Should You Expect From Us?

- To be treated with respect, dignity and be informed of his/her care needs to make appropriate decisions.
- Help plan his/her care and make changes to it.
- Expect that teaching materials will be provided in a manner he/she can understand.
- To be informed of the Medical Practice billing process.
- To have his/her records keep confidential except when consent has been given.
- To expect services to be professional, timely and appropriate.
- To communicate his/her complaints to the Medical Practice Manager and expect to receive follow-up without negative repercussions or changes in service.
- To receive care without discrimination due to race, religion, age, sex, disability or ethnic origin.

Thank You.

PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION (Please print)

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

Preferred Full Name (if different from above): _____

Address: _____

City, State, Zip: _____

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

Check to opt out of texting: ☐

E-Mail Address (*required* for patient portal): _____ Date of Birth: MM_____/DD_____/YYYY_____

Patient Social Security Number (*required* for patient portal): _____- _____ -_____

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.
☐ Other (not listed):_____

How did you hear about us? Friend/Family ☐ Website ☐ Physician ☐ Insurance ☐ Other (please list response): _____

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) _____

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

Emergency contact relationship to patient:_____ ☐ Guardian

Preferred Pharmacy Information

Pharmacy Name: _____

Phone Address: _____

Mail Order Pharmacy: _____

***** Please See Reverse Side for Consent Form *****

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: _____

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New Patient Health History

Name: _____ Previous/Referring Provider: _____

DOB: _____ Pharmacy Name: _____

Date of last physical exam: _____ Pharmacy Phone: _____

Please answer all questions if applicable. All information will be kept confidential.

Do you have any allergies? □ No □ Yes (please list below)

Are you currently taking any Prescription or Over-the-counter medications, herbal remedies or vitamins? □ No □ Yes (please list below)

Name of Medication	Dose (total mg)	How many times per day?	When do you take it? (Morning, afternoon, night)	Name of prescribing doctor?	How do you take the medication?
					□ Oral □ Injection □ Dermal
					□ Oral □ Injection □ Dermal
					□ Oral □ Injection □ Dermal
					□ Oral □ Injection □ Dermal
					□ Oral □ Injection □ Dermal
					□ Oral □ Injection □ Dermal
					□ Oral □ Injection □ Dermal
					□ Oral □ Injection □ Dermal

Review of systems Are you **currently** experiencing any of the following? (Please circle Yes or No)

Constitutional			**Resp./Pulmonology**			**Genital/Urinary**			**Neurology**		
Fatigue	No	Yes	Coughing	No	Yes	Blood in urine	No	Yes	Balance Issues	No	Yes
Fever	No	Yes	Shortness of breath	No	Yes	Painful urination	No	Yes	Numbness	No	Yes
Weight loss	No	Yes	Sleep apnea	No	Yes	Frequent urination	No	Yes	Seizures	No	Yes
Weight gain	No	Yes	Wheezing	No	Yes	**Gynecology**			Changes in speech	No	Yes
Skin & Breast			**Cardiology**			Abnormal bleeding	No	Yes	**Psychology**		
Lump in breast(s)	No	Yes	Chest pain	No	Yes	Infertility issues	No	Yes	Anxiety	No	Yes
Pain in breast(s)	No	Yes	Swollen Ankles	No	Yes	Painful intercourse	No	Yes	Changes in appetite	No	Yes
Skin lesions	No	Yes	Heart palpitations	No	Yes	Pelvic pain	No	Yes	Depression	No	Yes
HEENT			**Gastroenterology**			Vaginal itching	No	Yes	Insomnia	No	Yes
Change in vision	No	Yes	Blood in stool	No	Yes	**Musculoskeletal**			**Hem/ Lymph**		
Hearing Loss	No	Yes	Constipation	No	Yes	Joint/back pain	No	Yes	Anemia	No	Yes
Ringing in ears	No	Yes	Diarrhea	No	Yes	Muscle pain	No	Yes	Bruising easily	No	Yes
Congestion	No	Yes	Nausea/Vomiting	No	Yes				**Endocrinology**		
Sore Throat	No	Yes							Hair loss	No	Yes
Headache	No	Yes							Heat/Cold Intolerance	No	Yes

Past Medical & Family History Have you or anyone in your family ever had any of the following?

