COLORADO PEDIATRIC GASTROENTEROLOGY

MAIN OFFICE: 1601 East 19th Avenue – Suite 3500, Denver, Colorado 80218 (303) 830-9190 Phone (303) 226-7424 Fax

Patients Name: _____

How did you hear about us? _____ Who's your Primary Care Provider?_____

Please describe the Main Reason for today's visit, and any details _____

_____

List tests, if any, have been done for this problem, medicines tried or other treatments? _____

_____

Medical History:

Any medical problems in the first month of life? ☐ none. Any medical diagnoses? (i.e.diabetes, asthma, genetic syndromes)

Surgeries or Hospitalizations ☐ none If yes, please explain: _____

Allergies to to any drugs, foods, or latex? ☐ none _____ If yes, please explain: _____

List current prescription medication, over-the-counter, or herbal remedies? _____ _____

_____

Immunizations up to date? Yes/No _____ If No, please explain: _____

Any diet restrictions? _____

Review of Systems: Please check if the patient has had a significant issue with any of the following, as it relates to today's visit.

_____ chills/ fever	_____painful urination, bed wetting	___Diabetes, thyroid disease
_____ Skin disease	_____rashes, itching	___sleeping difficulties
_____ loss of vision/ eye pain	_____seizures, headaches	___broken bones, joint pains, arthritis
_____ mouth sores/throat pain	_____abdominal pain	___frequent bleeding/bruising, anemia
_____ Respiratory disease	_____anxiety/depression	___weight loss or gain
_____ Heart disease	_____constipation/diarrhea	___ Blood in stools

Family History Please list any chronic conditions in the space provided.

Mother ( ) none _____

Father ( )none _____

Brothers ( )none _____

Sisters ( )none _____

Maternal Family members ( ) none _____

Paternal Family members ( )none _____

Other medical condition _____

Social History

Tobacco use (Only if 13 years of age or older) (circle one): ☐ Never ☐ Current ☐ Unknown

Living Arrangements : ☐ Both Parents ☐ Mother Only ☐ Father Only ☐ Grandparents ☐ Alternates between parents home ☐ Other:

Recent travel _____

Physical Activities _____

Menstrual History (if applies) _____

_____ _____

Patient/Parent or Guardian Signature (if patient is under the age of 18) Date

_____

Printed Name of Parent or Guardian

Colorado Pediatric Gastroenterology
Jeff Rosensweig, M.D.

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This entire form must be completed in its entirety as neatly as possible, signed and dated at the bottom. Please complete all three (3) pages.

Patient Name: _____ **Nickname:** _____ **Gender:** ☐ Male ☐ Female

Address: _____
Physical Address **City** **State** **Zip**

Address: _____
Mailing/Billing Address **City** **State** **Zip**

Phone Number: _____ **Age:** _____ **Date of Birth:** _____

Race (Check One)**:** ☐ White ☐ Black/African American ☐ American Indian/Alaskan ☐ Other: _____ ☐ Decline

Ethnicity (Check One): ☐ Non-Hispanic/Non-Latino ☐ Hispanic/Latino

Primary Language (Check One)**:** ☐ English ☐ Spanish ☐ Italian ☐ Russian ☐ French ☐ Other: _____

Parent or Guardian Name: _____ **Date of Birth:** _____

Email Address: _____ **Social Security Number:** _____

Home Phone: _____ **Cell Phone:** _____

Address: _____ **Work Phone:** _____

Marital Status: ☐ Married ☐ Divorced ☐ Single **Relationship to Patient:** _____

Parent or Guardian Name: _____ **Date of Birth:** _____

Email Address: _____ **Social Security Number:** _____

Home Phone: _____ **Cell Phone:** _____

Address: _____ **Work Phone:** _____

Marital Status: ☐ Married ☐ Divorced ☐ Single **Relationship to Patient:** _____

EMERGENCY CONTACT Name: _____

Relationship to patient: _____ **Best Phone:** _____

Primary Doctor: _____ **Phone:** _____

Address/Location: _____ Fax: _____

Referring Doctor: _____ **Phone:** _____

Address/Location: _____ Fax: _____

PHARMACY OF CHOICE: _____ **Phone:** _____

Address/Location/Cross Streets: _____

PRIMARY INSURANCE: _____ **ID Number:** _____ **Group Number:** _____

Address: _____

Name of Policy Holder: _____

SECONDARY INSURANCE: _____ **ID Number:** _____ **Group Number:** _____

Address: _____

Name of Policy Holder: _____

By signing below, I confirm that all information contained on this form is true and accurate. I understand that this information is being obtained to better assist in the medical attention of my child or dependent and will supply any other information that is requested immediately upon request.

X _____ _____

Patient/Parent or Guardian Signature (if patient is under the age of 18) **Date**

Colorado Pediatric Gastroenterology

Jeff Rosensweig, M.D.

PATIENT NAME: **Date of Birth:**

MEDICAL HISTORY & PHARMACY RETRIEVAL APPROVAL

I, the undersigned parent and/or guardian of the patient listed above, hereby grant Colorado Pediatric Gastroenterology, its partners, staff and/or other affiliates, permission to obtain all medical history, medication and prescription information from pharmacies and other care providers, including doctors, hospitals, outpatient clinics, laboratories and imaging centers for the sole purpose of the patients medical care.

