

Dear Patient

Thank you for choosing Arapahoe Peak Health Center for your health care. In an effort to provide you with the best care possible, we would like to update you on a few of our policies.

INSURANCE CARDS: Present your insurance card each time that you check in. If you receive a new card from your insurance company, replace the one in your wallet, even if it appears the same. Providing us with the most accurate information will help prevent you from being billed for services that your insurance company should have paid.

COPAYS: Our contract with your insurance company requires that we collect a copay with each visit. Copays not paid on the day of service will be billed a service charge.

CANCELLATION: We must have a 24 hour cancellation notice on all Physical appointments. There will be a \$50 charge for any missed appointment.

MEDICATION REFILLS: Please call your pharmacy four days before you need your refill. This will assure that your refills are done correctly and that you don't miss any doses. By calling your pharmacy rather than our office you speed up the refill process. If you receive prescriptions by mail, we will write the prescription for you to send to the mail order company. (Allow 4 days for your written prescription to be ready.)

LAB RESULTS: Many labs come back within four days. If you have not heard from us within 7 days, please call. Some tests, including VAP cholesterol and hormones, take up to two weeks. Pap Smears, skin biopsies and some cultures take up to three weeks. Strep screens take three days.

SCHEDULING YOUR CT SCAN, ULTRASOUND OR MRI: If you have not heard from our office or the testing facility within 48 hours, please call us. It will typically be 7–10 days before your actual appointment. This allows time to get approval from your insurance and get you scheduled into the testing facility.

URGENT CARE NEEDS: We make every effort to accommodate same day appointment requests for illness and injury. We accept walk-in patients for urgent medical issues only.

OFFICE HOURS: Our regular office hours are 7 a.m. – 7 p.m. Monday thru Thursday, 7 a.m. – 5 p.m. on Friday and 8 a.m. – 1 p.m. on Saturday. We will be closed on major holidays and will post those closures. Saturdays are reserved for those issues that cannot wait until Monday.

Please feel free to call our office with questions or suggestions.

Sincerely
The Arapahoe Peak Health Team

Updated July 15, 2009

ARAPAHOE PEAK HEALTH CENTER

Registration Form

Patient Information

Patient Name: _____
Last First (legal) Initials/Nickname

Physical Address: _____

City: _____ State: _____ Zip: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: Home () _____ Work () _____ Cell () _____

Birth Date: _____ SS#: _____ Sex: *M F*

Marital Status: *S M W D* Spouse's Name: _____
Last First

Preferred Pharmacy _____ Email _____

May we discuss your care with your spouse or other person? Yes No If yes:

Name: _____ Relationship: _____ Phone: _____

If patient is a minor:

Mother's Name: _____ Contact Phone: _____

Father's Name: _____ Contact Phone: _____

Insurance Information

Responsible Party/Insurance Policy Holder: _____

SS#: _____ Date of Birth: _____

Address/Phone (*if different than listed above*): _____

Primary Insurance Coverage: _____

Secondary Insurance Coverage: _____

Please give current insurance card to the receptionist to copy for your chart.

Emergency Contact

Name of relative not living with you: _____

Relationship: _____ Phone: _____

How were you referred to us? _____

ARAPAHOE PEAK HEALTH CENTER

Statement of Authorization/Responsibility

Payment of insurance co-pays and all charges not covered by insurance are due at the time of service. (If you do not have Insurance coverage you will be asked to pay an estimation of the total amount owed at the end of each visit.) I understand that I am fully and personally responsible for payment of charges that might have been overlooked at the time of check-out. I understand that co-pays not paid on day of service will be assessed an additional fee.

Waiver of “Usual, Customary and Reasonable” Clauses

I acknowledge that the fees charged by Arapahoe Peak Health Center for services rendered to me, or to the person for whom I assume financial responsibility, may exceed the fees considered “usual, customary and reasonable”. I agree to pay all amounts assigned to patient responsibility by my insurance company even if that amount is greater than the reimbursement from my insurance company.

Release Medical Information – Assignment of Benefits

I authorize release of all medical information needed to process insurance claims or that is pertinent to the medical care of myself or the person for whom I am legally responsible. I authorize Arapahoe Peak Health Center to bill my insurance company for services and assign all medical and/or surgical benefits, including major medical benefits, to which we are entitled to Arapahoe Peak Health Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I release Arapahoe Peak Health Center of all responsibility for loss of confidentially through access and/or copies made of records released in compliance to this authorization.

