

Hampden Medical Group

221 E Hampden Ave
Englewood, CO 80113
(303) 789-2251

PATIENT INFORMATION

NAME (Last, First Middle)				MRN	SSN#	BIRTHDATE	SEX
LOCAL ADDRESS			CITY, STATE ZIP		SECONDARY/BILLING ADDRESS (if Applicable)		
HOME PHONE	DAY PHONE	EMAIL ADDRESS		REFERRING PHYSICIAN	CITY, STATE ZIP		
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE		
PRIMARY EMPLOYER				SECONDARY EMPLOYER (if Applicable)			
ADDRESS				ADDRESS			
CITY, STATE ZIP				CITY, STATE ZIP			
WORK PHONE				WORK PHONE			

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)				SSN#	BIRTHDATE	SEX	
LOCAL ADDRESS			CITY, STATE ZIP		SECONDARY/BILLING ADDRESS (if Applicable)		
HOME PHONE	DAY PHONE	EMAIL ADDRESS		CITY, STATE ZIP			
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE		
RELATIONSHIP TO PATIENT							

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY			POLICY#				
NAME OF INSURED			GROUP#				
ADDRESS OF INSURANCE COMPANY			COPAY AMT				
CITY, STATE ZIP		PHONE		DEDUCTIBLE			
RELATIONSHIP TO PATIENT			EFFECTIVE DATE		EXPIRATION DATE		

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY			POLICY#				
NAME OF INSURED			GROUP#				
ADDRESS OF INSURANCE COMPANY			COPAY AMT				
CITY, STATE ZIP		PHONE		DEDUCTIBLE			
RELATIONSHIP TO PATIENT			EFFECTIVE DATE		EXPIRATION DATE		

Emergency Contact _____ Emergency Phone _____ DL Number _____

I assign directly to Hampden Medical Group all insurance benefits. I understand that I am financially responsible for any balance due. I hereby authorize the Hampden Medical Group to release any information necessary to secure the payment of benefits. If I provide incorrect insurance information or my insurance has a PCP listed who is not a member of Hampden Medical Group and payment is denied, I will accept financial responsibility.

SIGNATURE OF PATIENT/GUARDIAN

DATE

Hampden Medical Group Patient Orientation

Welcome to Hampden Medical Group. We pride ourselves on providing the highest quality medical care for your whole family. We are glad you have chosen us. Please take a moment to review the following guidelines and policies to ensure that we can provide the best care possible.

