WHEAT RIDGE
INTERNAL MEDICINE
7821 West 38th Avenue, Wheat Ridge, CO 80033 | **P** 303-422-2343 | **F** 303-422-8291

Welcome to Wheat Ridge Internal Medicine!

We are looking forward to seeing you on _____ at _____ with _____.
We are sending you the enclosed packet and ask that you complete it **prior** to your scheduled appointment time.

As you complete the attached paperwork, please take a moment to note the following important items:

1. All new patient appointments are billable and submitted to your insurance company.
2. It is very important that you arrive on time for your appointment. If you are more than 10 minutes late, your appointment may be rescheduled.
3. If you do not show up for your appointment, you will NOT be rescheduled.
4. Please note that per office policy, no controlled substances will be prescribed at your initial visit.
5. Please bring the following to your appointment:
    a. This packet.
    b. Bottles of all your current prescription medications OR a detailed medication list
    c. Past medical records. If you do not have physical copies, please request that your previous health care provider forward all records to WRIM (Fax: 303-422-8291)
    d. Insurance card, photo ID, and copay. We accept cash, check, Visa, and Mastercard.

Please feel free to call us with any questions. We look forward to meeting you soon!

Wheat Ridge Internal Medicine Providers

Stanton Elzi, MD - Sofi Abraham, MSN, FNP-C, ONC - Sara Schmidt, MSN, AGNP-C - Crystal Culbert, PA-C - Elizabeth Cowan, NP

W. Scott Allan, MD - Kendra Baughn, PA-C - Megan Weaver, PA-C - Brooke Edwards, NP

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Wheat Ridge Internal Medicine is located behind Clear Creek Surgical Center on the north side of 38th Avenue

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Dear New Patient,

We are looking forward to your upcoming visit!

We request that you contact your insurance company a minimum of 48 hours prior to your scheduled appointment to ensure that our practice is in network with your insurance company. **If your policy requires a Primary Care Provider (PCP), please ensure that Dr. Stanton Elzi or Dr. William Scott Allan is listed as your PCP.** If one of our providers is not on file with your insurance company, it limits our ability to effectively order medications and testing or complete referrals for you.

As long as one of the above providers is listed as your PCP, you may see any of the providers at Wheat Ridge Internal Medicine.

Insurance companies do not allow medical offices to make PCP changes on behalf of patients, so this must be completed by you prior to your visit.

If you have any questions or need assistance, please contact our billing office at 303-422-2343 ext. 107 or 122.

Thank you,

The Staff of Wheat Ridge Internal Medicine

Patient Information

Name: _____ Date of Birth: _____

Social Security #: _____ Marital Status: _____

Address: _____ City:_____ State: _____ Zip: _____

Home Phone #: _____ Cell #: _____ Work #: _____

Email: _____

Occupation: _____ Employer: _____

Employer Address: _____

Spouse's Name: _____ Date of Birth: _____

Social Security #: _____ Spouse's Employer: _____

Spouse's Phone: _____ Spouse's Work #: _____

Insurance Information

(If incomplete, patient will be billed)

Primary Insurance: _____ Policy/Subscriber #: _____

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

Subscriber's Name: _____ Group #: _____

Secondary Insurance: _____ Policy/Subscriber #: _____

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

Subscriber's Name: _____ Group #: _____

I authorize the release of any medical information necessary to process my claim to an insurance company, organization, employer, hospital, or physician. I understand that I am responsible for any and all charges that my insurance company may not pay. I authorize payment of my medical benefits to be paid directly to Wheat Ridge Internal Medicine as indicated by the signature on file/accept assignment on the claim form.

I CERTIFY THAT I HAVE READ AND UNDERSTOOD THE ABOVE AND THAT THE INFORMATION I HAVE PROVIDED IS TRUE AND CORRECT.

Patient/Legal Guardian Signature: _____ Date: _____

Additional Information

Name: _____ DOB: _____ Initials: _____

☐ I refuse to complete this form

Race:

☐ Native American/Alaska Native

☐ Asian

☐ Black/African American

☐ Native Hawaiian/Other Pacific Islander

☐ White

☐ Undefined

☐ More than one race

Ethnicity:

☐ Hispanic/Latino

☐ Not Hispanic/Latino

Preferred Language: _____ Birthplace: _____

Common Questions and Answers:

Why do we ask you to complete this form? The Centers for Medicare and Medicaid have mandated that we ask these questions. The responses are used in disease management reporting, as well as other types of reporting.

What is the difference between race and ethnicity? Race describes biological descent. Ethnicity describes cultural heritage.

What if I don't want to answer these questions? You have the right to refuse. Just check the "refuse to complete" box above.

