Flatiron Internal Medicine/Flatiron Premier Medicine

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Patient Name_____ **Date**_____

Street Address_____ **Apt or Unit #** _____

City _____ **State**_____ **Zip Code**_____

Home Phone Number_____ **Cell Phone Number**_____

Work Phone Number_____ **Email Address**_____

Preferred Method of communication_____

Patient Date of Birth _____ **Age**_____ **Patient Sex M F Marital Status M D W S**

Ethnicity:_____ **Race:**_____

Social Security Number_____ **Employer** _____

Emergency Contact _____ **Phone Number** _____

Relationship_____ **Address if not living with you**_____

How did you learn about our practice? □ **Our Website** □ **Insurance Website** □ **Internet Search**

□ **Physician**_____ □ **Patient**_____ □ **Other**_____

Billing Information

Last Name_____ **First Name**_____ **SS#**_____

Relationship to Patient_____ **Responsible Party's DOB** _____

Address of Responsible Party _____ **Phone Number**_____

Primary Insurance Information

Insurance _____ **Effective Date**_____

Policy Holder_____ **Date of Birth**_____ **Relationship**_____

Policy/Member #_____ **Group #**_____

Secondary Insurance Company

Insurance_____ **Effective Date**_____

Policy Holder_____ **Date of Birth**_____ **Relationship**_____

Policy/ Member #_____ **Group #**_____

Consent To Payment and Privacy Policy:

I accept responsibility for payment on any service provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance or if Flatiron Internal Medicine does not participate with my insurance.

I authorize payment of medical benefits directly to my provider and release of any medical information necessary to process claims.

I acknowledge receipt of a privacy notice that more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations.

_____ _____

Signature of Patient or Patient's Representative ***Date***

Medical History Form

Please list any chronic illness or diseases that have been diagnosed by a doctor: _____

_____

_____

Please list any operations you have had (include date, type of surgery, name and location of hospital):
_____

_____

_____

List previous hospitalizations (other than operations): _____

_____

Have you ever received a blood transfusion? _____ yes _____ no

Please list any allergies you have (and the reaction): _____

_____

What medications are you currently taking? (Please include over the counter medications, including vitamins or herbal remedies. If you need more room, please attach a separate page.

Medication	Dose (strength)	How often	Reason for taking
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

<u>Social History and General Questions:</u>
What is your job or occupation? _____

Do you have any children? _____ yes _____ no How many? _____
Sons _____ Ages: _____ Daughters_____ Ages: _____

Have you ever been a smoker? _____ yes _____ no If you have quit, when?_____
How much per day?_____ For how many years?_____

How much alcohol do you drink? _____ drinks per day week month (please circle one)

What do you do for exercise? _____ How many days per week do you exercise? _____

When was your last tetanus shot? _____ Pneumonia shot ?_____

Medical History Form, continued

Males Only: If you are over the age of 45, when was your last prostate exam? _____

Females Only:

Number of pregnancies: _____ Number of live births: _____

Number of miscarriages: _____ Number of abortions: _____

Date of last menstrual period: _____

When was your last Pap smear?_____ Was it normal? _____ yes _____ no

When was your last mammogram? _____ Was it normal? _____ yes _____ no

Family History:

	Age if living	Cause of death (if dead)	Age of death
Father			
Mother			
Brothers **Number Living** **Number Dead**			
Sisters **Number Living** **Number Dead**			

List any other illnesses that run in your family: (hypertension, strokes, diabetes, heart attacks, cancer, thyroid problems):

_____

_____

_____

_____

_____

Review of Systems Form

Patient Name:_____ Date of Appointment: _____

Constitutional: Do you have the following:
NO – skip to the next section
YES - please indicate below

Weight Gain _____ Weight Loss _____
Fever _____ Fatigue _____
Chills _____ Night Sweats _____
Malaise_____
Comments:
_____

Hematologic/Lymphatic: Do you have the following:
NO – skip to the next section
YES - please indicate below

Easy Bleeding _____
Easy Bruising _____
Swollen lymph nodes _____
Comments: _____
_____
_____

Head, Eyes, Ears, Throat: Do you have the following:
NO – skip to the next section **YES - please indicate below**

Eyes: Double Vision _____ Redness _____ Pain____ Itching _____ Visual changes_____
History of: Lasik _____

Ears: Hearing Loss _____
Pain _____
Ringing _____
Discharge _____

Nose & Sinus: Nasal drainage _____
Decreased Smell ____
Allergies _____
Sinus pressure_____

Throat: Frequent Sore Throats _____
Cold Sores _____
Sore Tongue _____
Tooth Pain _____

Comments: _____
_____

Respiratory: Do you have the following:
NO- skip to the next section
YES - please indicate below

TB Exposure _____
Shortness of Breath _____
Wheezing _____
Chronic cough _____
Comments: _____
_____

