

Med Peds Clinic of Fort Collins, LLC  
4674 Snow Mesa Drive, Ste 120  
Fort Collins, CO 80528

Adult Registration Sheet

Patient's Name \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
Home Phone# \_\_\_\_\_  
Last First Middle  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Social Security # \_\_\_\_\_ Sex M F Date of Birth \_\_\_\_\_  
In case of emergency who should be notified? \_\_\_\_\_ Phone# \_\_\_\_\_  
 Single  Married  Widowed  Separated  Divorced Secondary Phone# \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ Business Phone# \_\_\_\_\_

**Guarantor (Person to whom we should send bills or other correspondence)**

Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address (if different than patient) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone # \_\_\_\_\_

**Primary Insured (Name of individual under which the insurance is held)**

Name of Primary Individual Insured \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address (if different than patient) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone # \_\_\_\_\_

**Protected Health Information Waiver**

Please list the names of any individuals to whom you give the staff at Med Peds Clinic permission to discuss protected health information with.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Assignment of Benefits/Release**

I, the undersigned certify that all information entered on this form is true to the best of my knowledge. I hereby assign all insurance benefits directly to the Med Peds clinic. I authorize the use of this signature on all insurance submissions including appeals and complaints to the Colorado Insurance Commission.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Relationship to patient \_\_\_\_\_

**Med Peds Clinic of Fort Collins, LLC**  
**4674 Snow Mesa Drive, Ste 120**  
**Fort Collins, CO 80528**  
Phone: (970)266-3650      Fax: (970)266-3660

**Notice of Privacy Practices**  
**Patient Acknowledgment**

I have access to this practice's Notice of Privacy Practices written in plain language. The Notice provides the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's of legal duties with respect to my protected health information. This notice includes:

- \* A statement that this practice is required by law to maintain the privacy of protected health information.
- \* A statement that this practice is required to abide by the terms of the notice currently in effect.
- \* Types of uses and disclosures that this practice is permitted to make for each of the following purposes:
  - Treatment, payment and health care operations
- \* A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent/authorization.
- \* A description of uses and disclosures that are prohibited or materially limited by the law.
- \* A description of uses and disclosures that will be made only with my written authorization and that I may at any time revoke such authorization.
- \* My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice and to the Secretary of the HHS if I believe my privacy rights have been violated and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restriction on certain uses and disclosures of my protected health information and that the practice is not required to agree to a requested restriction.
  - The right to receive confidential communication of protected health information
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices upon request.

Patient Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

In order to best serve our patients and families, the following policies have been implemented:

**Treatment Policy**

We think all treatment started should be completed unless directed by the clinic. Incomplete treatment leads to problems, complications, misunderstandings and possibly further progression of disease. Be sure to complete all treatments unless changes are made by the doctors or nurses of the clinic.

**Appointment Policy**

Appointments are scheduled at times mutually convenient to the patient and doctor. Please be prompt for all appointments. We do understand that urgent or emergent situations arise which may prevent you from keeping an appointment. Please give us as much notice as possible (preferably 24 hours) so that other patients may be scheduled. Patients who are more than 10 minutes late may need to be rescheduled and the staff reserves the right to make the call on rescheduling appointments.

**Prescription Refill Policy**

We request 24 hours on all prescription refills. We also request that you contact your pharmacy directly to order refills. We will always make a sincere effort to refill prescriptions by the end of the day we receive them. Calling multiple times to check on the status of a refill only slows down the process. Also, to keep from running out of pills, always try to call in a refill when you still have 5 pills left in the bottle.

**Medical Records Policy**

It is the policy of this clinic to only release records generated by our clinic. Please understand that we will not release records from other physicians. For further information on the release of protected health information, please refer to the Notice of Privacy Practices.

**Mutual Respect Policy**

Our staff performs tasks to the best of their ability. They make a sincere effort to treat every patient in our clinic with respect and professionalism. They in turn expect a certain level of respect from you. Please treat all members of our staff with the same courtesy you would expect from them.

Please keep in mind that the front office staff has very little to do with calling in refills, returning messages, handling referrals or contacting patients about lab/x-ray results. They will do their best to help you get what you need by leaving complete and accurate messages for the nurses.

We reserve the right to terminate patients that we feel have violated this policy. Just as we would terminate any employee who did not treat our patients with respect, we will terminate patients who do not show our office staff respect.

**Financial Policy**

All co-pays and outstanding account payments are due and will be requested at the time of service. We will gladly accept cash, checks, Visa and MasterCard for payments.

Insurance is designed to cover some of the costs of health care. Because there are so many insurance companies and plans, it is impossible for us to have complete knowledge of them all.

Insurance is a contract between you and your insurance company. We are not a party to this contract. We file insurance claims as a courtesy to our patients. We are not required to become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance or other matters regarding reimbursement. The kind of benefits in your contract depend upon what you or your employer have negotiated with the insurance company and the amount you choose to pay in premiums.

Please be aware if your claims are not paid in full within 60 days after our filing your claims to your insurance carrier, you will be responsible for the full balance due. If and when your insurance pays your claims we will refund the amount due you.

Please also note that we can not bill your insurance if we do not have a current front and back copy of your card on file in our office. It is very important that you have your card with you each time you come to the office so that we can verify that all billing information is current. If your insurance changes and you do not have the card with you, then you will be billed for all charges until we receive a copy of the current card.

It is important for you to understand that you are ultimately responsible for your account and that our office will submit claims to insurance companies in a timely manner. By signing these policies you are acknowledging that you understand and agree to abide by them.

Should you have any questions regarding your account or these policies, please contact our billing staff during normal business hours.

**Acknowledgment**

I understand and agree to abide by all office policies of the Med Peds Clinic.

Patient Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_