** We follow current Federal Standards published by the Office of Management and Budget (OMB).

For Office Use Only:

Account#

Medical History

Name: _____ Today's Date: _____

Sex at birth: _____ Preferred pronoun:_____ Email: _____

Home #: _____ Cell #: _____ Work #:_____

(Former) occupation: _____

Please answer the following questions to help us maintain accurate records and provide high-quality care. All information will be kept confidential. Please discuss any questions with your provider or clinical staff.

Do you have a living will, advanced directive or DNR? ☐ Yes ☐ No

Do you have special hearing needs: ☐ Yes ☐ No

Do you have vision impairment beyond reading glasses: ☐ Yes ☐ No

Please indicate if you have ever been diagnosed with the following:

Cardiovascular
- ☐ Hypertension
- ☐ Congestive Heart Failure
- ☐ Arrythmia/Atrial Fibrillation
- ☐ Heart Attack
- ☐ Stroke/TIA
- ☐ Pacemaker
- ☐ Coronary Artery Disease
- ☐ Hyperlipidemia
- ☐ Other: _____

GI
- ☐ Irritable Bowel Syndrome
- ☐ GERD
- ☐ Colon Polyps
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Other: _____

Pulmonary
- ☐ Asthma
- ☐ COPD/Emphysema
- ☐ Chronic Bronchitis
- ☐ Sleep Apnea

Kidney/Endocrine/Auto-immune
- ☐ Diabetes I/II
- ☐ Rheumatoid Arthritis
- ☐ Chronic Kidney Disease
- ☐ Kidney Stones
- ☐ Thyroid Disease
- ☐ Osteoporosis
- ☐ Other: _____

Mental Health
- ☐ Depression
- ☐ Anxiety
- ☐ Mood Disorder
- ☐ Drug Use
- ☐ Alcoholism
- ☐ Other: _____

Neurologic
- ☐ Neuropathy
- ☐ Seizures
- ☐ Headaches/Migraines
- ☐ Other: _____

Hematologic
- ☐ Blood Clots
- ☐ Bleeding Disorder
- ☐ Blood transfusion
- ☐ Anemia
- ☐ Other: _____

Cancer/Infectious Disease
- ☐ Skin Cancer
- ☐ Breast Cancer
- ☐ Prostate Cancer
- ☐ Colon Cancer
- ☐ HIV
- ☐ Hepatitis
- ☐ Other: _____

Family Medical History

Is your mother alive? ☐ Yes ☐ No If not, please list age at death and cause of death: _____

Is your father alive? ☐ Yes ☐ No If not, please list age at death and cause of death: _____

Please indicate if **anyone in your immediate family** has ever been diagnosed with the following:

	Mother	Father	Sibling	Child
High Blood Pressure				
High Cholesterol				
Stroke				
Heart Attack				
Heart Failure				
Bleeding/Blood Disorder/Blood Clot				
Diabetes				
Thyroid Disorder				
Osteoporosis				
Kidney Disease				
Liver Disease				
Alcoholism				
Drug Use				
Breast Cancer				
Colon Cancer				
Prostate Cancer				
Other Cancer (please list): _____				

Surgical History

Please list all operations you have had and the approximate date of each:

Operation	Date

Please list any providers you have seen in the last 2 years:

_____ _____

_____ _____

Women's Health

Number of Pregnancies: _____ Births: _____ Miscarriages: _____ Abortions: _____

History of abnormal pap smear? ☐ Yes ☐ No

Date of Last Pap: _____ Result: _____

Date of Last Mammogram: _____ Result: _____

Are you currently sexually active? ☐ Yes ☐ No

If yes, ☐ Single Partner or ☐ Multiple Partners If yes, ☐ Male Partner(s) and/or ☐ Female Partner(s)

Are you using any form of birth control? ☐ Yes ☐ No If yes, what method? _____

Men's Health

How often do you examine your testicles? _____

Are you currently sexually active? ☐ Yes ☐ No

If yes, ☐ Single Partner or ☐ Multiple Partners If yes, ☐ Male Partner(s) and/or ☐ Female Partner(s)

General Health Questions:

Do you use tobacco products? ☐ Yes ☐ No If yes, what kind? _____ How much? _____

What age did you start? _____ If you have quit, when did you quit? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much and how often? _____

Do you use marijuana or other recreational drugs? ☐ Yes ☐ No If yes, what do you use? _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, when? _____

Have you had a colonoscopy? ☐ Yes ☐ No If yes, when? _____ Result? _____

Have you had a bone density test? ☐ Yes ☐ No If yes, when? _____ Result? _____

Do you wear a seat belt when driving? ☐ Yes ☐ No

Do you wear sunscreen? ☐ Yes ☐ No

Do you take calcium supplements? ☐ Yes ☐ No

Have you ever had a sexually transmitted disease? ☐ Yes ☐ No If yes, when? _____ What? _____

