Forum Family Medicine Patient Information

Patient Information

Legal Name (First MI Last)			Preferred Name	Date of Birth
Address			City/State/Zip	
Email		Home phone	Work phone	Cell phone
Sex ☐Male ☐Female	Marital Status ☐Single ☐Divorced ☐Married ☐Widowed	Race ☐White ☐Black ☐Asian ☐Hispanic ☐Other	Ethnicity ☐Hispanic ☐Non-hispanic	Preferred language ☐English ☐Spanish ☐Other ___________
New Patients Who can we thank for referring you? ☐ family/friend ______________ ☐ insurance ☐website ☐ other___________				

If Patient is a child (aged 17 or under), please complete parent information

Parent Name (First, MI, Last)	Employer
Parent address ☐same as patient	Work phone
Parent City/State/Zip	Home phone

Insurance Information *(Only complete * items if card copy attached)*

	Primary Insurance	Secondary Insurance
Insurance Company *		
Effective date		
Subscriber Name *		
Subscriber ID# & SSN		
Group Number		
Subscriber Employer *		
Mail Claims to:		

Payment Terms and Agreements

I, the undersigned, in consideration for services rendered to the patient by Forum Family Medicine understand and agree to the following:

1. I understand that any co-payments, deductibles, and coinsurance (or payments for services not covered by insurance), are due in full at the time of service.
2. I understand that my insurance coverage may not provide payment for all charges incurred in obtaining treatment from Forum Family Medicine. I will be responsible for any co-payment, deductible, or services not covered by my insurance provider. If I do not have insurance coverage for services rendered by Forum Family Medicine, I agree to pay all charges resulting from such services.
3. I understand that my insurance coverage may not provide benefits for routine or preventive care. I understand that it is my responsibility to know my benefits and that I will be financially responsible for services that are not covered.
4. I hereby authorize Forum Family Medicine to file with my insurance carrier, and I assign payment of medical benefits to Forum Family Medicine.
5. I understand as a patient, it is my responsibility to verify with my insurance company that Forum Family Medicine's physicians are participating providers. I understand that I am responsible for providing accurate and complete information for insurance billing (such as a current and valid insurance card) and if such is not provided, I will be expected to pay charges in full at the time of service. I will be responsible for notifying the office of any changes in my insurance coverage. Failure to notify the office of such changes will make me responsible for claims not accepted by the insurance company.
6. **No Show/Cancellation Fee. I understand that if I do not keep a scheduled appointment or fail to provide 24-hour notification to cancel an appointment, I will be responsible for a $45.00 administrative fee**.

____ _____________________________

Signature (Must be a parent or guardian for children 17 and under) **Date**

Forum Family Medicine Patient Consent

Patient Name: ____ **Date of Birth:** ________________

Consent for Treatment: By signing below, I voluntarily agree to the tests, procedures, and/or treatments which the physician has deemed necessary and which are administered to or performed on me under the direction of the physician or his/her designee. I understand that the practice of medicine is not any exact science and that diagnosis and treatment may involve risks. No guarantees have been made to me as to the results of my treatment at Forum Family Medicine.

Consent for Treatment of Minors: By signing below, I understand that a minor child (17 and under) must have my consent to be treated. I understand that I must be present at each appointment for any child aged 14 and under. If the child is between the ages of 15 and 17, I understand that I must send a note with the child to the appointment consenting for the child to be treated. The note must contain the date, a statement of consent, and my signature. Further, I understand that consent for treatment does not alter the legal requirements for confidentiality. I also understand that Colorado Law provides for minors to seek care without parental consent for certain issues.

Consent to Communicate Medical Results: By signing below, I understand that medical results will be communicated directly to me unless I specifically identify individuals to whom information may be communicated (see box below to authorize other family members to receive results). Please indicate how we may inform you of test results (check all that apply):

- ❒ Call my work number: ____________________ Okay to leave message at work? ❒Yes ❒No
- ❒ Call my cell phone: _______________________ Okay to leave message on cell ❒Yes ❒ No
- ❒ Call my home number: ______________________ Okay to leave message at home? ❒Yes ❒ No

In the event that I am not available to receive medical results when called, I authorize Forum Family Medicine to leave medical information with any of the persons identified below. It is my responsibility to notify these persons that such information may be left with them and I agree not to hold Forum Family Medicine responsible for information not conveyed to me through these persons.

(Please indicate below which family members are authorized to receive result information.)

Family Information ***(Please list all members of your household who are authorized to receive results.)***

Name	❒Male ❒Female	Date of birth	Relation
Name	❒Male ❒Female	Date of birth	Relation
Name	❒Male ❒Female	Date of birth	Relation

Emergency Contact Information (Name or relative or friend to contact in case of emergency)		
Name	Relation	Phone

Consent for Use and Disclosure of Protected Health Information: By signing below, I give my consent for Forum Family Medicine (FFM) to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operation (TPO). (The Notice of Privacy Practices provided by FFM describes such uses and disclosures more completely.) I have the right to review the Notice of Privacy Practices prior to signing this consent. FFM reserves the right to call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others. With this consent, FFM may mail to my home or other alternative location any items that the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential." I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, FFM may decline to provide treatment to me.

____ ________________________

Signature (must be a parent or guardian for children 17 and under) **Date**

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Printed name/relationship (if parent/guardian)