2016 Patient Information Intake Form

20 MILE URGENT CARE & FAMILY MEDICINE
11355 S. Parker Road, Suite 103
Parker, Colorado 80134
720-974-7210

Welcome To Our Clinic. Please Print and Complete All Parts

Today's Date _____ **Reason for Visit** _____

PATIENT INFORMATION: (This section is for patient only) **Referred by/PCP Name:** _____

First Name_____MI_____Last Name_____Nickname_____

Address _____Apt#_____City_____State_____Zip_____

Mailing Address if different from above _____

Home Phone _____ Cell Phone _____ Work Phone _____

Date of Birth ___/___/_____ Age _____ Sex _____ Ethnicity _____ Marital Status_____

Social Security # _____-_____-_____ Email Address_____

Spouse_____ Primary Language_____

Employer_____ Company Work Number_____

Relationship to Responsible Party: Self ◉ Son ○ Daughter ○ Spouse ○ Other ○

RESPONSIBLE PARTY OF INSURANCE: (Primary Insurance Person/Carrier) *REQUIRED INFORMATION*

Name_____Social Security #_____-_____-_____

Address _____Apt#_____City_____State_____Zip_____

Home Phone_____ Work Phone_____ Date of Birth _____/_____/_____

INSURANCE INFORMATION: *REQUIRED INFORMATION*

Primary Insurance_____ Policy ID #_____Group#_____

Secondary Insurance_____ Policy ID#_____ Group#_____

EMERGENCY CONTACT:

Name_____ Home Phone _____ Cell Phone_____

Address_____ City_____ State_____ Zip_____

PHARMACY INFORMATION: *REQUIRED INFORMATION*

Primary Pharmacy_____ Cross Streets_____

PLEASE SIGN BOTH X'S

I authorize payment of medical to go directly to 20 Mile Urgent Care and Family Medicine for these services and all future claims.

X_____ Signed (Insured or Authorized Person)

I authorize the release of any medical information necessary to process this and all future claims.

X_____ Signed (Insured or Authorized Person)

Patient Financial Responsibilities

20 MILE URGENT CARE
& FAMILY MEDICINE
11355 S. Parker Road, Suite 103
Parker, Colorado 80134
720-974-7210

Please Read and Initial Each Line That You Have Read and Understand Each Section.
(Initials Required)

PATIENT NAME:_____ **DATE OF BIRTH**_____

In order for us to serve you better, please read and initial all the following information, Please and Thank You.
We participate with most insurance plans, with several we have a dual contract being both Family Medicine and Urgent Care. You must check with your insurance to verify your plan participation with our clinic.

BENEFITS AND REFERRALS

It is your responsibility to know your insurance benefits. We require that you provide us with copies of a photo ID and your current insurance card. If we cannot verify your insurance benefits with the information you provide, payment in full is expected at your time of visit. If your insurance requires that you have a referral for a visit other than at your primary care physician's office, then it is your responsibility to obtain that referral.

INITIALS_____

FINANCIAL RESPONSIBILITIES

Co-payments are collected at the time service is rendered. Any outstanding balance from deductibles, co-insurances, or co-pays is your responsibility to pay in full upon receipt of your statement. Any service determined to be a non-covered benefit under the provisions of your insurance plan, either due to a pre-existing condition, waiting period, deemed not medically necessary, or not paid due to lack of proper notification, will be your responsibility as well.

INITIALS_____

SELF-PAY

We offer services for non-medically insured patients; however, the reception staff is unable to quote prices for these services. Our basic office visit begins at $115.00. Any additional charges resulting from added testing or services, for diagnostic purposes, will be discussed with you before they are performed. All charges are payable & expected in full at time of service.

INITIALS_____

MEDICARE

This clinic accepts Medicare assignment. Medicare pays 80% of allowable charges after the annual deductible is met. It is the patient's responsibility to pay the deductible and the 20% co-insurance. If you have additional secondary insurance coverage please provide us with this information and make sure that Medicare is aware of this additional coverage as well. If you are insured by a Medicare Replacement Plan, Medicare will not pick up your co-pay. It will be collected at the time of service.

INITIALS_____

RETURN CHECK FEES

I understand that there will be a charge of $30.00, if I present a check for payment that is not honored by the bank it is drawn on. This overdraft could also prevent the clinic from accepting checks for payment in the future.

INITIALS_____

I have read the above "The Patient Financial Responsibilities" and with my signature I agree to pay co-pays, co-insurance, deductibles, outstanding balances that are owed and/or any out of pocket fees that are not covered at the time of service.

SIGNATURE_____ **DATE**_____

HIPPA Authorization Form

20 MILE URGENT CARE
& FAMILY MEDICINE
11355 S. Parker Road, Suite 103
Parker, Colorado 80134
720-974-7210

COMMUNICATIONS: (Number to best contact you as a patient regarding any medical issues or test results. With Privacy and HIPPA related information we are not able to leave any detailed message unless the phone number can be verified as yours the Patient.)

Y= Yes, N= No, or N/A= Not Applicable **Please Circle One**

Preferred # to reach you _____ Ok to leave message Y N N/A

AUTHORIZED PERSON(S) THAT MAY RECEIVE YOUR TEST RESULTS OR DISCUSS YOUR MEDICAL ISSUES

Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____

E-MAIL COMMUNICATIONS (REQUIRED FOR BILLING DEPARTMENT)

I, the undersigned, understand that e-mail communication is optional and does not replace traditional means of communication. I understand that I may receive information on my email confirming my Payment, Receipts, or requesting answers to billing questions or literature that relates to 20 Mile Urgent Care & Family Medicine.

_____ _____

NAME (PRINT) **DATE**

_____

SIGNATURE

CONSENT FOR TREATMENT OF MINORS: (This is the only paragraph that pertains to Minors only.)

I, the undersigned, understand that a minor child (17 and under) must have my consent to be treated at 20 Mile Urgent Care & Family Medicine. I understand that I must be present at each appointment for any child aged 14 or younger. If the child is between 15 and 17, I understand that I must send a note with the child to the appointment consenting for the child to be treated. I also understand that Colorado Law provides minors to see care without parent consent for certain issues.

_____ _____

SIGNATURE **DATE**