AgLands Family Health
Caitlin Philpy, NP-C
Missouri Krantz, NP-C
2215 San Juan Ave.
La Junta, CO 81050
Phone: 719-363-1533 Fax: 719-363-1534

Patient Information Form (Adult)

PLEASE PRINT (**ONE** form per person)

Date:

Patient Information

Legal Name: Last ___________________________ First _____________________________ M.I. ______ Birth Date: ____/____/_____ Social Security # _______-_______-_______

Sex: ❑ Male ❑ Female ❑ Transgender Male/Female-to-Male ❑ Transgender Female/Male-to-Female ❑ Other ❑ Decline

Physical Address:________________________________City:_________________ State: _________ Zip:__________ Mailing Address: ________________________________City:_________________ State: _________ Zip:__________ Phone(s): Day: (____)______-___________ Cell : (____)______-___________ Email address: ________________________ Employer: ____ Work Number: (____)______-______________

Guarantor Information (Person Responsible for Payment of Accounts/Services)

Same as above

Legal Name: Last ______________________________ First _______________________________ M.I. _______ Birth Date: ____/____/______ Social Security # _______-_______-_______ Relationship to Patient: ______________

Mailing Address: ________________________________City:_________________ State: _________

Zip:_____________

Phone(s): Day: (____)______-____________ Cell: (____)______-____________ Email address: ____________________

Employer: ______________________________________ Work Number: (____)______-______________

Person to Notify in Case of Emergency (Spouse, Parent, Guardian or Other)

Name: _____________________________Relationship to Patient: ________________ Phone: (___) _____-__________________

Insurance Information
(Provide current copy of insurance card to AFH staff)

Name of Insured: _____________________________________Name of Insurance_____________________________________ Policy Number: ________________ Group Number: _____________________ Policyholder Name: ____________________ Effective Date: _________________ Patient's Relation to Policyholder: Self Spouse Child Other Policyholder SSN#:___/_____/______ Policyholder DOB: __________________

Secondary Insurance Name: ____________________________________ ID# ______________________________ Is your visit due to a(n): Auto Accident? Yes No Job Related Injury? Yes No

Household Income Information

Number of People Living in Household: ___________________

Estimated Monthly Household Income: $__________________ (If no income, please enter "0")

Additional Information
Please answer the following questions in order for us to better serve you.

What language is preferred? English Spanish Other ________________________

US Veteran Status: Have you (patient) completed service in the Uniformed Services of the United States? Yes No

Ethnicity: Check one of the following ethnic groups that best pertains to you (patient).
Hispanic/Latino; Non-Hispanic/Non-Latino

Race: Check one of the following racial groups that best pertains to you (patient).
Asian
Native Hawaiian
Other Pacific Islander
Black/African American (including Blacks or African American of Latino/Hispanic descent)
American Indian/Alaska Native (including American Indians or Alaskan Natives of Latino/Hispanic descent) White (including Whites of Latino/Hispanic descent)

Marital Status:
Married (Common Law)
Single
Widowed
Divorced
Other _____________

Sexual Orientation:
Straight (not lesbian or gay)
Lesbian or Gay
Bisexual
Something else
Don't know
Decline to disclose

I hereby certify the information provided is correct and true to the best of my knowledge. I permit AgLands Family Health, PLLC (AFH) representatives to contact any necessary person or agency to verify this information. I agree to notify AFH promptly of any change in household members, address, phone, income, insurance, or other essential information. I understand that I must show my card at time of service based upon the guidelines established by AFH and the State of Colorado. Co-payments/nominal fees are to be made at time of service unless authorized beforehand.

I understand AFH may request additional information from me in the future to qualify me for programs that will help cover the costs of my care, prescriptions and other services while I am an AFH patient.

X____ Date: ______/_____/_______
Signature of Patient (If patient is over 18), GUARDIAN (If patient is under age 18, OR WITNESS (If adult patient is unable to sign)
Print Name: _____________________________________
Relationship to Patient:
_____Self
_____Parent/guardian
_____Authorized Representative
_____Other: _________________

Authorized Use Only

Staff initials: ___________________________________ Dept: ___________________________________
New patient: Yes No

HIPAA Acknowledgement

Date: _________________ Patient Name: ________________________________ Patient DOB: _____________

ALL NEW PATIENTS MUST COMPLETE THIS FORM.

ACKNOWLEDGEMENT

I ___________________________ (Patient Name) acknowledge receipt and reviewed the AgLands Family Health, PLLC Notice of Privacy Practices (please sign below).
I would like to receive a copy of any amended Notice of Privacy Practices by email: ___Yes ____No
If yes, please provide email address: ____

COMMUNICATION

I also would like AgLands Family Health, PLLC to follow these instructions when contacting me regarding my health care (please mark all that apply):

At day phone number listed (preferred contact number): (_____) ______-_________
Leave messages on my answering machine/voice mail ___ Allow ___ Not allow
Leave messages with any other person ___ Allow ___ Not allow

At alternate phone number: (_____) ______-_________
Leave messages and tell them who is calling if asked ___ Allow ___ Not allow
Leave messages on alternate phone voicemail or answering machine ___ Allow ___ Not allow

Signature of Patient/Guardian: ____ Date __________________
Parent/Guardian Name (Please Print): __________________________________

If not signed by patient (or plan member), please complete section below and indicate your relationship:

Parent/Guardian of minor patient.
Mother's Name: ______________________ Father's Name: ________________________
_____Beneficiary or personal representative of deceased patient (Copy of court order needed)
_____Guardian or Conservator of an incompetent person (Copy of court order needed)
_____Other (specify) ____

Privacy Practice Acknowledgement must be signed before initial visit to AgLands Family Health, PLLC. You may end or change "Communication" section in this form at any time by filling out a new form. All previous "HIPAA Acknowledgement & Confidential Communication Request" forms will be void.

Staff Initials: _________ Dept: _____________________________

Date sent to Med Rec: ___________ Med Rec Clerk Initials: _____________ Scanned Date: ______________

Confidential Communication Request

Date: _________________ **Patient Name:** ________________________________ **Patient DOB:** _____________

PATIENT WILL COMPLETE UPON REQUEST

AUTHORIZATION

I, ____, give my permission to AgLands Family Health, PLLC and/or any staff member of AgLands Family Health, to discuss my health care with the individuals noted below who may, from time-to-time, help me receive and pay for health care. This may include, but is not limited to, attending my appointments, helping me follow treatment recommendations, picking up medicines, helping me understand my test results, helping me understand and make payments for health care

Name_______________________________________ Relationship___________________ Phone #______________

Name_______________________________________ Relationship___________________ Phone #______________

Please note: This form does not replace the Release of Information form that must be completed to release PHI to another entity (person/business).

RESTRICTIONS

The following people shall not be allowed access to my Personal Health Information:

Name____ Relationship___________________

Name____ Relationship___________________

Signature of Patient/Guardian: ____ Date __________________

Parent/Guardian Name (Please Print): ___________________________________

If not signed by patient (or plan member), please complete section below and indicate your relationship:

_____ Parent/Guardian of minor patient.

Mother's Name: ___________________________ Father's Name: ________________________

_____ Beneficiary or personal representative of deceased patient (Copy of court order needed)

_____ Guardian or Conservator of an incompetent person (Copy of court order needed)

_____ Other (specify) ____

You may end or change the directions in this form at any time by filling out a new form. All previous "HIPAA Acknowledgement & Confidential Communication Request" forms will be void.

Staff Initials: _________ Dept: ______________________________

Date sent to Med Rec: ___________ Med Rec Clerk Initials: _____________ Scanned Date: ______________

Consent to Treat/Bill
(Please complete one form per patient)

I authorize release of Protected Health Information necessary to obtain payment, provide treatment and to conduct healthcare operations as described in AFH's Notice of Privacy Practices.

I consent for the clinician to treat my medical, behavioral health and/or dental condition.

I authorize payment of benefits to AFH for services rendered and agree to pay all balances due, including collection costs.

I consent to be contacted by regular mail, by email or on my phone (including my cell phone) regarding any matter related to any account where I am the guarantor at AFH, its successors, or outside agency as assigned by AFH. This consent includes any updated or additional contact information that I may provide and includes phone calls that employs auto-dialer technology and prerecorded messages. This consent applies to all AFH healthcare providers. If I wish to revoke consent to call my cell phone, I agree to provide you notice of that revocation by mailing such revocation to AgLands Family Health, PLLC, 2215 San Juan Ave., La Junta, CO 81050.

______________________ ______________________

Patient Name (Please Print) Patient DOB

____

Patient Signature

______________________ ______________________

Parent/Guardian Signature Parent/Guardian Name (Please Print)

____

Date Signed

Consent to Treat/Bill must be signed annually by patient.