Cardiovascular: Do you have the following:
NO – skip to the next section
YES - please indicate below

Chest Pain _____
Swelling in legs/ ankles _____
Palpitations _____

Gastrointestinal: Do you have the following:
NO – skip to the next section **YES - please indicate below**

Loss of appetite _____
Abdominal Pain _____
Nausea _____
Vomiting _____
Constipation _____
Heartburn_____
Blood in stool_____
Diarrhea _____
Comments: _____

Review of Systems Form, continued

Date of Appointment: _____

Genitourinary: Do you have the following:
NO – skip to the next section YES - please indicate below

Urinary frequency _____
Urinary incontinence _____
Painful urination _____
Blood in urine _____
Slow stream _____

Female Reproductive: Do you have the following:
NO – skip to the next section YES - please indicate below

Abnormal Pap_____ Hot flashes_____
Irregular menses_____ Vaginal discharge_____
Pain during menstruation_____
Painful intercourse _____

Male Reproductive: Do you have the following:
NO – skip to the next section
YES - please indicate below
Erectile dysfunction _____
Penile Discharge _____
Sexual dysfunction_____

Musculoskeletal: Do you have the following:
NO – skip to the next section
YES - please indicate below
Joint pain _____
Back Pain _____ Neck Pain_____
Muscle Weakness _____

Metabolic/Endocrine: Do you have the following:
NO – skip to the next section YES - please indicate below
Cold Intolerance _____ Heat Intolerance _____
Excessive Thirst _____ Excessive hunger _____
Generalized Weakness _____ Infertility _____

Comments: _____

Neuroligical/Psychiatric: Do you have the following:
NO – skip to the next section YES - please indicate below
Gait Disturbance _____ Anxiety_____
Numbness _____ Depression_____
Dizziness _____ Insomnia_____
Memory Loss _____
Comments: _____

Dermatologic: Do you have the following:
NO – skip to the next section YES - please indicate below
Brittle hair/nails_____ Hair loss_____ Mole changes_____ Rash_____ Skin lesion_____
Comments: _____

Immunological: Do you have the following:
NO – skip to the next section YES - please indicate below
Contact allergy_____ Food allergies_____
Seasonal allergies_____ None_____
Comments: _____

Do you have an advanced directive?
Living will_____
Name of Durable power of attorney_____

Any additional comments: _____

Consent to Release Information

If you would like us to be able to share any of your health care information with someone (such as a spouse or other relative), please complet this form.

Patient's Date of Birth: _____

I, _____ give permission for Flatiron Internal Medicine/Flatiron Premier Medicine to discuss my medical informatio with the parties listed below. I understand that this may include, but not be limited to, office notes, prescriptions, test results and office notes from other offices. I agree that this release shall be for the entire contents of my medical record contained in this office and may include items that are related to mental health conditions, sexually transmitted diseases, and drug and/or alcohol abuse, unless otherwise noted.

People with whom you can share my medical information: *(Please list person's name and relationship to you):*

_____

_____

_____

_____ _____

Signature of Patient Date

Flatiron Internal Medicine
Erik Mondrow, MD, FACP; Aimee Morin, FNP; Michaela Romero, DNP, Harma Drenth, FNP
Release of Records Authorization

In reviewing this release, please note that you have the right to exclude certain information from the release of your medical record. However, please realize that if you exercise that right, a chart review may have to be conducted by our privacy officer. In certain cases, you may be charged a fee for that service. Our privacy officer will notify you in advance if there is going to be a fee. In addition, please also realize that if you exclude access to certain information, you may impede your medical treatment. If the information is being requested for other reasons, the person requesting the information may make an adverse decision if they do not have a complete copy. In addition, our office charges a copying fee to release an entire record of your chart; the fees are set by Colorado Statutes. If you'd like to know the fee before the copies are released, please contact the office.

_____ _____
Patient Name Date of Birth

I authorize the following release of my confidential medical information.

Please Release Information from:

_____
_____
_____
_____
_____

Information to be Released to:

Flatiron Internal Medicine
90 Health Park Drive, Suite 320
Louisville, CO 80027
Phone: (303) 666-7560; Fax: (303) 666-7511
front.office@flatironinternalmed.com

I authorize only the release of those items I have specifically listed below:

_____ _____
_____

I authorize an entire copy of my medical record to be released with the **EXCEPTION** of :

____ Progress Notes
____ Drug Abuse or Alcohol Abuse, if any
____ Psychological or Psychiatric Conditions, if any
____ Sexually Transmitted Diseases
____ Other _____

I understand that this information will be used for:

____ Further evaluation and treatment
_____ To obtain payment from my insurance company or other party
____ Other_____

This release will expire three (3) years from the date this document is signed, unless I have otherwise noted right here: _____. I understand that this release will remain effective through that date unless I notify Flatiron Internal Medicine in writing.*

_____ _____
Signature of Patient Date

**Flatiron Internal Medicine is not responsible for late or misdirected mail.*

FLATIRON INTERNAL MEDICINE
90 Health Park Dr, Ste 320
Louisville, CO 80027
303-666-7560

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE LEGALLY USED AND DISCLOSED IN THE PROCESS OF PROVIDING YOU THE BEST POSSIBLE CARE. IT INCLUDES YOUR RIGHTS REGARDING PERSONAL HEALTH INFORMATION UNDER FEDERAL LAW. PLEASE REVIEW IT CAREFULLY.

