PT ID _____

PATIENT INFORMATION

YourName_____

Driver's License #/State _____ Social Security Number: _____

Date of Birth: _____ Age: _____ Gender: ❑ Male ❑ Female

Street Address: _____

City/State/Zip: _____

Email: _____ Physical Address Same as Mailing? ❑ Yes ❑ No

If not, please list **mailing address**: _____

Preferred Phone: _____ ❑ Home ❑ Mobile ❑ Work

Secondary Phone: _____ ❑ Home ❑ Mobile ❑ Work

Emergency Contact Name: _____

Phone: _____ Relationship: _____

Race: ❑ American Indian or Alaskan Native ❑ Asian or Pacific Islander ❑ Black ❑ White ❑ Refuse to Report

Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Refuse to Report

Primary Language: ❑ English ❑ Spanish ❑ Other _____

How did you hear about us? ❑ Phone book ❑Drive by ❑ Insurance Comp. ❑ Family ❑ Friend ❑Internet❑

❑ Facebook ❑ www.boulderprimarycare.com

Marital Status: ❑ Married ❑Single ❑ Divorced ❑ Widowed ❑Other _____

PHARMACY INFORMATION

Pharmacy Name: _____ Phone Number: _____

Street Address: _____ City/State/Zip: _____

Do you have a Prescription Drug ID card ? ❑ Yes ❑ No Member ID #_____

RX Bin # _____ RX Group # _____

❑**Yes** ❑**No** ***I hereby authorize Boulder Primary Care to access my electronic medication history and formulary information***

PT ID _____

PRIMARY INSURANCE INFORMATION

Payer (e.g. BC/BS): _____ Plan: _____

Insurance Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

Policy Holder Name: _____ Policy Holder Gender: ❑ Female ❑ Male

Date of Birth: _____ Social Security Number: _____

Policy/I.D. Number: _____ Group Number: _____

Employer: _____ Phone number: _____

Address: _____

Occupation: _____

SECONDARY INSURANCE INFORMATION

Payer (e.g. BC/BS): _____ Plan: _____

Insurance Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

Policy Holder Name: _____ Policy Holder Gender: ❑ Female ❑ Male

Date of Birth: _____ Social Security Number: _____

Policy/I.D. Number: _____ Group Number: _____

FINANCIAL POLICY

You are financially responsible for the medical services you receive. Please review our policies below and sign at the end to indicate your agreement to these terms

APPOINTMENTS

1. **Co-payments.** Copayments for clinic visits are due at the time of service. If you are unable to make your copayment at the time of service, Boulder Primary Care reserves the right to reschedule your appointment until a time that you are able to make your copayments. Payment for any outstanding balance is due at your appointment.

2. **Procedure/Manipulation Prepayment**. Boulder Primary Care collects your payment for a procedure at the time when the procedure is performed. Your prepayment is based on an estimate of your expected financial responsibility. **This is an estimate only.** You are responsible for any unpaid balance after your insurance (if applicable) has been billed. In the event of overpayment, you may request a refund according to our refund policy below. We reserve the right to reschedule your procedure until prepayment has been made.

3. **Cancellations**, **Missed Appointments and Late Arrivals**. Appointments must be cancelled 24 hours prior to the appointment time. If you are more than 12 minutes late, we may reschedule your appointment. If you are more than 40 minutes late, or if you do not show up for your appointment, you will be responsible for a missed appointment fee. Missed appointments and cancellations less than 24 hours are subject to a $35 charge. **These charges are your responsibility and will not be billed to any insurance carrier.**

INSURANCE PAYMENTS

4. **Financial Responsibility**. Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment in full for all medical services provided to you. Any charge not paid by your insurer will be your responsibility, except as limited by our contract (if any) with your insurance carrier.

5**. Coverage Changes and Timely Submission**. It is your responsibility to inform us in a timely manner of any changes to your billing or insurance information. There is a time limit within which Boulder Primary Care must submit a claim on your behalf to your insurer. If Boulder Primary Care is unable to submit your claim within this period because we have not been supplied with your correct insurance information, you will be responsible for all charges.

6. **Self-Pay.** If you do not have health insurance, or if your health insurance will not pay for services rendered by Boulder Primary Care you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule (available from our front desk).
Self-pay patients are expected to make payment in full at the time of service.

BENEFITS AND AUTHORIZATION

7. **Insurance Plan Participation**. We participate in many but not all insurance plans. It is your responsibility to contact your insurance company to verify that your assigned physician participates in your plan. Out of network charges may have higher deductibles and copayments.

8. **Prior Authorization and Non-Covered Services**. Boulder Primary Care may provide services that insurance plans exclude or require prior authorization. If insured, it is ultimately your responsibility to ensure that services provided to you are covered benefits and authorized by your insurer. Boulder Primary Care as a courtesy to our patients makes a good faith effort to determine if services we order are covered by your insurance plan, and if so, whether or not prior authorization for treatment is required. If determined that a prior authorization is required, we will attempt to obtain such authorization on your behalf.