Acknowledgment of Notice of Privacy Practices

I hereby acknowledge that I have been offered or have received a copy of the Arapahoe Peak Health Center Notice of Privacy Practices.

Authorization for Treatment

I authorize the providers of Arapahoe Peak Health Center to render medical services as deemed necessary to myself/my child/person under my guardianship.

Acknowledgement of Office Policies

I have read, understand and accept the Arapahoe Peak Health Center office policies.

I have read all of the above and understand/agree to all provisions therein regarding: authorization for treatment, responsibility for payments and release of medical information.

Patient’s Name: _____ Date: _____

Signature of Patient or Parent/Legal Guardian

Printed Name

If Parent/Legal Guardian – Relationship to Patient: _____

Health Summary

Patient's Name: _____ Date: _____

Allergies Check here if none: _____

Medications Check here if none: _____

Include birth control pills, herbs, vitamins, dietary supplements and over the counter medications.

Health Conditions

Please check all conditions that you currently have or have had in the past.

YES	NO	DISEASE	YES	NO	DISEASE
		Irregular Heart Beat			Prostate Problems
		Congestive Heart Failure			Gout
		Heart Attack			Arthritis
		Rheumatic Fever			Osteoporosis
		High Cholesterol			Skin Disease, Type:
		High Blood Pressure			Stroke
		Asthma			Epilepsy/Seizures
		Emphysema/Chronic Bronchitis			Thyroid Problems— too low or too high
		Blood Clot in Lung			Diabetes/High Blood Sugar
		Blood Clot in Leg			Anemia/Low Blood
		Tuberculosis			Bleeding Problems, Type:
		Gallstones			Blood Transfusion
		Liver Disease, Type:			Cancer, Type:
		Ulcers in Bowels/Stomach			Anxiety
		Bleeding from Bowels			Depression
		Kidney Disease, Type:			Glaucoma
		Kidney Stones			Other:

Surgeries

Please check all surgeries that you have had.

YES	NO	SURGERY	YES	NO	SURGERY
		Cataract Surgery, Left or Right			Joint Scope Surgery
		Tonsils Removed			Joint Replacement of Knee or Hip
		Neck Artery Surgery			Back Disc Surgery
		Open Heart or Catheterization			Prostate Surgery
		Appendectomy			Hernia Surgery
		Gallbladder Removal			Vasectomy
		Abdominal Surgery			Hysterectomy
		Broken Bone Repair			Other:

Family History

YES	NO	DISEASE	RELATIONSHIP TO YOU	YES	NO	DISEASE	RELATIONSHIP TO YOU
		Heart Attack				Epilepsy/Seizures	
		High Blood Pressure				Bleeding Problems	
		High Cholesterol				Diabetes/High Blood Sugar	
		Asthma				Sickle Cell Anemia	
		Tuberculosis				Thyroid Problems	
		Liver Disease				Cancer, Type:	
		Kidney Disease				Alcohol Abuse	
		Gout/Arthritis				Anxiety or Depression	
		Osteoporosis				Glaucoma	
		Stroke				Other:	

Lifestyle History

Exercise: Never Rarely Other

When was your last: Tetanus Shot: _____ Hepatitis B Vaccine: _____

Flu Shot: _____ Pneumonia Vaccine: _____

Have you ever smoked? Yes No How many years did you smoke? _____

When did you quit? _____ How many packs per day do you smoke now? _____

Do you use smokeless tobacco? Yes No

Do you drink alcohol? Yes No How much? _____ How often? _____

Female Patients Only

Number of Pregnancies _____ Number of Deliveries _____

Number of Abortions _____ Number of Miscarriages _____

When was your last menstruation? _____

How old were you when you went through menopause? _____

When was your last PAP smear? _____

Have you ever had an abnormal PAP smear? Yes No If yes, when was the abnormal PAP smear? _____

What was the abnormality? _____

What kind of treatment did you have? _____

When was your last Mammogram? _____ Have you ever had an abnormal Mammogram? Yes No

If yes, when was the abnormal Mammogram? _____

The above information is current and correct to the best of my knowledge.

Signature Patient/Guardian

Date

Physician's Initial

Date