- 1. Access to Care:** We will care for patients regardless of age, race, gender, creed, or religion. We are able to see patients by appointment only. Emergency conditions may need to be referred to an Urgent Care facility or to an Emergency Room. Office hours are 8:00am-12:00pm and 1:45pm-5:00pm Monday through Friday. After hours medical emergencies are handled by phone by one of our on-call physicians at 303-762-2899. This service is for medical emergencies only (not for prescription refill or non-emergent medical conditions). Because of time constraints, please be respectful of your allotted appointment; a typical appointment can only accommodate 1-2 medical issues. We ask that you arrive at our office 15 minutes before your scheduled appointment. If you arrive more than 5 minutes after the start time of your appointment you may be required to reschedule.
- 2. Prescription Refills:** If you have no remaining refills on your prescription, please contact your pharmacy. They will request authorization and fill the prescription if approved. They/we need approximately 3 business days in order to process these requests. Contacting us repeatedly will only delay the process. We are unable to write or refill a prescription if we have not seen you recently for the condition treated by the medication. Prescriptions are only refilled during regular office hours.
- 3. Insurance Coverage:** If we are participating physicians with your insurance plan, we will bill them for the care you receive. You are responsible for co-payments at the time of your appointment. If you cannot pay at the time of your visit, there will be a \$10 administrative fee for billing. *You must also present a valid insurance card at each visit.* If you are uninsured, we will see you on a fee-for-service basis, with minimum payment due at the time of the visit. Self-paying patients have the option to prepay at least \$75 for an office visit, and be billed for the remainder; or you may receive a 10% discount by making payment in full at the time of service. You are responsible for knowing which services are covered by your insurance. If we provide a service we feel is medically prudent which is a non-covered benefit, you are responsible for payment (e.g., certain plans do not cover routine physicals). We will provide the care we feel is medically prudent, and it is your responsibility to know what your insurance will or will not cover.
- 4. Appointment Cancellation:** If for any reason you are not able to make your scheduled appointment, we require 24 hours notification. This will allow us to fill your appointment slot with someone who may need care urgently. Otherwise you are considered a "no-show" for the appointment, and we reserve the right to charge you a "no-show" fee of \$100 for a missed Physical Exam, and \$75 for any other appointment type. After 3 "no-shows" we reserve the right to dismiss you from the Practice. We realize that emergencies and extenuating situations do come up, and we will take this into account individually, but wasted appointment slots hurt other patients as well as the Practice.
- 5. Privacy:** We comply with Federal regulations known as HIPAA. Should you have any questions or concerns regarding the privacy of your Protected Health Information (PHI), please discuss them with your physician or our Office Manager. At any time, you may request a copy of our Health Information Practices policy. The policy is also available on our website.
- 6. Medical Records/Referrals:** Medical Records are the property of Hampden Medical Group, and we are required to keep the originals for 7 years after your last visit with us. We will provide you copies as needed; the first copy for free, subsequent copies at a cost. Before releasing any PHI, we must first have you sign a HIPAA-compliant authorization, which is available both in our office and on our website. We require 10-14 business days on medical records requests. If you are referred for specialty care, you must make us aware of the appointment time, date, and physician as soon as possible so that we have adequate time to clear the referral.
- 7. Past Due Accounts:** Your account will be considered past due if we have not received payment within 60 days of the balance becoming your responsibility. At such time, there will be a \$10 per month administrative fee to continue billing you. If payment is not received after 150 days, we reserve the right to turn your account over to an outside collection agency, and both you and your dependent family members may be dismissed from the Practice. If such action occurs, you will be responsible for any costs, fees, and interest accrued during the collection process. We understand financial hardships, so if you find yourself unable to pay your balance, we will be willing to make a mutually agreeable payment plan. Please contact our office to discuss rather than leaving a balance delinquent.

Again, we welcome you to the Practice. We will do our best to treat you with the kindness and respect you deserve, and deliver the best medical care to your family. If you have any questions regarding this or any other aspect of our relationship, please ask your Provider or our Office Manager.

I have reviewed and understand these policies for my family. (You may request a copy of this form)

Printed Name _____ Date _____ Signature _____

Hampden Medical Group Patient Contact Authorization Form

Print Patient Name

Date of Birth

Primary Phone number: _____

Hampden Medical Group **MAY / MAY NOT** leave messages related to my health information
(circle one)

Secondary Phone number: _____

Hampden Medical Group **MAY / MAY NOT** leave messages related to my health information
(circle one)

Hampden Medical Group **MAY / MAY NOT** discuss **MY / MY DEPENDENT'S** health information with:
(circle one) *(circle one)*

Name of Individual

Relationship to patient

Name of Individual

Relationship to patient

Name of Individual

Relationship to patient

The following person(s) is/are authorized to pick up written Prescriptions, correspondence, or Medication samples on my behalf:

Name of Individual

Relationship to patient

Name of Individual

Relationship to patient

Name of Individual

Relationship to patient

Patient / Guardian Signature

Today's Date

Printed Name of Guardian

Relationship to Patient

This Authorization Expires after _____
(length of time, or event)

HAMPDEN MEDICAL GROUP

Name of Patient (please print)

Date of Birth

Acknowledgment of Notice of Privacy Practices

I hereby acknowledge that I received Hampden Medical Group Notice of Privacy Practices.

Signature of patient or patient representative

Date

**Documentation of Good Faith Efforts
To obtain patient's acknowledgment that they received provider's
Notice of Privacy Practices**

(For use when acknowledgment cannot be obtained from the patient.)