Illness	(Circle Yes or No)		If yes, who? (self or which maternal or paternal family member)	Illness	(Circle Yes of No)		If yes, who? (Self or which maternal or paternal family member)
Anemia	No	Yes		Eating Disorder	No	Yes	
Arthritis/joint pain	No	Yes		Glaucoma	No	Yes	
Asthma	No	Yes		High Blood Pressure	No	Yes	
Cancer	No	Yes		Kidney Disease	No	Yes	
-If yes, type of cancer:				Pneumonia	No	Yes	
Chronic Lung Disease	No	Yes		Seizures/epilepsy	No	Yes	
High Cholesterol	No	Yes		Stroke	No	Yes	
Heart Disease	No	Yes		Thyroid Disease	No	Yes	
Depression/anxiety	No	Yes		Tuberculosis	No	Yes	
Diabetes	No	Yes		Other: _____	No	Yes	
DVT's/Clotting Disorder	No	Yes		Other: _____	No	Yes	

Immunizations

Chickenpox?	No	Yes	Date last received:	Influenza	No	Yes	Date last received:
Gardasil (HPV vaccine)	No	Yes	Date last received:	MMR	No	Yes	Date last received:
Hepatitis A	No	Yes	Date last received:	Tetanus/ Tdap	No	Yes	Date last received:
Hepatitis B	No	Yes	Date last received:	Other:	No	Yes	Date last received:

Date	Surgery/Hospitalization	Date	Surgery/Hospitalization

Personal Health History			Women ONLY		
As a child have you ever had: ☐ Measles ☐Mumps ☐ Rubella			Date of your last Pap:		
☐ Chickenpox ☐ Polio			Have you ever had an abnormal Pap?	☐No	☐Yes
Have you ever had a blood transfusion?	☐No	☐Yes	-If yes, when?		
Do you experience frequent falls?	☐No	☐Yes	Age when periods began?		
Do you have an Advance Directive or Living Will?	☐No	☐Yes	Date last period began: ☐/ ☐/		
***Have you had a colorectal cancer screening?**	☐No	☐Yes	How many days do your periods last? _____		
-If yes, when was your last?			How would you describe your flow? ☐ Light ☐ Moderate ☐Heavy		
			Do you have pain with your periods?	☐No	☐Yes
Sexual History			Total number of Pregnancies:_____ # of live births: _____		
Are you sexually active? ☐			In the last year have you had:		
-If yes, is your partner: ☐ Male ☐ Female ☐Both			☐ Urinary Tract Infections ☐ Bladder infections ☐ Kidney infections		
How many sexual partners in the last year?	☐No	☐Yes	Do you experience any involuntary urine leakage?	☐No	☐Yes
Do you have a history of sexual abuse/ assault?	☐No	☐Yes	***Have you ever had a Mammogram?**	☐No	☐Yes
Do you have a history of sexually transmitted infections?	☐No	☐Yes	-If yes, when was your last?		
- If yes, what?			-Where?		
Current method of contraception: _____ ☐ **N/A**					
			Men ONLY		
Social History			Do you urinate at night?	☐No	☐Yes
Do you drink alcohol? ☐			-If yes, how many times?		
-If yes, # drinks/day: # drinks/week:			-Pain or burning with urination?	☐No	☐Yes
Have you ever smoked cigarettes? ☐ Currently ☐ Previously ☐ Never			-Blood in the urine?	☐No	☐Yes
-Packs/day: _____ -# of years: _____			-Has the force of your urination decreased?	☐No	☐Yes
Do you exercise regularly?	☐No	☐Yes	In the last year have you had:		
- If yes, #/week: type:			☐ Urinary Tract Infections ☐ Bladder infections ☐ Kidney infections		
Do you use recreational drugs?	☐No	☐Yes	Any problems emptying your bladder completely?	☐No	☐Yes
-If yes, what type:			Any difficulty or pain with erection or ejaculation?	☐No	☐Yes
Do you drink caffeine?	☐No	☐Yes	Any testicle pain or swelling?	☐No	☐Yes
- If yes, # drinks/week?			Do you feel burning discharge from your penis?	☐No	☐Yes
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed			Recently had unprotected intercourse with a new partner?	☐No	☐Yes
			Date of last prostate and rectal exam?		

List any medical problems diagnosed by other physicians:

Diagnosis	Physician Name	Diagnosis	Physician Name

Is there anything else you would like to discuss with us or let us know about?

_____

_____

_____

Patient's signature: _____ Date: _____

Health ONE Denver Internal Medicine Physician Care℠

Patient name: _____

Date of birth: _____

Patient Consent for Financial Communications

Financial Agreement

- I acknowledge, that as a courtesy, DENVER INTERNAL MEDICINE may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection. I acknowledge DENVER INTERNAL MEDICINE may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to DENVER INTERNAL MEDICINE any insurance or other third-party benefits available for health care services provided to me. I understand DENVER INTERNAL MEDICINE has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to DENVER INTERNAL MEDICINE, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to DENVER INTERNAL MEDICINE by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for DENVER INTERNAL MEDICINE, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that DENVER INTERNAL MEDICINE or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or DENVER INTERNAL MEDICINE or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/patient Representative Signature: _____ **Date:** _____

If you are not the patient, please identify your relationship to the patient. Circle or mark relationship(s) from list below:

☐ Spouse
☐ Parent
☐ Legal Guardian
☐ Guarantor
☐ Healthcare Power of Attorney
☐ Other (please specify) _____