WHEAT RIDGE INTERNAL MEDICINE

7821 West 38th Avenue. Wheat Ridge. CO 80033 | P303-422-2343 | F303-420-3508

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 items please take a moment to note the following **important** items:

- It is very important that you arrive on time for appointment. If you are greater than 10 minutes late for appointment it my need to be rescheduled.
- Please bring the attached information with you completed.
- **Please bring any prescription bottles or list medications that you are currently taking.**
- It would also be helpful to the Physicians if you either bring past medical records with you or request they be sent to our office from your previous doctor(s).
- **Please bring current insurance card(s), photo ID and copay (We accept cash, check, Visa, and Mastercard).**
- **ATTENTION NEW PATIENTS... Office policy dictates that controlled substances will NOT be prescribed at initial visit!**

Please feel free to call us if you have questions about any of the attached information. We look forward to meeting you!

WHEAT RIDGE INTERNAL MEDICINE PHYSICIANS

Stanton Elzi, MD, Sofi Abraham, MSN, FNP-C, OCN, Sara Schmidt, MSN, AGNP-C, Crystal Culbert, PA-C, Steve Krebs, MD, W. Scott Allan, MD, Melissa Fountain, PA-C, David Hager, MD, Emily Piala, PA-C, Kendra Baughn, PA-C

We cultivate good health.

wheatridgeinternalmedicine.com

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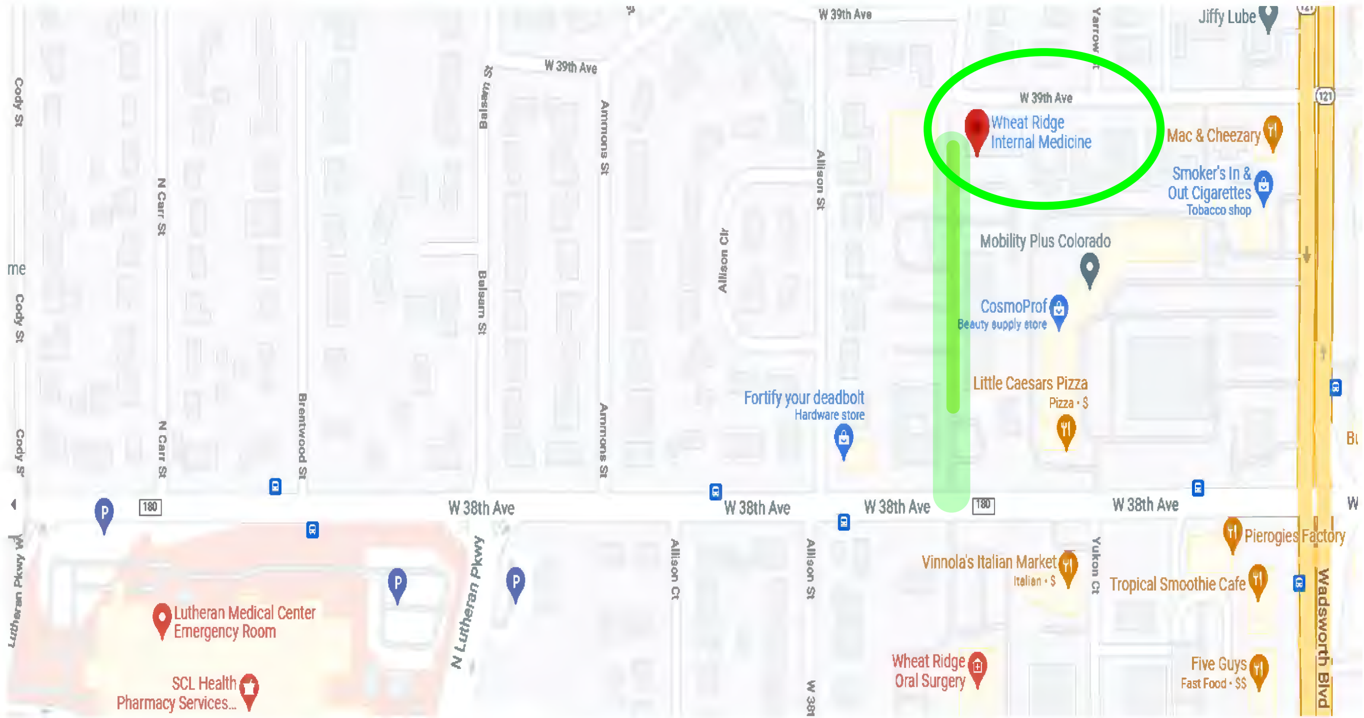
Wheat Ridge Internal Medicine is behind Clear Creek Surgical Center
North Side of 38th Avenue



