

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 7:00 am – 5:00 pm 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 a refill authorization from us and fill the prescription if it is 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 your co-payment at the time of your visit, there will be a \$10 administrative fee for billing your copay to you. You must be able to 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 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. It is not the responsibility of our office staff to quote your benefits for you.** If we provide a service we feel is medically indicated that is a non-covered benefit, you are responsible for payment. 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. If you cancel your appointment with less than 24 hour's notice, do not show to your appointment, or arrive after your appointment time we reserve the right to charge you a "no-show" fee of \$35. 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.
- 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 Practice 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 upon request; the first copy at no charge, 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 to process 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 Practice 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

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