I. UNDERSTANDING YOUR HEALTH INFORMATION

Each time you visit Flatiron Internal Medicine, a record of your visit is created. This record contains your name and other information about you, including your symptoms, examination and test results, diagnoses, treatment, plan for future health care, and financial information. This record is sometimes referred to as your "medical record" or "medical chart."

This record allows:

- Doctors, nurses, and other health professionals to plan your treatment;
- Flatiron Internal Medicine to obtain payment for services we provide to you, such as from health plans, Medicare/Medicaid, or you; and
- Flatiron Internal Medicine to measure the quality of care provided to you.

As we have in the past, we are committed to keeping your health information confidential. We will not use or give to others your health information without your written permission, except as stated in this Notice.

II. HOW WE WILL USE AND SHARE YOUR HEALTH INFORMATION

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS: We will use and give out your health information to provide you with health care treatments, to get paid for our services, and to help us operate our medical practice. For example:

- We will give your health information to health care professionals not on our staff, such as other doctors and hospital staff, who help care for you. This health information may be shared in fax, paper or electronic formats. Your provider is a member of a community of practices (Integrated Physician Network) that use a common enterprise medical record to make your healthcare safer, more efficient and of highest quality. Your health information may be shared electronically within this network with other physicians, providers and practices but only if they are participating in your care.
- We may send a bill to your health insurance plan or to you.
- Flatiron Internal Medicine may use your medical record to review the performance of your healthcare team and to assist them in their mission to deliver quality, safe and efficient health care.

OTHER USES AND DISCLOSURES ALLOWED OR REQUIRED BY FEDERAL LAW: We may use or share your health information for the following purposes under limited circumstances:

- To people designated by you who are involved in your care or who help pay for your care, such as your family, your close personal friends, or any other person you chose, to notify them of your location, general health, and to assist you in your health care (such as to pick-up medicine or help with follow-up care).
- To government agencies that oversee our medical practice or community health centers (such as license and certification inspectors).
- To government agencies that have the right to receive and collect health information (such as Public Health Officials).
- When we are ordered by a court or judge.

◆ To workers' compensation programs when your health problem is from a work-related injury.

◆ When law enforcement requests information in the course of a criminal investigation (such as to prevent danger or injury).

◆ To coroners and funeral directors to allow them to carry out their duties.

◆ To organ donor agencies (subject to applicable laws).

◆ To avoid a serious threat to the health or safety of others.

◆ We may share limited health information to business associates of Flatiron Internal Medicine only to the extent this information is essential to help us perform required tasks, such as working with our accountants, computer consultants, and billing companies (and only if the business associate agrees in writing to keep your health information confidential as required by law).

◆ For any other purpose required or allowed by law.

OTHER USES AND DISCLOSURES REQUIRING YOUR WRITTEN PERMISSION: Except as stated above, we will only use or give out your health information after getting your written permission on a Records Release Authorization form. You may revoke your authorization(s) at any time by notifying us in writing that you wish to do so.

III. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION:

Subject to certain legal limits, you have rights regarding the use and disclosure of your health information. These rights include:

◆ Requesting limits on uses of your health information.

◆Receive confidential communications of your health information.

◆Inspect and copy your health information for your own use.

◆Request a change to your health information.

◆Receive a record of how we have used and shared your health information.

◆Obtain a copy of this Notice of Privacy Practices

IV. QUESTIONS, CONCERNS, AND CHANGES TO THIS NOTICE

If you have any questions or concerns about any of the information in this Notice of Privacy Practices, please contact our Practice Manager.

If you believe your privacy rights have been violated, you may file a complaint with our Practice Manager, the iPN Security Officer (303-269-2054), or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. We will not retaliate against you for filing a complaint.

We may change our Notice of Privacy Practices in the future. Such changes will apply to your health information that we created or received before the effective date of the change. We will notify you of any changes to our Notice of Privacy Practices by distributing the changed Notice during future office visits and by posting it in our reception areas.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF
PRIVACY PRACTICES MUST BE MADE IN WRITING AND A COPY KEPT IN YOUR MEDICAL RECORD.

Flatiron Internal Medicine/Flatiron Premier Medicine

Acknowledgement of Privacy Practices

I have been given the privacy policies and had an opportunity to ask question to my satisfaction.

_____ _____

Print Name Date of Birth

_____ _____

Patient Signature Date

_____ _____

Employee Signature Date