Have you ever tested positive for tuberculosis by skin test? ☐ Yes ☐ No

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Immunizations:

Have you received the following vaccinations:

Tetanus ☐ Yes ☐ No Date: _____

Measles, Mumps, Rubella ☐ Yes ☐ No Date: _____

Polio ☐ Yes ☐ No Date: _____

Hepatitis B Vaccine ☐ Yes ☐ No Date: _____

Hepatitis A Vaccine ☐ Yes ☐ No Date: _____

Pneumonia (pneumococcal23 and/or Prevnar 13 ☐ Yes ☐ No Date: _____

Shingles Vaccine (Shingrix and/or Zostavax) ☐ Yes ☐ No Date: _____

Human Papillomavirus Vaccine (HPV) ☐ Yes ☐ No Date: _____

Patient Health Questionnaire:

Over the past 2 weeks, how often have you been bothered by any of the following problems:

	Not at all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things:	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless:	☐	☐	☐	☐

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Medication List

Name: _____ DOB: _____

Preferred Pharmacy: _____ Pharmacy Phone Number: _____

Please list all medications you are **CURRENTLY TAKING** including prescriptions, over-the-counter medications, vitamins, and herbal remedies:

Medication:	Dosage:	Frequency:	Reason for taking:	Ordering Dr. :

Medication Allergies

Name: _____ DOB: _____

Preferred Pharmacy: _____ Pharmacy Phone Number: _____

Please list all medications you are **ALLERGIC TO** including prescriptions, over-the-counter medications, vitamins,
and herbal remedies:

Medication:	Reaction:

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No Show Policy

This policy has been established to help us better serve our patients and ensure patients have access to timely medical care.

Effective August 15, 2022

Cancellation of an Appointment

If is necessary for us to make appointments in order to see our patients as efficiently as possible. To be respectful of the medical needs of all our patients, please be courteous and call promptly if you are unable to attend an appointment. Appointments are in high demand, and your early cancellation will give another patient the opportunity to access medical care in a timely manner.

As a courtesy and to remind patients of their scheduled appointments, Wheat Ridge Internal Medicine sends out confirmation calls the day prior to the appointment. If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you and accommodate other patients.

No Show Charge

A failure to present at the time of a scheduled appointment will be recorded in your chart as a "no show" and a fee of $25.00 will be assessed for each no show and billed to your account. This fee will need to be paid before scheduling further appointments.

*Please understand that insurance companies consider this charge to be entirely the patient's responsibility.

To cancel or reschedule an appointment, please call Wheat Ridge Internal Medicine at 303-422-2343.

_____ Date: _____

Patient Acknowledgement (please sign)
Or Personal Representative

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Financial Policy

I understand that payment for medical services is due and payable at the time services are rendered unless financial arrangements have been made. I understand that I am responsible for all costs of collection including attorney fees, collection fees of 30%, and court costs. I understand that my unpaid balances will assess interest at the rate of 18.00% (1.5% monthly). Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for the payment of fees not covered by insurance. I authorize the submission of claims without obtaining my signature on each claim submitted. I give my authorization and consent for treatment after having a full explanation of proposed treatment, alternatives, and risks by my doctor. I have been advised of my privacy rights as provided by the Healthcare Information Portability and Accountability Act of 1996. I hereby authorize Wheat Ridge Internal Medicine and its employees, agents, and assignees to contact me via e-mail, text messaging, and to my cellular devices using automated telephone dialing systems.

_____ _____

Patient Signature Date

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HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPPA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14th, 2003. Many of the policies have been our practice for years. This form is a "reader friendly" version – a more complete text is posted in our office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, and health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ Date: _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPPA Information Form and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

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Contact Preferences and Authorization

In the circumstances that Wheat Ridge Internal Medicine needs to contact me, **I** wish to be contacted at the following numbers:

Preferred Phone #: _____ Alternate Phone #: _____

I give Wheat Ridge Internal Medicine permission to leave messages on my voicemail ☐ Yes ☐ No

I, _____ authorize the following person(s) to receive messages regarding my care or test results from the staff of Wheat Ridge Internal Medicine (WRIM):

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

The above person(s) may receive information from WRIM in my name until I stipulate otherwise. This includes, but is not limited to, medical conditions, treatments, results, medications, and/or any other type of protected health information in order to facilitate and coordinate my care, treatment, and payment.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Witness Name: _____

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Authorization to Use or Disclose My Health Information

Name: _____ Date of Birth: _____

You may use or disclose the following healthcare information (check all that apply):

