SOUTHERN COLORADO CLINIC
PATIENT PROFILE

Patient Name:_____ Date of Birth:_____

Address:_____ Apt/Space No:_____ Social Security No.:_____

City:_____ State:_____ Zip:_____ ☐Single ☐ Married ☐ Widow ☐Divorced

Home Phone: (____)_____ Primary Doctor:_____

Work Phone: (____)_____ Are you a full time student ? Yes ☐ No ☐

Cell Phone: (____)_____ If yes, name of school_____

BILLING RESPONSIBILITY

Name:_____

☐ Billing Address same as above

Address:_____ Apt/Space No:_____

City, State, Zip:_____

Social Security No.:_____

Date of Birth: ____/____/____

Relationship to patient☐ Mother☐ Father☐ Other_____

EMPLOYER INFORMATION

Employer :_____

Address:_____

City, State, Zip:_____

Phone: (____)_____

☐Employed☐Retired☐Unemployed ☐Student

Occupation:_____

INSURANCE INFORMATION

Primary Insurance:_____

claims address can be found on the backside of your Insurance card.

Claims Address:_____

City, State, Zip:_____

Member ID:_____

Group No.:_____

Ins. Phone: (____)_____

Policyholder Name:_____

Birthdate:____/____/____ SSN:_____

Secondary Insurance:_____

claims address can be found on the backside of your Insurance card.

Claims Address:_____

City, State, Zip:_____

Member ID:_____

Group No_____

Ins. Phone:(____)_____

Policyholder Name:_____

Birthdate:____/____/____ SSN:_____

Assignment of Benefits

I authorize and direct the Insurance Carrier to pay directly to Southern Colorado Clinic PC, all insurance payments. I understand that I am financially responsible to Southern Colorado Clinic for all charges deemed "patient responsibility," including any and all charges denied by the Insurance Carrier for lack of referral from patient's primary care physician. Furthermore, if necessary to pursue legal means for collection of this bill. I understand that I will be responsible for the legal fees, attorney fees, court cost, interest and penalties.

X_____ _____

Patient/Guardian Signature Date Drivers License Number

Emergency Contact Information

Name:_____

☐Spouse ☐Parent ☐Son ☐Daughter ☐Sibling

Address:_____

City, State, Zip:_____

Phone: (____)_____

Additional Patient Information

Please Circle One:

Preferred Language: English Spanish Other:_____

Race: Hispanic Asian Caucasian African American Black American Indian or Alaska Native Native American Other

Ethnicity: Hispanic or Latino Non Hispanic or Latino Other

Dear Patient,

At this time we would like to update our records with your email address. Please provide your email address below:

Email address: _____

Patient Name:_____

Thank you,

SCC Staff

Office Use Only:

Email address added to system Yes No

Entered by:_____ Date:_____

Southern Colorado Clinic PC

AUTHORIZATION FOR RELEASE OF INDIVIDUAL HEALTH INFORMATION TO A DESIGNATED PARTY

This form releases the authorization for a family member of your choice to have access to the following information:

This authorization grants permission to the designated party to:

I, _____ authorize permission to the
(Patient Name)

Designated party to: ***(ANYONE OTHER THAN PARENTS)***
Siblings must be over 21

____ have access to my medical records, including test results

____have access to my billing information

____make and confirm appointments

____other, please specify ***bring patient to appts and sign paperwork***

Please be aware we will NOT release any of the following types of records

- Alcohol, Drug or Substance Abuse Records
- Sexually Transmitted disease Information
- Mental Health or Psychotherapy Records

Person authorized to share information with:

_____ _____
(Name of Designee) (Relationship)

_____ _____
(Name of Designee) (Relationship)

_____ _____
(Name of Designee) (Relationship)

_____ _____
Signature of Patient or Representative Date

SOUTHERN COLORADO CLINIC, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge receiving and reading a complete copy of the Notice of Privacy Practices of SOUTHERN COLORADO CLINIC, P.C., on this _____ day _____, 20__.

I further acknowledge that, as of today's date, I have no questions regarding the Notice of Privacy Practices.

_____
Signature of Patient

_____
Signature of Staff

_____
Printed Name of Patient

_____
Printed Name of Staff

_____

_____
Address of Patient

_____
Telephone Number of Patient

SOUTHERN COLORADO CLINIC P.C.
Notice of Privacy Practices

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.