WHEAT RIDGE
INTERNAL MEDICINE

Patient Information

Patient Name
Date of Birth Social Security# Marital Status
Address City State Zip
Home Phone# Work # Mobile#
Email
Employer Occupation
Employer's Address
Spouse's Name Date of Birth
Social Security # Spouse's Employer
Spouse Work# Spouse's Mobile #
Emergency Contact Contact Number

*Insurance Information - If incomplete the patient will be billed

Primary Insurance Policy/Subscriber#
Insurance Co. Address City State Zip Phone#
Subscriber's Name Group#
Subscriber's Social Security# Relationship to Patient
Secondary Insurance Policy/Subscriber#
Insurance Co. Address City State Zip Phone#
Subscriber Name Group#

Additional Information

No information you provide will be used in a discriminatory manner

Race: American Indian/ Alaska Native American Black/ African American
More than one Race Native Hawaiian/Pacific Islander Refused to report
Undefined White

Ethnicity: Hispanic/Latino Not Hispanic/Latino Refused to report

Preferred Language(please complete) Birthplace

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 agree to pay all co-pay amounts at the time services are rendered. 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

WHEAT RIDGE
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I Refuse to complete this form.

(Please Initial)

Name:

Date of Birth:

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:

Place of Birth

Possible questions and answers that you may have:

Why do we have to do this after so many years? Some of you have been our patients for many years prior to disease report management. The Centers for Medicare & Medicaid have mandated 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 refuse to answer? You have a right of refusal. Just check the box "refused" if you choose to do so.

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

For office use only:

Account#

WHEAT RIDGE
INTERNAL MEDICINE

I, authorize the following person(s) to receive messages or test results performed on myself from the staff of Wheat Ridge Internal Medicine.

Name:
Relationship: Phone:

Name
Relationship: Phone:

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

I wish to be notified at the following numbers:

1st Choice:

2nd Choice:

I give permission to leave messages on my answering machine.

Patient Signature Date

Witness Signature Date

Please Print Name

WHEAT RIDGE
INTERNAL MEDICINE

7821 West 38th Avenue. Wheat Ridge. CO 80033 | P303-422-2343 | F303-420-3508

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

It 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 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 person the possibility to have access to timely medical care.

As a courtesy, and to help patients remember their scheduled appointments Wheat Ridge Internal Medicine sends out confirmation calls the day prior to the appointment. If your scheduled 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 and speak with a patient coordinator.

________________________________ Date: ________________

Patient Acknowledgment (please sign) Or

Personal Representative

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INTERNAL MEDICINE

Financial Policy

I understand that responsibility for payment of medical services in this office is due and payable at the time of 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 any unpaid balance will be assessed 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 payment of fees not covered by insurance. I also assign all benefits to Provider. 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.

Signature of Patient or Responsible Party	Print Full Name	Date

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 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the 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. HIPPA 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. Deportment 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, 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 the 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.

WHEAT RIDGE
INTERNAL MEDICINE

Medical History

Name: Today's date

Sex: M F (Former) Occupation: Email:

Home#: Work#: Mobile#

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

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

Do you have any special hearing needs? Yes No

Do you have vision impairment beyond reading glasses? Yes No

Chronic Conditions / Past Medical History

Please check if you or your family have ever had any of the following:

	Self	Family	Which member?
Skin Cancer			
Eczema			
Psoriasis			
Cataracts			
Glasses/Contacts			
Glaucoma			
Ulcers			
Urinary tract infections			
Kidney disease Kidney			
stones Enlarged			
prostate Incontinence			
Impotence Infertility			
Abdominal aneurysm			
Chronic heart pain			
Abnormal EKG			
Heart attack			
Heart failure			
Heart murmur			

	Self	Family	Which member?
Chronic headaches			
Migraines			
Seizures			
Stroke			
TIA (mini stroke)			
High blood pressure			
High cholesterol			
Pacemaker			
Rheumatic fever			
Breast lump removed			
Breast cancer			
Hearing loss Diabetes			
Osteoporosis			
Thyroid problems			
Asthma			
Blood clots			
Abnormal chest x-ray			
Emphysema			

	Self	Family	Which member?
Tuberculosis			
Chronic bronchitis			
Colon polyps			
Crohns disease			
Ulcerative colitis			
Gallstones			
Hemorrhoids			
Hepatitis / Liver disease			
Hernia			
Pancreatitis			
Irritable bowel disease			
Gout			
Herniated disc			
Chronic back pain			
Degenerative arthritis			
Rheumatoid arthritis			
Sprain/strain			
Bone fractures			
Other (please list)			

