SOUTH POINTE MEDICAL

PLEASE PRINT AND COMPLETE ALL ENTRIES					
PATIENT NAME (LAST – FIRST—MIDDLE INITIAL)		ADDRESS			CITY,STATE
ZIP	PREFERRED PHONE		SECONDARY PHONE		
PATIENT DATE OF BIRTH	PATIENT SSN	SEX ☐ Male ☐ Female	MARITAL STATUS ☐ Single ☐ Married ☐ Other________		
PATIENT EMPLOYER NAME		ETHNICITY / RACE	EMAIL		
HOW DID YOU HEAR ABOUT SOUTH POINTE MEDICAL?					

INSURED / RESPONSIBLE PARTY INFORMATION			
NAME (FIRST – LAST – MIDDLE INITIAL	ADDRESS (if different from patient)	RELATION TO PATIENT: ☐ SPOUSE ☐ PARENT ☐ GUARDIAN	
PREFERRED PHONE	EMAIL (if different)	SSN	BIRTH DATE

INSURANCE INFORMATION		
PRIMARY INSURANCE NAME	ADDRESS (STREET – CITY- STATE – ZIP)	PHONE
GROUP NUMBER	ID NUMBER	EFFECTIVE DATES
SECONDARY INSURANCE NAME	ADDRESS (STREET – CITY- STATE – ZIP)	PHONE
GROUP NUMBER	ID NUMBER	EFFECTIVE DATES

EMERGENCY CONTACT		
CONTACT NAME	RELATIONSHIP	PHONE NUMBER

ASSIGNMENT / RELEASE AND FINANCIAL RESPONSIBILITY: I hereby authorize my insurance benefits to be paid directly to the physician and that I am financially responsible for non-covered services. I authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees associated with my account /s.

If I am an **un-insured, self-pay patient,** I agree to pay the $100 co-pay along with any services rendered the date of visit at a discounted rate set by South Pointe Medical. All services must be paid in **FULL** at the time of visit. If for any reason, services are billed after the initial visit, they will be billed at the full rate mandated by the Medicare Fee Schedule and will have **30 days** to pay the account in full. I will be responsible for obtaining this information and I agree that if I am unable to pay for any services rendered in a timely manner that is agreed upon with South Pointe Clinic, I will be discharged for non-compliance with payment.

PLEASE READ

PATIENT SIGNATURE	DATE

HIPPA Policy

SOUTH POINTE MEDICAL

380 Empire Rd
Lafayette, CO 80026
303-665-8444

Medical Information Release

(PLEASE CHECK ONE)

- ☐ **I do not** authorize South Pointe Medical to release my Medical Information
- ☐ I authorize South Pointe Medical to release my Medical Information (e.g. lab results, appointment times) to any of following persons listed below. This will remain in effect until otherwise notified.

Contacts:	**Relationship to Patient:**
____________________	____________________
____________________	____________________
____________________	____________________

____________________ Name of Patient (PLEASE PRINT)

____________________ Date

____________________ Signature/guardian's signature if patient is a minor

____________________ Name of guardian

SOUTH POINTE MEDICAL

Cancellation / No Show Policy for Appointments

Effective January 1, 2017

We understand that there are times when you must miss an appointment due to an emergency, or obligations for work or family. However, when you do not call to cancel your appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel or no show and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If your appointment is not cancelled at least 24 hours in advance, you will be charged a $50.00 fee; this will not be covered by your insurance company.

We understand that delays can happen, however we must try to keep the other patients and provider on time. We ask you to please arrive **10-15 minutes** prior to your appointment. Although we will do our best to accommodate you, if you are **one minute** or more past your appointment time, you may be rescheduled for another date. If you are more than 15 minutes past your appointment without prior notice, you will automatically be rescheduled and charged the No-Show fee. **After 3 missed appointments (failure to show or call), you may be discharged from care as a direct result of being "noncompliant to treatment."**

We value our patient/doctor relationships and will do everything we can to accommodate you. Your communication and compliancy are not only very much appreciated, but will help us to help you and others achieve a positive outcome.

Please sign below acknowledging you have read and understand the above statement.

____
Print Patient Name

______________________________ Date____________________
Signature of Patient or Guardian

SOUTH POINT MEDICAL

Notice of Privacy Practices

This notice describes how health information about you as a patient may be used and disclosed and how you can gain access to your health information. Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize these laws are complicated but we must provide you with the following important information.

The following circumstances may require us to use or disclose your health information:
1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order, or if required by a law enforcement official
3. When necessary to reduce or prevent a serious threat to your health and safety of you or another individual.
4. If you are a member of U.S. or foreign military forces (including veterans) and if required by authorities
5. To federal officials for intelligence and national security activities authorized by law.
6. To correctional institution or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.
7. For Worker's Compensation and similar programs.

Your rights regarding your health information:
1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location.
2. You can request a restriction in our use, or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals in your care or the payment of your care. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records. You must submit your request in writing.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. Your request must be made in writing and include a reason that supports your request for amendment.
5. You are entitled to receive a copy of this Notice of Privacy Practices and may ask for a copy at any time.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing and you will not be penalized for filing a complaint.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. If you have any questions regarding this notice or health information privacy policies, please contact us.

By signing below, you acknowledge and understand the above practices and that you have the right to receive a copy at any time.

Printed Name:____

Signature:______________________________ Date:____________________

Name:

*****PREFERRED PHARMACY AND LOCATION

MEDICATIONS: List any medications you are currently taking (including OTC meds) PLEASE PRINT LEGIBLY

MEDICATION	DOSAGE	TIMES PER DAY

ALLERGIES	REACTIONS

FAMILY HISTORY (circle all that apply)

MOTHER	Arthritis Cancer Diabetes Heart Disease Hypertension Stroke Thyroid Disorder
FATHER	Arthritis Cancer Diabetes Heart Disease Hypertension Stroke Thyroid Disorder
SIBLINGS	Arthritis Cancer Diabetes Heart Disease Hypertension Stroke Thyroid Disorder

SOCIAL HISTORY

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced

Do you drink alcohol? ☐ **NO** ☐ **YES** (X's__________ a day, week, month, year)
Do you drink Caffeine? ☐ **NO** ☐ **YES** (X's__________ a day, week, month, year)
Do you use illicit drugs? ☐ **NO** ☐ **YES** (Type_________, How often_____________)
Do you use tobacco? ☐ **NO** ☐ **YES** (**Smoke or Chew** X's__________ a day, week, month, year)

Past Surgical History: Please list any hospitalizations, pregnancy, surgeries, fractures or major illnesses you have had.

TYPE	DATE AND YEAR

MEDICAL HISTORY / ONGOING CONDITIONS: Do you currently have or ever had any of the following?

☐ No issues
☐ Allergies
☐ Anemia
☐ arthritis conditions
☐ asthma
☐ arterial fibrillation
☐ bleeding problems
☐ coronary artery disease
☐ cancer
☐ cardiac arrest
☐ celiac disease
☐ chest pain
☐ congestive heart failure
☐ chronic fatigue syndrome
☐ depression
☐ diabetes
☐ drug/alcohol abuse
☐ erectile dysfunction
☐ fibromyalgia
☐ Gerd
☐ heart disease
☐ high cholesterol
☐ hypertension
☐ hypogonadism male
☐ hypothyroidism
☐ infection problems
☐ insomnia
☐ irritable bowel syndrome
☐ kidney problems
☐ menopause
☐ migraines/headaches
☐ neuropathy
☐ onychomycosis
☐ organ injury
☐ osteoporosis
☐ pulmonary embolism
☐ blood clots
☐ seizure disorders
☐ shortness of breath
☐ sinus conditions
☐ stroke
☐ tremors
☐ wheat allergy
☐ other___________

Preventative Services Please list dates of last:

Annual Physical ______________
Mammogram _______________
Pap________________________
PSA________________________
Colonoscopy________________
Sigmoidoscopy________________
Dexa Scan___________________
EKG_________________________
Cardiac Testing______________
Flu Shot____________________

NAME:____

DOB:____

SYMPTOMS: check symptoms you currently have or have had in the past year. Leave blank if not.
Your health care provider will review this form with you

Constitutional
____ Chills
____ Fever
____ Feeling poorly
____ Feeling tired
____ Weight gain
____ Weight loss

Respiratory
____ Cough
____ Wheezing
____ Shortness of breath
____ Trouble breathing w/exercise
____ Trouble breathing w/laying flat
____ Snoring

Skin
____ Skin lesions
____ Rash
____ Itching
____ Change in a mole
____ Dry skin
____ Unusual growth

Heme/Lymph
____ Easy bleeding
____ Easy bruising
____ Swollen glands

Eyes
____ Eye pain
____ Red eyes
____ Eyesight problems
____ Discharge from eyes
____ Dry eyes
____ Eyes itch

Gastrointestinal
____ Abdominal pain
____ Nausea/Vomiting
____ Constipation
____ Diarrhea
____ Heartburn
____ Blood in stool

Neurological
____ Numbness
____ Weakness
____ Dizziness
____ Fainting
____ Confusion
____ Headache

ENT
____ Ear ache
____ Loss of hearing
____ Nosebleeds
____ Nasal discharge
____ Sore throat
____ Hoarseness

Genitourinary
____ Pain w/urination
____ Incontinence
____ Urination at night
____ Genital lesions

Psychiatric
____ Suicidal
____ Sleep Disturbances
____ Anxiety
____ Depression
____ Change in personality
____ Emotional problems

Cardiovascular
____ Chest pain
____ Palpitations
____ Fast pulse
____ Slow pulse
____ Leg pain w/exercise
____ Leg swelling

Musculoskeletal
____ Pains in joints
____ Neck pain
____ Joint swelling
____ Joint stiffness
____ Muscle aches

____ Limb swelling Endocrine
____ Droopy eyelids
____ Hot flashes
____ Muscle weakness
____ Change in the voice
____ Weakness

WOMEN Only
____ Breast lump
____ Abnormal pap smear
____ Irregular bleeding
____ Severe cramps
____ Pelvic pain
____ Painful intercourse
____ Vaginal discharge
____ Nipple discharge

MEN Only
____ Erection difficulties
____ Lump in testicle
____ Sore on penis
____ Discharge from penis