I. Understanding Your Health Information

When you receive healthcare services from Southern Colorado Clinic P.C. (hereafter "We," "Us," "Our"), a record of your visit is created. This record usually contains your name and other information that may identify you and your symptoms, examination and test results, diagnoses, treatment, and/or plans for future health care. This record is sometimes referred to as your "medical record" or "medical chart." This record allows:

- Doctors, nurses, and other health professionals to plan your treatment;
- Health insurance plans, such as Medicare, Medicaid, or a third party payor, to pay for your care; and
- Us to measure the quality of care provided to you.

We are required by law to maintain the privacy of your health information, to provide you with notice of our legal duties and privacy practices with respect to your health information, and to notify you following a breach of your unsecured health information. We will not use or give to others your health information without your written permission, except as stated in this Notice.

II. How We Will Use and Give Out Your Health Information

a. Treatment, Payment, and Health Care Operations

We will use and give out your health information to provide you with health care treatments, to get paid for our services, and to help us operate. We are not required to obtain your permission prior to using your health information for these purposes. For example:

- We will give your medical record to health care professionals not on our staff, such as other doctors and hospitals who help care for you;
- We may send a bill to your health insurance plan or to you; and
- Our employees may use your medical record to review our performance and make sure you receive quality health care.

b. Other Uses and Disclosures Allowed or Required by Law

We also may use or give out your health information without your permission for the following purposes, under limited circumstances:

- To people who are involved in your care or who help pay for your care, such as your family, your close personal friends, or any other person chosen by you, to notify them of your location, general health, and to assist you in your health care (only after providing you with the opportunity to object);
- To maintain a facility directory and newsletter, which enables us to share your location and announcement of your date of birth with your family, your close personal friends, and other residents (only after providing you with the opportunity to object);
- To government agencies that oversee us (such as license and certification inspectors);
- To government agencies that have the right to receive and collect health information (such as to control disease outbreaks);
- For court proceedings (such as in response to a court order or other request by a judge);
- To workers' compensation programs when your health problem is from a work-related injury;
- For law enforcement purposes (such as providing limited information to find a suspect or missing person);
- To coroners and funeral directors to allow them to carry out their duties;
- To organ donor agencies (subject to applicable laws);

- For research studies that meet all privacy law requirements (such as research to stop a disease);
- To avoid a serious threat to the health or safety of others;
- To contact you about new treatments or medicines that may help you;
- To our business associates that help us perform required tasks, such as our accountants, computer consultants, and billing companies (only if the business associate agrees in writing to keep your health information confidential as required by law);
- To contact you in efforts to raise funds for us (subject to providing you with the opportunity to opt out of receiving future fundraising communications); and
- For any other purpose required or allowed by law.

c. Uses and Disclosures Requiring Your Written Permission

Other than those uses and purposes listed above, we will make other uses and disclosures of your health information only after first obtaining your written permission to do so. Examples of uses and disclosures for which we need your written permission include, but are not limited to, uses or disclosures of psychotherapy notes related to your care, uses or disclosures for purposes of marketing, and the sale of your health information that will result in payment to us. If you authorize a particular use, you may revoke your authorization at any time by notifying us in writing that you wish to do so.

III. Your Rights Regarding Your Health Information

Subject to certain legal limits, you have rights regarding the use and disclosure of your health information, including each of the following rights.

- To request restrictions on certain uses and disclosures. We are not generally required to grant all requested restrictions. However, we must grant any request to restrict disclosure of your health information to your health plan if (a) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (b) the health information pertains solely to a health care item or service for which you, or a person other than the health plan on behalf of you, has paid us in full.
- To receive confidential communications of your health information.
- To inspect and copy your health information.
- To request an amendment to your health information.
- To receive an accounting of our uses and disclosures of your health information.
- To obtain a copy of this Notice of Privacy Practices.

IV. Questions, Concerns, and Changes to this Notice

If you have any questions about this Notice of Privacy Practices, please contact our Privacy Officer, Kim Garnett at (719) 553-2200. If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact our Privacy Officer at P.O. Box 9000 Pueblo, Colorado 81008. To file a complaint with the Secretary of the Department of Health and Human Services, submit your complaint to:

The Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Ave., SW
Room 509 HHH Bldg.,
Washington D.C., 20201

All complaints must be submitted in writing unless you are unable to write, in which case someone will assist you with putting your complaint into a written form. We will not retaliate against you for filing a complaint.

We reserve the right to revise our Notice of Privacy Practices and to make the revisions apply to your health information that we created or received before the effective date of the revision. We will notify you of any revisions to our Notice of Privacy Practices by posting the revised notice in the common area and on our web site.

Southern Colorado Clinic, PC
Office and Financial Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. *Please read each section carefully and initial.* If you have any questions, do not hesitate to ask a member of our staff.

Appointments

1) We value the time we have set aside to see our patients. If you are not able to keep an appointment, we require 24-hour notice.
2) If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.
3) We strive to minimize any wait time; however, emergencies do occur and we appreciate your understanding.
4) Before making an annual physical appointment, check with your insurance company as to whether the visit will be covered. During routine physical examinations, if additional medical problems are found or discussed, including any abnormalities or preexisting problems, your insurance will be billed for those services. **Based on your medical plan benefits you may be responsible for additional co-pay, deductibles or out of pocket expenses. These charges will be your responsibility.**

Initial: _____

Insurance Plans

Please understand

1) It is your responsibility to keep us updated with your correct insurance information. **If the insurance company you designate is incorrect or you fail to update your information, you will be responsible for payment of the services provided.**
2) If we are your primary care physician, make sure your name or phone number appears on your card if applicable. If your insurance company has not yet been informed that we are your primary care physician, you may be financially responsible for your current visit.
3) It is your responsibility to understand your benefit plan with regard to, out of pocket expenses, covered services and participating laboratories. For example
    a. Not all plans cover annual healthy (well) physicals, sports physicals, or hearing and vision screenings. If these are not covered, you will be responsible for payment.
    b. During routine physical examinations, if additional medical problems are found or discussed; including any abnormalities or preexisting problems your insurance will be billed for those services. **Based on your medical plan benefits you may be responsible for additional co-pay, deductibles or out of pocket expenses. These charges will be your responsibility.**
    c. For children younger than 2 years, there is a limit as to the number of allowable well visits per year. If the number of visits is exceeded, your insurance company may not pay and you will be responsible for payment.
    d. If your insurance has a dedicated laboratory it is your responsibility to have your labs drawn at the appropriate site.
4) It is your responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered. Please confirm all referrals and authorizations are in place prior to your appointment or you may be responsible for payment.

Initial: _____

Referrals/Prior Authorizations

1) Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days.
2) It is your responsibility to know if a selected specialist participates in your plan.
3) Remember, we must approve referrals before they are issued. If you have not been seen in the last 6 months you may be asked to make an appointment with your PCP before a referral is approved.
4) It is your responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered. Please confirm all referrals and authorizations are in place prior to your appointment or you may be responsible for payment.

Initial: _____

Financial Responsibility

1) According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
2) **Co-payments** are due at the time of service.
3) Self-pay patients are expected to pay for services in **FULL** at the time of the visit.
4) If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit.
5) Patient balances are billed upon receipt of your insurance plan's explanation of benefits. Your remittance is due within **10** business days of your receipt of your bill.
6) If previous arrangements have *not* been made with our billing office, any account balance outstanding longer than 90 days will be forwarded to a collection agency.
7) For scheduled appointments, past due balances must be paid at the time to the visit.
8) If you participate with a high-deductible health plan, you may be required to pay for the visit if your deductible has not been met.
9) We accept cash, checks, Visa, and MasterCard credit and debit.
10) A fee will be charged by "CHECKWAY" for any checks returned for insufficient funds.

Initial: _____

Forms

1) Forms are subject to a form fee for completion. Payment is due when the forms are dropped off. We require 3-day turnaround time.

Initial: _____

Transfer of Records

1) If you transfer to another physician, we will provide a copy of your medical record to your new physician, free of charge, as a courtesy to you. A copy of the medical records will be mailed directly to the physician office listed on the medical record release form. Please allow 7-10 business days for processing.
2) A copy of your complete record is available for:
    a. $14.00 for the first 10 pages.
    b. $0.50 for each additional page 11-40 pages
    c. $0.33 for each additional page over 40 pages

A $14.00 deposit is required for request to be processed.

Initial: _____

Prescription Refills

1) For monthly medication refills, we require 48 hours' notice, during regular business hours. Please plan accordingly.
2) **To expedite your request please call your pharmacy to request a refill**

Initial: _____

Website **www.southerncoloradoclinic.com**

Our website provides you with access to our current physician directory, patient portal, services available and registration forms available for you to download.

You may also access our patient portal directly at https://www.mysccmd.com to create a secure account. This will allow you to communicate with our office in a secure manner to request appointments, pay your bill or update your information.

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s)_____

Responsible Party Member's Name _____**Relationship**_____

Responsible Party Member's Signature _____ **Date** _____