	Self	Family	Which member?
Aids			
Anemia			
Bleeding problem			
Blood disorder			
Alcoholism			
Depression			
Drug abuse			
Anxiety/panic attack			
Polio			
Shingles			
Syphilis			
Gonorrhea			
Skin cancer			
Colon/rectal cancer			
Stomach cancer			
Prostate cancer			
Leukemia			
Other cancer (Please List)			

Is your Mother alive? Yes No If not, age at death and cause of death

Is your Father alive? Yes No If not, age at death and cause of death

Surgical History

Please list all OPERATIONS you have had and give the approximate DATE of each:

	Date	Operation	**(other)**
Appendectomy			
Gallbladder out			
Hysterectomy			
Heart surgery			
Joint surgery			

Please list ANY providers you have seen since your last visit:

Women's Health

Number of pregnancies births miscarriages abortions

When was your last pap smear and what was the result?

When was your last mammogram and what was the result?

Are you on birth control? If so what method?

Men's Health

How often do you examine your testicles?

General Health Questions

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

If you have quit, when did you quit?

Do you drink alcohol? Yes No If yes, how much?

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

Have you had a colonoscopy? Yes No

If so, when and what was the result?

Have you had a bone density test? Yes No

If so, when and what was the result?

Do you wear a seatbelt? Yes No

Do you use any marijuana or other recreational drugs? Yes No

Do you take calcium supplements? Yes No

Do you wear sunscreen? Yes No

Have you ever had a sexually transmitted disease? Yes No

If yes, what and when

Immunizations

Have you received the following and if so, when?

	Yes	No	Date
Tetanus			
Measles, Mumps Rubella			
Polio			
Hepatitis B vaccine			
Hepatitis A vaccine			
Pneumonia vaccine (Pneumococcal23 and /or Prevnar 13)			
Shingles vaccine (Shingrex and / or Zostavax)			
Have you ever tested positive for tuberculosis by skin test?			

Patient Health Questionnaire

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

Please check only one box that applies to each question:	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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LIST OF MEDICATIONS

Patient Name (please print):

Pharmacy Name: **Phone Number:**

Please list all medications you are currently taking *including* over the counter medications, vitamins, and herbal remedies.

Medication:	*Dosage:*	*Directions:*	*Reason for taking:*	*Ordering Dr.:*

WHEAT RIDGE
INTERNAL MEDICINE

LIST OF MEDICATION ALLERGIES

Patient Name(please print)**:**

Pharmacy Name: **Phone Number:**

Please list all medications you are allergic to *including* over the counter medications, vitamins, and herbal remedies.

Medication:	**Dosage:**	**Reaction:**

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INTERNAL MEDICINE

7821 West 38th Avenue. Wheat Ridge. CO 80033 P 303-422-2343 F 303-420-3508

-Ws Cultivate Good Health•

AUTHORIZATION TO USE OR DISCLOSE MY HEALTH INFORMATION

PATIENT NAME DOB:

MY AUTHORIZATION

You May Use or Disclose The Following Health Care Information (check all that apply):

All my health information maintained by the above named practice

My health information relating to the following condition:

My health information for the date(s):

Release Records From:

Name:

Address:

City: State:

Phone: Fax:

Disclose This Health Information To:

Name: Wheat Ridge Internal Medicine

Address: 7821 West 38th Avenue

City: Wheat Ridge State: CO Zip Code: 80033

Phone: 303-422-2343 Fax: 303-420-3508

Reason(s) for This Authorization (check all that apply):

At my request

Other (specify)

THIS AUTHORIZATION ENDS:

On (date):

When the following event occurs:

(IF NOTHING IS CHECKED ABOVE, THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE ONE YEAR FROM THIS DATE THE PATIENT SIGNS).

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 TO PATIENT

WHEAT RIDGE
INTERNAL MEDICINE

Questions?

Dear Patient,

As you prepare for your visit to Wheat Ridge Internal Medicine, you may have many thoughts and questions. Often times, you think of a million things you need to ask, but then seem to draw a blank when you are in the office. Please use this form to jot down questions to ask the provider, medical assistant, or staff at the time of your visit.

WHEAT RIDGE
INTERNAL MEDICINE

Wheat Ridge Internal Medicine

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 IT 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 health care 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 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 wlll 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 they have all 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 hea lth 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 might 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. 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 health care 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.

F9r more information regarding this policy please contact the Practice Administrator at 303-422-2343

Changes to this notice: 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: