

Patient Information Form (Pediatric)

PLEASE PRINT (ONE form per person)

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: _____



Supplemental Information Form - **Minors**

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

Date: _____

Patient Information

Legal Name: Last _____ First _____ M.I. _____

Birth Date: ____/____/____

Parent Information

1st Parent Name/ Guardian: Last _____ First _____ M.I. _____

Birth Date: ____/____/____ Relationship to Patient: _____

Phone(s): Day: (____)____-____ Cell: (____)____-____

Secondary Contact Number: (____)____-____

2nd Parent Name/ Guardian: Last _____ First _____ M.I. _____

Birth Date: ____/____/____ Relationship to Patient: _____

Phone(s): Day: (____)____-____ Cell: (____)____-____

Secondary Contact Number: (____)____-____

Delegated Consent to Treat

Please complete this section if you want to appoint a person(s) to bring minor in for appointment.

I (We) _____ and _____
Parent/Guardian Name Parent/Guardian Name

hereby state that I/we, the parent(s) or legal guardian(s) of _____, a minor, born on _____

authorize _____, _____, _____, (Assigned Person(s) Name), an adult, to consent to any necessary examination, medical diagnosis or treatment to be rendered to the above named minor under the general or special supervision and on the advice of any provider licensed to practice at AgLands Family Health.

Signature of Parent/Guardian _____ Date _____

Authorized Use Only

Staff initials: _____ Dept: _____



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 (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

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.

Complete one form per patient.

AUTHORIZED USE ONLY

Staff Initials: _____ Dept: _____ Date sent to Medical Records: _____ Med Rec Clerk Initials: _____

Scanned Date: _____