The patient presented to the office/hospital on [insert date] and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- Patient refused to sign.
- Patient was unable to sign or initial because:

- The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.
- Other reason (describe below):

Signature of Employee Completing Form

Date

HAMPDEN MEDICAL GROUP PATIENT HISTORY

Patient Name

Name (last, first, mi)

DOB:

Date:

Allergies and Reactions (Please use the back if more space is needed)

-
-
-
-

Personal Medical History

In the past I have had or I am currently being treated for:

Allergies	Yes	No	HIV Virus/ AIDS	Yes	No
Anemia	Yes	No	Hyperlipidemia	Yes	No
Angina	Yes	No	Hypertension	Yes	No
Anxiety	Yes	No	Insomnia	Yes	No
Arthritis	Yes	No	Irritable bowel disease	Yes	No
Asthma	Yes	No	Joint Disease	Yes	No
Atrial fibrillation	Yes	No	Kidney or bladder infection	Yes	No
Benign prostatic hypertrophy	Yes	No	Lung disease	Yes	No
Blood clots	Yes	No	Measles	Yes	No
Cancer(s)	Yes	No	Memory Problems	Yes	No
Cerebrovascular accident (Stroke)	Yes	No	Migraine headaches	Yes	No
Chicken Pox	Yes	No	Myocardial infarction (Heart Attack)	Yes	No
COPD (Emphysema)	Yes	No	Osteoarthritis	Yes	No
Coronary Artery Disease	Yes	No	Osteoporosis	Yes	No
Crohn's Disease	Yes	No	Pneumonia	Yes	No
Depression	Yes	No	Peptic ulcer disease or G.E.R.D	Yes	No
Diabetes	Yes	No	Renal disease	Yes	No
Epilepsy or Convulsions	Yes	No	Seizure disorder	Yes	No
Gallbladder Disease	Yes	No	Sickle cell anemia	Yes	No
Gout	Yes	No	Sleep apnea	Yes	No
Heart Disease	Yes	No	STD	Yes	No
Hepatitis C	Yes	No	Thyroid disease	Yes	No
High blood pressure	Yes	No			

Other: _____

Surgical History (Please use the back if more space is needed)

Surgery	Date	Outcome	Performing Doctor

Family History

Do you have any family with the following medical history?

Disease	Which Member	Age of Onset	Cause of Death
ADD/ADHD			
Alcoholism			
Allergies			
Alzheimer's			
Asthma			
Blood disease			
CAD (Heart Attack)			
Cancer			
CVA (Stroke)			
Depression			
Developmental Delay			
Diabetes			
Eczema			
Hearing Deficiency			
Hyperlipidemia			
Hypertension			
Irritable Bowel Syndrome			
Learning Disability			
Mental Illness			
Migraines			
Obesity			
Osteoarthritis			
Osteoporosis			
Peripheral Vascular Disease			
Renal Disease			
Seizure Disorder			

Other: _____

Females

Last period: _____

Total pregnancies: _____

Currently pregnant? _____ Yes No

Last mammogram _____

Last Pap smear _____

Social History

Birthplace: _____

Hand dominance: Right Left

Language spoken: _____

Marital Status

Status: _____

Education/ Employment/ Occupation/ Military Experience

Education

Last grade completed: _____

Did you graduate? _____ Yes No

Degree: _____

Continued Education: _____

Learning Disability? _____ Yes No

Special Needs? _____ Yes No

Employment

Occupation? _____

Employee Status? _____

Restrictions? _____

Retire Date? _____

Occupational Hazards? _____

Do you have Military Experience: _____ Yes No

What religion do you practice? _____

Social History/Habits

Do you use tobacco? _____ Yes No

What type? _____ How often? _____

For how long? _____ Ever tried to quit? _____ Yes No

Do you drink alcohol? _____ Yes No

Do you use illegal drugs? _____ Yes No

Do you consume caffeine? _____ Yes No

What type? _____ How often? _____

Do you exercise? _____ Yes No

What type? _____ How often? _____

Home Safety

Do you have animals in the home? Yes No

If yes – Birds Dogs Rodents Cats Reptile Other _____

Do you have smoke detectors? _____ Yes No

Do you have carbon monoxide detectors? _____ Yes No

Do you have firearms in you home? _____ Yes No

Radon in home? Yes No Treated Untested

Health Care Proxy

Power of Attorney: _____

Living Will: _____ DNR: _____

