PCP: ____________

Patient Registration Form 2021

Date: ____________

(please print) ***PLEASE FILL OUT ALL SECTIONS BELOW ***

Patient Information

Last Name: | First Name: | Previous name / Nickname

Mailing Address:

City/State/Zip:

Primary Phone #: (cell) | Secondary Phone #: (home / landline) | Can we leave a detailed message regarding medical care and/or test results? Yes ☐ No ☐

Preferred Method of Contact? ☐ Phone #1 ☐ Phone #2 ☐ Portal Msg | Reminder calls and other electronically generated messages: ☐ Voice ☐ Text ☐ Decline | How did you hear of our office? If another pt, name please

Email address: | Do You Use The Patient Portal? Yes ☐ No ☐ (marking "NO" will disable portal)

Date Of Birth: / / (M D Y) | Sex: F (Female) M (Male) T (Transgender) | Marital Status: S (Single) M (Married) D (Divorced) W (Widowed)

Race (please select one): White ☐ Hispanic ☐ Asian ☐ American Indian/Alaska Native ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Decline ☐

Ethnicity (please select one): Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline ☐

Preferred Language (please select one): English ☐ Spanish ☐ Sign ☐ Other ____

Emergency Contact: Name: | Phone:

Social Security # | Employer Name: | Employer Phone:

Preferred Pharmacy Name(s): Local | Mail Order

Cross Streets | Phone: | City/State: | Phone:

Responsible Party

☐ **Self (18+)**

Last Name: | First Name:

Mailing Address: ☐ same as patient

City/State/Zip:

Phone: | Date of Birth: | Social Security #:

Other Parent(s) Name: | Phone(s):

Insurance Information

Primary Medical Insurance		Secondary Medical Insurance (if applicable)
Ins. Co. Name:	Primary card on file ☐	Ins. Co. Name:
Policy Holder Name:		Policy Holder Name:
Policy Holder DOB:	Secondary card on file ☐	Policy Holder DOB:
Policy Holder Employer:		Policy Holder Employer:
Patient Relationship to Policy Holder:		Patient Relationship to Policy Holder:
Member ID #:	Staff Initials	Member ID #:
Group ID #:		Group ID #:
Copay Amount: $		Copay Amount: $

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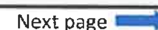
Financial Policy - 2021

*******Please initial each line item***

Section	Initial	Policy
Insurance		Complete and accurate and/or updated insurance information must be provided at every visit. Please have your current insurance card available. Pinon Family Practice (PFP) reserves the right to deny service, reschedule or make your account self-pay at any time if this information is not present and/or inaccurate.
		Pinon Family Practice (PFP) only bills for professional services rendered by our providers (office visits, rapid in-office labs, vaccine/medication administration, minor surgical procedures etc....). Blood, sputum, fecal and/or urine collected and forwarded to a laboratory for result, imaging or other tests ordered and performed outside of PFP will be billed by those providers/entities.
		By signing below, you authorize PFP to file with your insurance carrier and assign payment of medical benefits to Pinon. You authorize release of any and all medical records and information necessary to process any claim generated by a service you or your dependent(s) receive. It is your responsibility to be familiar with your insurance policy so you are aware of what services are covered and/or non-covered. We do not know and cannot guarantee coverage. You will be responsible for payment of any medical services provided if your insurance denies payment.
		As per our Credit Card Authorization Policy, established January, 2019, PFP will securely hold an encrypted version of your credit card on file to process any/all out of pocket expenses not covered by your insurance. See account balances below for details.
		All co-pays are due at the time of service for every visit. You will be asked to reschedule if you do not have the means to pay. Any outstanding balance due will be collected at check-in or you may be asked to reschedule until payment is made. PFP cannot waive or write off co-pays, deductibles, non-covered services that are due as per your insurance policy. PFP is contractually obligated to collected these fees.
Self-pay		If you have insurance and we are in-network/participating in the plan, we are contractually obligated to bill for any services rendered. If PFP does not accept your plan, you can choose to pay as self-pay. If you have Medicaid of CO, legally we cannot enter into a self-pay agreement.
		Payment in full is due at the time of your appointment, including tele-health encounters. We offer 15% discount for all professional services (vaccines and medications are excluded). We will take an $106 deposit (cash, check or credit card) up-front. If your visit is less we will refund you at the time of service (cash and credit card only). If your visit is more, you will be expected to pay the difference at the time of service. If you leave without settling your visit balance, you will forfeit any self-pay discount and incur a $10 billing fee.
Account Balance		As we identify any unmet deductible amount due (after an electronic download of your insurance benefits) we will require the minimum contractual allowed amount be paid at the time of service.
		Any additional out of pocket amount is due immediately upon the processing of your claim(s) by insurance. We will hold a current credit/debit/HSA card on file and process no sooner that 14 days from when we are notified by your insurance carrier. This should allow you time to review and contact us if necessary (you are able to access your insurance Explanation of Benefits as they process your claim(s) so you should be aware of any amounts owed per your policy prior to our processing the card on file). You can access your statements anytime on our Patient Portal. We accept Visa, Mastercard and Am. Express
		There will be a $10.00 billing charge assessed for every 30 days your account is past due. If you choose not to leave a credit card on file and fail to pay within 14 days as indicated above, you will incur this billing charge as a result. Please note: if you allow your account to become "delinquent" at any time, Pinon does reserve the right to and may deny services, prescriptions, paperwork etc...
		If a delinquent account is sent to our outside collection agency, the undersigned Responsible Party agrees to pay all costs of collection; principal balance, fees and accrued interest, as well as any reasonable attorney's fees. Furthermore, you and your family members may be discharged from PFP due to nonpayment.
		There will be a $25.00 fee for any returned checks and Pinon will require cash or credit card for future payments.
		There will be a $79 fee for no-showing scheduled appointments and/or cancelled appointments without providing 24-hour notice.
Paperwork		Paperwork/forms needing to be completed outside of a scheduled appointment will incur a fee. FLMA and Disability paperwork - $75 upfront fee; Sports Physical forms, handicap sticker, UBER/LIFT, return to work and biometric screening forms etc...- $35 upfront fee. If any of these forms are needed, you must also have had your annual physical in order to complete them.
		Chart note/immunization record printing: pages 1-10 $16.50, 11-40 pages $.75 per page and 41+ pages .50 per page. You can access, download and print your chart notes at any time through your Patient Portal account, free of charge.

My signature below indicates that I have read and agree to the above Financial Policy and terms set above. *If under 18 years of age, you must have a parent or guardian (Responsible Party) sign below*.

Signature of Guarantor / Responsible Party	**Date:**

Next page 

PIÑON FAMILY PRACTICE

Consent and Release of Information

If under 18 years of age, you must have a parent or guardian sign below

I voluntarily agree to treatment including but not limited to diagnostic tests, procedures and/or treatments or other modalities by which the attending provider has deemed necessary and of which are administered to or to be performed on me under the direction of the attending provider and his/her designee.

I allow Pinon Family Practice to access my medication history by electronic download from all local pharmacies and CORHIO – CO Regional Health Information Exchange.

I understand that if a controlled substance is being provided to me, limited information will be submitted into Colorado Prescription Drug Monitoring Program for limited purposes allowed under Colorado Law.

I understand that vaccinations received will be entered into the Colorado Immunization Information System (CIIS).

I understand that it may be necessary for other healthcare providers to review information in my medical records in order to render medical care to me. I authorize Pinon Family Practice discuss with and/or to copy part or all of my medical record in the event that it be needed by another provider in order to provide treatment.