☐ All my health information maintained by the below named practice
☐ My health information relating to the following condition: _____
☐ My health information for the date(s): _____

Release Records From:	Disclose Records To:
Office Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____	Wheat Ridge Internal Medicine 7821 West 38th Avenue Wheat Ridge, CO 80033 Phone: 303-422-2343 Fax: 303-422-8291

Reason(s) for this Authorization (check all that apply):
☐ At my request
☐ Other (please specify): _____

This Authorization Ends (select one):
☐ On (date): _____
☐ When the following event occurs: _____
(If nothing is checked above, this authorization will automatically expire one year from date signed)

Once our office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or Legally Authorized Signature: _____ Date: _____
Printed Name (if signed on behalf of patient): Relationship:

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Questions?

Dear Patient,

As you prepare for your visit to Wheat Ridge Internal Medicine, you may have many thoughts and questions. Please use this form to jot down questions/concerns that you would like to discuss with the provider, medical assistant, or staff at the time of your visit.

Notice of Health Information Privacy Practices

Effective Date of this Notice: June 1, 2018

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

About Us

In this Notice, we use terms like "we," "us," "our," or "practice" to refer to Wheat Ridge Internal Medicine, its physicians, employees, staff, and other personnel. All of the sites and locations of WRIM follow the terms of this Notice and may share health information with each other for treatment, payment, or health care operations purposes and for other purposes as described in this Notice.

Purpose of this Notice: This notice describes how we may use and disclose your health information to carry out treatment, payment or healthcare operations and for other purposes that are permitted or required by law. This notice also outlines our legal duties for protecting the privacy of your health information and explains your rights to have your health information protected. We will create a record of the services we provide to you, and this record will include your health information. We need to maintain this information to ensure that you receive quality care and to meet certain legal requirements related to providing you care. We understand that your health information is personal, and we are committed to protecting your privacy and ensuring that your health information is not used inappropriately.

Our Responsibilities: we are required by law to maintain the privacy of your health information and to provide you notice of our legal duties and privacy practices with respect to your health information. We are also required to notify you of a breach of your unsecured health information. We will abide by the terms of this Notice.

How We May Use or Disclose Your Health Information:

The following categories describe examples of the way we use and disclose health information without your written authorization:

For Treatment: We may use and disclose your health information to provide you with medical treatment or services. For example, your health information will be shared with your oncology doctor and other health care providers who participate in your care. We may disclose your health information to another physician for the purpose of a consultation. We may also disclose your health information to your primary care physician or another health care provider to be sure that they have all of the information necessary to diagnose and treat you.

For Payment: We may use and disclose your health information to others so they will pay us or reimburse you for your treatment. For example, a bill may be sent to you, your insurance company, or a third-party payer. The bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

As Required by Law: We may use and disclose your health information when required to do so by federal, state, or local law.

Judicial and Administrative Proceedings: If you are involved in a legal proceeding, we may disclose your health information in response to a court or administrative order. We may also release your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Health Oversight Activities: We may use and disclose your health information to health oversight agencies for activities authorized by law. These oversight activities are necessary for the government to monitor the health care system, government benefit programs, compliance with government regulatory programs, and compliance with civil rights laws.

Law enforcement: We may disclose your health information, within limitations, to law enforcement officials for several different purposes:

Public Health Activities: We may use and disclose your health information for public health activities, including the following:

Military and Veterans activities: If you are a member of the armed forces, we may disclose your health information to military command authorities. Health information about foreign military personnel may be disclosed to foreign military authorities.

Research: We may use and disclose your health information for certain research activities without your written authorization. For example, we may use some of your health information to decide if we have enough patients to conduct a Cancer Research study. For certain research activities, an Institutional Review Board (IRB) or Privacy Board may approve uses and disclosures of your health information without your authorization.

If you authorize us to use or disclose your health information, you may revoke your authorization, in writing, at any time period if you revoke your authorization, we will no longer use or disclose your health information as specified by your revocation, except to the extent that we have taken action in reliance on your authorization.

Your Rights Regarding Your Health Information

You have the following rights regarding the health information we maintain about you:

Right to Request Restrictions: You have the right to request restrictions on how we use and disclose your health information for treatment, payment, or healthcare operations.

Right to Request Confidential Communications: You have the right to request that we communicate with you in a certain manner or at a certain location regarding the services you receive from us.

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care.

For more information regarding this policy, please contact the Practice Administrator at 303-422-2343

Changes to this Notice: Wheat Ridge Internal Medicine (WRIM) will abide by the terms of this notice currently in effect. However, WRIM reserves the right to change the terms of this notice at any time. Any new notice provisions will be effective for all health information from the time the changes are effective within WRIM.

Patient or Patient's Representative: _____ Date: _____