Flatiron Internal Medicine/Flatiron Premier Medicine

Erik Mondrow, M.D.,FACP

Sarah Kressy, ANP-BC

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**________________

<u>Billing Information</u>

Last Name______________________________ **First Name**______________________**SS#**______________

Relationship to Patient___________________________________ **Responsible Party's DOB** _______________

Address of Responsible Party ____________________________________ **Phone Number**_______________

<u>Primary Insurance Information</u>

Insurance ____ **Effective Date**__________________

Policy Holder____________________________ **Date of Birth**__________**Relationship**__________________

Policy/Member #____**Group #**_________________

<u>Secondary Insurance Company</u>

Insurance____**Effective Date**___________________

Policy Holder____________________________**Date of Birth**__________**Relationship**__________________

Policy/ Member #____**Group #**_________________

<u>Consent To Payment and Privacy Policy:</u>

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

If yes, how many? _______________

Sons _________ Ages: _________ Daughters_________ Ages: _________

Have you ever been a smoker? yes no If you have quit, when?_________

If current smoker, how much per day?___________ For how many years?_______________

How much alcohol do you drink? ___________ drinks per day week month (please check 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):

____

____

____

____

____

Preferred Pharmacy:

Mail-Order Pharmacy Name	Local Pharmacy Name & Address

Review of Systems Form

Patient Name: ____________________________ Appointment Date: ______________

Please indicate if you are experiencing any of the following:

Constitutional		
Please check if all negative		
Negative	Positive	
		Chills
		Fatigue
		Fever
		Malaise
		Night sweats
		Weight gain
		Weight loss
Comments/Other:		

Head, Ear, Eyes, Nose, Throat		
Please check if all negative		
Negative	Positive	
		Ear drainage
		Ear pain
		Eye discharge
		Eye pain
		Hearing loss
		Nasal drainage
		Sinus pressure
		Sore throat
		Visual changes
Comments/Other:		

Respiratory		
Please check if all negative		
Negative	Positive	
		Chronic cough
		Cough
		Known TB exposure
		Shortness of breath
		Wheezing
Comments/Other:		

Cardiovascular		
Please check if all negative		
Negative	Positive	
		Chest pain
		Leg/Ankle pain (Claudication)
		Leg/Ankle swelling (Edema)
		Palpitations
Comments/Other:		

Gastrointestinal		
Please check if all negative		
Negative	Positive	
		Abdominal pain
		Blood in stools
		Change in stools
		Constipation
		Diarrhea
		Heartburn
		Loss of appetite
		Nausea
		Vomiting
Comments/Other:		

Genitourinary		
Please check if all negative		
Negative	Positive	
		Dribbling (Males)
		Painful urination (Dysuria)
		Blood in urine (Hematuria)
		Excessive urination (Polyuria)
		Slow stream
		Urinary frequency
		Urinary incontinence
		Urinary retention
Comments/Other:		

Male Reproductive		
Please check if all negative		
Negative	Positive	
		Erectile function concerns
		Penile discharge
		Sexual function concerns
Comments/Other:		

Female Reproductive/Breast		
Please check if all negative		
Negative	Positive	
		Abnormal Pap
		Pain during menstruation (Dysmenorrhea)
		Painful intercourse (Dyspareunia)
		Hot flashes
		Irregular menses
		Vaginal discharge
		Breast discharge
		Breast lump
Comments/Other:		

Review of Systems Form (Continued)

Patient Name: ____________________________ Appointment Date: _______________

Metabolic/Endocrine		
Please check if all negative		
Negative	Positive	
		Cold intolerance
		Heat intolerance
		Excessive thirst (Polydipsia)
		Excessive hunger (Polyphagia)
Comments/Other:		

Neurological		
Please check if all negative		
Negative	Positive	
		Dizziness
		Extreme numbness
		Extremity weakness
		Gait disturbance
		Headache
		Memory impairment
		Seizures
		Tremors
Comments/Other:		

Psychiatric		
Please check if all negative		
Negative	Positive	
		Anxiety
		Depression
		Insomnia
Comments/Other:		

Integumentary		
Please check if all negative		
Negative	Positive	
		Brittle hair
		Brittle nails
		Hair loss
		Unwanted, male-pattern hair growth in females (Hirsutism)
		Hives
		Itching (Pruritus)
		Mole changes
		Rash
		Skin lesion
Comments/Other:		

Musculoskeletal		
Please check if all negative		
Negative	Positive	
		Back pain
		Joint pain
		Joint swelling
		Muscle weakness
		Neck pain
Comments/Other:		

Hematologic/Lymphatic		
Please check if all negative		
Negative	Positive	
		Easy bleeding
		Easy bruising
		Swollen lymph nodes (Lymphadenopathy)
Comments/Other:		

Immunologic		
Please check if all negative		
Negative	Positive	
		Contact allergy
		Environmental allergies
		Food allergies
		Seasonal allergies
Comments/Other:		

Advance Directive		
Yes	No	
		Do you have a living will?
Name of durable power of attorney		

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 complete this form.

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.

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

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____

____

____ __________________

Signature of Patient Date

Flatiron Internal Medicine

Erik Mondrow, MD, FACP; Sarah Kressy ANP-BC

Release of Records Authorization to Flatiron Internal Medicine

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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.

______________________________ ______________________________

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.

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.

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 WILL BE 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 questions to my satisfaction.

____ ________________

Print Name Date of Birth

____ ________________

Patient Signature Date