9. Out of Network Payments. If we are not part of your insurance carrier's network (out-of-network) and your insurance carrier pays you directly, you are solely responsible for payment and agree to forward the payment to Boulder Primary Care immediately.

FORM COMPLETION

10. A charge of $50.00 is charged and due before any forms will be completed. (Disability, FMLA, Physician statements etc.)

ACCOUNT BALANCES AND PAYMENTS

11. **Reassignment of Balances**. If your insurance company does not pay within a reasonable time, we may transfer the balance to your sole responsibility. Please follow up with your insurance carrier to resolve non-payment issues. Balances are due within 30 days of receiving a statement.

12. **Collection of Unpaid Accounts**. If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and /or an attorney, which may result in reporting to credit bureaus and/or legal action. Boulder Primary Care reserves the right to refuse treatment to patients with outstanding balances over 120 days old. You agree to pay Boulder Primary Care for any expenses we incur to collect on your account, including reasonable attorneys' fees and collection cost.

13. **Returned Checks**. Returned checks will be subject to a $50 returned check fee.

14. **Refunds.** Refunds for overpayment or prepayment on cancelled procedures are made only after there has been full insurance reimbursement for all medical services on your account. Please allow for all bookkeeping to be completed.

15. **Statements**. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing dates. A rebilling fee will be added each month to unpaid balances.

AGREEMENT AND ASSIGNMENT OF BENEFITS

I agree to reimburse Boulder Primary Care the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, and all costs, and expenses, including reasonable attorney's fees, which are incurred in such collections efforts.

I have read and understand the financial policy of Boulder Primary Care and I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier (s) to issue payment directly to Boulder Primary Care. I understand that I am financially responsible for all services I receive from Boulder Primary Care. This financial policy is legally binding upon you and your estate, executor and /or administrators, if applicable.

Print Name: _____

Signature: _____ **Date: _____**

PT ID _____

AUTHORIZATION TO RELEASE RECORDS TO BOULDER PRIMARY CARE

Patient Name: _____ Date of Birth: _____

I Hereby Authorize _____

Phone: _____ Fax: _____

or its agent(s) to disclose my health information as described in this authorization to:

BOULDER PRIMARY CARE Health Information to Be Disclosed: (check appropriate box)

❑2 years prior from last date seen by the healthcare provider

❑ The following health information (be specific):

_____

The Health Information Is Being Disclosed for The Following Purpose: (check appropriate line):

❑Change of Insurance or Physician ❑ Continuation of Care

If no date, event or condition is written, this authorization will expire 1 year from the date signed.

A photocopy of this Authorization will be considered effective and valid as original.

❑I understand I may revoke this Authorization at any time by sending written notice of my revocation to **BOULDER PRIMARY CARE.** I understand that my revocation will not be effective to the extent the healthcare provider has taken action in reliance on this Authorization. Unless revoked sooner, this Authorization will expire on the following date, event or condition: _____

❑I understand that the health information authorized to be disclosed under this Authorization may include information regarding drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV related diseases and communicable disease-related information.

❑I understand that **BOULDER PRIMARY CARE** may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that the Recipient may re-disclose the records and that the records may no longer be protected by Federal Privacy Regulations

I have read the Authorization and I acknowledge that I am familiar with and fully understand its terms and conditions

_____ _____

Signature of Patient/Parent/Guardian or Authorize Representative ***Date***

(Guardian or Authorized Representative must attach documentation of such status)

_____ _____

Printed Name and Telephone Number ***Relationship***

PT ID _____

PRIVACY POLICY

Boulder Primary Care takes your privacy seriously. We will not disclose your medical records (Protected Heath Information) to any party without your signed consent, except as stipulated in our Notice of Privacy Practices. This form authorizes Boulder Primary Care to release your medical records to parties indicated.
Records request must be signed by the patient and specifically describe all records released and the express purpose for the requested records.

TELEPHONE MESSAGES

Boulder Primary Care will, from time to time be required to leave voicemail messages as reminders or notifications. While no health information will be left on voice mail, a message that labs, prescriptions or imaging results need to be discussed may be left. An appropriate message revealing no health information will be left.

CONSENT TO TREAT

By signing below on behalf of a minor child or an incapacitated adult that requires a guardian I am consenting to all examinations and treatment of said minor or incapacitated adult.

All information is true and correct at the time that it was written

_____ _____ _____

Signature of Patient/ Parent / Guardian Authorized Representative **Date** **Telephone**

_____ _____

Printed Name of Authorized Representative **Relationship Capacity of Patient**