X ☐

Patient/Parent or Guardian intial (if patient is under the age of 18)

PATIENT CONSENT & FINANCIAL OBILIGATION

I hereby assign all medical and/or surgical procedures to include major medical benefits to which entitled, including Medicare, Medicaid, private and group insurance or other health plans to: Colorado Pediatric Gastroenterology. Except as prohibited by any agreement between my insurance company and Colorado Pediatric Gastroenterology or by state of federal law, I agree to be responsible for my co-payments, deductible amounts and any other charges for medical services NOT covered by my insurance or third party payers. This includes late payment fees and no show and/or cancelation of appointment fees.

I authorize Colorado Pediatric Gastroenterology to file any claims for payment of any portion of the payment bills and assign all rights and benefits to Colorado Pediatric Gastroenterology as appropriate. I further agree, subject to state and federal law, to pay all costs, attorney fees, expenses and interested in the event that Colorado Pediatric Gastroenterology has to take action to collect the same because of my failure to pay in full all incured charges.

*I understand that if I do not provide all the requested and necessary information, that I will be billed directly for all charges until such information is approved.

**I understand that Colorado Pediatric Gastroenterology is not party to any legal payment of medical co-pays, deductibles or any other outstanding balances between divorced/separated parents/guardians.

If patient(s) DO NOT SHOW for a scheduled appointment(s), or do not cancel within 24 hours prior to the scheduled appointment(s), Colorado Pediatric Gastroenterology reserves the right to charge a fee of $50.00 per each missed appointment, per each child/patient.

X ☐

Patient/Parent or Guardian Inital (if patient is under the age of 18)

Notice Of Privacy Practices

I, the undersigned patient or parent/guardian of the patient listed above, acknowledge that I have received and read a copy of the HIPAA Privacy Practices or I consent to receive an email copy.

X ☐

Patient/Parent or Guardian Initial (if patient is under the age of 18)

I, the undersigned Patient or parent/guardian of the patient listed above, acknowledge that I have read, initialed, and understand all of statements above.

X _____ _____

Patient/Parent or Guardian signature (If patient is under the age of 18) **Date:**

Colorado Pediatric Gastroenterology
1601 E. 19th Avenue, Suite 3500
Denver, CO 80218
303.830.9190

Financial Policies and Information

Our commitment is to provide the very best care to our patients while recognizing the need to limit services to only those that are necessary for each patient. To meet this commitment, we recognize the need for a definite understanding and agreement concerning our patient's health care and financial arrangements for that medical care. Your clear understanding of our financial policies is important to our professional relationship. Please contact our billing office regarding any questions about our fees, financial policies, or your insurance coverage and your responsibilities.

Professional fees: Our fees for medical services are comparable to other similarly trained physicians in the community and reflect the complexity of your specific needs, the physician time dedicated to your care, the specialized nature of the doctor's training and education, supplies, and support costs associated with providing and coordinating your care.

Patient Payments/Balances: Co-payment, deductibles, services not covered by your insurance plan or outstanding balances are due at the time of your appointment. **All account balances must be paid within 90 days of receiving your first statement.** Payment may be made by: cash, check, Visa or MasterCard. Nonpayment may result in your account being turned over to a collection agency.

Patients having medical procedures: If your deductible and co-insurance amounts have not been met, we will collect $250.00 from you at least three (3) business days prior to your procedure. Once we receive the Explanation of Benefits from your insurance company, and if a refund is due to you, we will provide a refund payment to you within ten (10) business days.

Insurance Payments: We participate in assignment of payment with **specific** insurance plans in the area. When the correct insurance information is provided, we will submit your claims as a courtesy to you, our patient. Your insurance coverage is a contract between you and your insurance plan. You are responsible for unpaid balances left on your account regardless of the amount your insurance coverage.

Self-Pay: Patients who are not billing a third party or health insurance are required to pay at the time of service for all office services at the time of service and will receive a 25% discount off our fee schedule. All procedures requiring services at a facility (hospital or surgery center) are pre-paid to the office within three (3) business days and will receive a 25% discount. If payment is not received within the specified time period, the procedure will need to be rescheduled.

Missed appointments: Please understand your appointment is time that has been reserved for your needs and that your lack of attendance at that visit prevents others from receiving care at that particular time. To assist patients with access to our physicians, we will charge a fee of $50.00 for any office appointment not canceled 24 hours in advance.

Medical Forms: The completion of disability forms, FMLA, attending physician statements and other supplemental insurance/employer forms require additional physician and staff time. A fee of $25.00 will be charged for all forms to be completed.

Collection Agencies: If it becomes necessary to place your account with a third party collection agency due to your non- payment, the account of the person responsible will be turned over to collections, and the patient will be dismissed from our practice.

Bounced Checks: A $35.00 charge will be applied for each check returned by the bank.

Your signature on this page constitutes an agreement to this policy.

Patient/Responsible Party Signature_____ **Date** _____

Patient Name (Print) _____

Informed Consent for Telemedicine Services

Medical Record # to be completed by Provider:

Patient Name:_____ Location Of Patient: _____	Date of Birth: _____	Medical Record #: _____

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Colorado Pediatric Gastroenterology providing health care services to me via telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit.

I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Colorado Pediatric Gastroenterology at 303-830-9190. As long as this consent is in force (has not been revoked) Colorado Pediatric Gastroenterology may provide health care services to me via telemedicine without the need for me to sign another consent form.

Signature of Patient (or person

authorized to for patient): _____ *Date:* _____

If authorized signer,

relationship to patient: _____

I have been offered a copy of this consent form (patient's initials) _____