

# Flatiron Internal Medicine/Flatiron Premier Medicine

Erik Mondrow, M.D., FACP

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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 |
|------------|-----------------|-----------|-------------------|
| _____      | _____           | _____     | _____             |
| _____      | _____           | _____     | _____             |
| _____      | _____           | _____     | _____             |
| _____      | _____           | _____     | _____             |
| _____      | _____           | _____     | _____             |

Social History and General Questions:

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:**

|   | <b>Age if living</b> | <b>Cause of death (if dead)</b> | <b>Age of death</b> |
|---|----------------------|---------------------------------|---------------------|
| <b>Father</b>                                   |                      |                                 |                     |
| <b>Mother</b>                                   |                      |                                 |                     |
| <b>Brothers</b><br>Number Living<br>Number Dead |                      |                                 |                     |
| <b>Sisters</b><br>Number Living<br>Number Dead  |                      |                                 |                     |

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

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**Review of Systems Form**

Patient Name: \_\_\_\_\_ Date of Appointment: \_\_\_\_\_

|  |  |
|--|--|
| <b>Constitutional: Do you have the following:</b><br><b>NO – skip to the next section</b><br><b>YES - please indicate below</b><br>Weight Gain _____      Weight Loss _____<br>Fever _____      Fatigue _____<br>Chills _____      Night Sweats _____<br>Malaise _____<br>Comments: _____<br>_____ | <b>Hematologic/Lymphatic: Do you have the following:</b><br><b>NO – skip to the next section</b><br><b>YES - please indicate below</b><br>Easy Bleeding _____<br>Easy Bruising _____<br>Swollen lymph nodes _____<br>Comments: _____<br>_____<br>_____ |
|--|--|

|  |                         |               |                             |
|--|-------------------------|---------------|-----------------------------|
| <b>Head, Eyes, Ears, Throat: Do you have the following:</b><br><b>NO – skip to the next section</b> <b>YES - please indicate below</b> |                         |               |                             |
| Eyes:  | Double Vision _____     | Redness _____ | Pain _____                  |
|  | History of: Lasik _____ |               | Itching _____               |
|  |                         |               | Visual changes _____        |
| Ears:  | Hearing Loss _____      | Nose & Sinus: | Nasal drainage _____        |
|  | Pain _____              |               | Decreased Smell _____       |
|  | Ringing _____           |               | Allergies _____             |
|  | Discharge _____         |               | Sinus pressure _____        |
|  |                         | Throat:       | Frequent Sore Throats _____ |
|  |                         |               | Cold Sores _____            |
|  |                         |               | Sore Tongue _____           |
|  |                         |               | Tooth Pain _____            |
| Comments: _____<br>_____   |                         |               |                             |

|  |   |
|--|---|
| <b>Respiratory: Do you have the following:</b><br><b>NO- skip to the next section</b><br><b>YES - please indicate below</b><br>TB Exposure _____<br>Shortness of Breath _____<br>Wheezing _____<br>Chronic cough _____<br>Comments: _____<br>_____ | <b>Cardiovascular: Do you have the following:</b><br><b>NO – skip to the next section</b><br><b>YES - please indicate below</b><br>Chest Pain _____<br>Swelling in legs/ ankles _____<br>Palpitations _____ |
|--|---|

|  |                      |
|--|----------------------|
| <b>Gastrointestinal: Do you have the following:</b><br><b>NO – skip to the next section</b> <b>YES - please indicate below</b> |                      |
| Loss of appetite _____   | Heartburn _____      |
| Abdominal Pain _____   | Blood in stool _____ |
| Nausea _____   | Diarrhea _____       |
| Vomiting _____   |                      |
| Constipation _____   |                      |
| Comments: _____<br>_____   |                      |