______I acknowledge my receipt and understanding of the Financial Policy and Office Information and Policies

Release of Information

[ ] I authorize the release of information including the diagnosis, visit information, diagnostic and test results and claims/billing information rendered to me. This information may be released to:

[__] Spouse________________________________ Phone:______________________________

[__] Child(ren)______________________________ Phone:______________________________

[__] Other_________________________________ Phone:______________________________

[__] Information is not to be released to anyone.

______This Release of Information will remain in effect until terminated by me in writing.

Acknowledgement and Receipt of Notice of Privacy Practices

The undersigned Patient or legally authorized representative ("Agent") of the Patient acknowledges that he or she personally received a copy or was offered a copy of Pinon Family Practice, LLP's Notice of Privacy Practices on the date indicated below. *If under 18 years of age, you must have a parent or guardian sign below.*

I agree that a photocopy or digital image of this agreement shall be as valid as the original.

Patient Name (please print): ______________________________________

Signature of Patient/Guarantor: ______________________________ **Date:** ______________

Information about the Agent (attach appropriate documentation) or Guarantor – *please print*

Agent/Guarantor:____________________________________ Title/Relationship:______________

Patient Portal - Informed Consent

You are responsible for taking steps to protect yourself from unauthorized use of online communications, such as keeping your username and password confidential. Pinon is not responsible for breaches of confidentiality caused by you or an independent third party. You agree to take steps necessary to keep your Patient Portal and subsequent medical information confidential including:

- Do not download or store your personal information on your employer-provided computer; otherwise personal information could be accessible or owned by your employer.
- Use screen savers or close your portal instead of leaving your open chart on the screen for passersby to read and keep your password safe and private.
- Do not allow other individuals or other third-party access to the computer(s) upon which you store your personal medical information.
- Update your contact information as soon as it changes including any changes to your regularly used email address. Pinon will not use your standard email account for security reasons, but notifications are sent to your standard email address when a message has been sent to you and is waiting for you on your Patient Portal.

Withdrawal of this informed consent must be done by written online communications or in writing to Pinon Family practice.

_______ I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the Patient Portal, and consent to the conditions outlined herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that my physician may impose to communicate with patients via online communications. I have had a chance to ask any questions that I had and to receive answers.

Appointment Reminder Calls
&
Follow-up Communication

TEXT MESSAGE AND INFORMED CONSENT: In order to enhance patients' care and experience, Pinon Family Practice will send appointment reminder calls/text messages for appointments schedule 2 or more days in advance. We may also have important announcements to send, such as when it's time for flu shots or return appointment, bloodwork or vaccine notifications. We may also contact you after your visit in order to request feedback on your experience by phone call, SMS text message, e-mail, voicemail, or mobile application, some of which may be via automated means. By signing below, you understand and agree to be contacted in this manner with communications related to this visit, and any future visits.

If you are not interested in these services, please select the "**Opt out**" option at the bottom of this form. If in the future you decide to opt-out, you may do so by notifying us in writing. Standard telephone minute and text messaging charges may apply when we contact you.

MOBILE SAFETY TIPS: While we work hard to protect your information, remember that electronic communication is never 100% secure. It's very unlikely, but information you send via text, email or mobile application, or that you leave on your mobile device, could be exposed to people other than your doctor. Here are a few safety tips to follow:

- Use a password on your mobile device to prevent strangers from seeing what is on your phone.
- DO NOT send sensitive health information to us. Please send a portal message or call us to discuss something private or sensitive.
- If you are worried about those close to you seeing your messages, you can delete them from your email or messaging app. This won't erase them completely, but will make it hard for others to see them.

Please select one:

_______ I choose **to receive** calls/text messages **Personal cell #:** ______________________________

~ OR ~

_______ I choose **to opt-out** of receiving calls/text messages **(No reminder calls/text messages!)**

I agree that a photocopy or digital image of this agreement shall be as valid as the original. *If under 18 years of age, you must have a parent or guardian sign below.*

Patient Name (please print): ______________________________

Signature of Patient/Guarantor: ______________________________ **Title/Relationship:** ______________