**Review of Systems Form, continued**

Date of Appointment: \_\_\_\_\_

|  |   |
|--|---|
| <p><b>Genitourinary: Do you have the following:</b><br/> <b>NO – skip to the next section      YES - please indicate below</b></p> <p>Urinary frequency _____<br/>         Urinary incontinence _____<br/>         Painful urination _____<br/>         Blood in urine _____<br/>         Slow stream _____</p>  | <p><b>Female Reproductive: Do you have the following:</b><br/> <b>NO – skip to the next section      YES - please indicate below</b></p> <p>Abnormal Pap _____      Hot flashes _____<br/>         Irregular menses _____      Vaginal discharge _____<br/>         Pain during menstruation _____<br/>         Painful intercourse _____</p> |
| <p><b>Male Reproductive: Do you have the following:</b><br/> <b>NO – skip to the next section</b><br/> <b>YES - please indicate below</b></p> <p>Erectile dysfunction _____<br/>         Penile Discharge _____<br/>         Sexual dysfunction _____</p>  | <p><b>Musculoskeletal: Do you have the following:</b><br/> <b>NO – skip to the next section</b><br/> <b>YES - please indicate below</b></p> <p>Joint pain _____<br/>         Back Pain _____      Neck Pain _____<br/>         Muscle Weakness _____</p>  |
| <p><b>Metabolic/Endocrine: Do you have the following:</b><br/> <b>NO – skip to the next section      YES - please indicate below</b></p> <p>Cold Intolerance _____      Heat Intolerance _____<br/>         Excessive Thirst _____      Excessive hunger _____<br/>         Generalized Weakness _____      Infertility _____</p> <p>Comments: _____</p> |   |
| <p><b>Neurological/Psychiatric: Do you have the following:</b><br/> <b>NO – skip to the next section      YES - please indicate below</b></p> <p>Gait Disturbance _____      Anxiety _____<br/>         Numbness _____      Depression _____<br/>         Dizziness _____      Insomnia _____<br/>         Memory Loss _____</p> <p>Comments: _____</p>  |   |
| <p><b>Dermatologic: Do you have the following:</b><br/> <b>NO – skip to the next section      YES - please indicate below</b></p> <p>Brittle hair/nails _____      Hair loss _____      Mole changes _____      Rash _____      Skin lesion _____</p> <p>Comments: _____</p>   |   |
| <p><b>Immunological: Do you have the following:</b><br/> <b>NO – skip to the next section      YES - please indicate below</b></p> <p>Contact allergy _____      Food allergies _____<br/>         Seasonal allergies _____      None _____</p> <p>Comments: _____</p>   | <p><b>Do you have an advanced directive?</b><br/> <b>Living will _____</b><br/> <b>Name of Durable power of attorney _____</b></p>  |

Any additional comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Consent to Release Information**

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*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 complete this form.*

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Patient's Date of Birth: \_\_\_\_\_

I, \_\_\_\_\_ give permission for Flatiron Internal Medicine/Flatiron Premier Medicine to discuss my medical information 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):*

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Signature of Patient

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Date

**Flatiron Internal Medicine**  
**Erik Mondrow, MD, FACP; Aimee Morin, FNP-BC; Sarah Kressy Giliberti, ANP-BC**  
**Release of Records Authorization**

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*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.*

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\_\_\_\_\_  
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.

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.

IF YOU WOULD LIKE A COPY OF THIS POLICY PLEASE INFORM THE FRONT OFFICE STAFF.

### 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 also 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 only 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 via 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.
- ◆ Your provider participates in CORHIO’s Health Information Exchange (HIE) system, PatientCare 360®. This allows our clinical team to utilize a patient lookup system to retrieve pathology results, consult reports, hospital reports, etc. from participating hospitals, labs, and medical facilities. You may choose to opt out and not make your health information available. By making this choice, your health information will not be accessible to providers who utilize CORHIO’s Health Information Exchange. To opt out or revoke a prior opt out request, please request a form from the front office staff.
- ◆ 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, care takers, personal friends, or any other persons you designate, to notify them of your location, general health, or 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 change. To obtain the most recent Notice of Privacy Practices, please request a copy from the front office staff.

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

A member practice of the Integrated Physician Network



**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.

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Print Name

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Date of Birth

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Patient Signature

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Date