IGNACIO FAMILY MEDICINE, INC **PATIENT INFORMATION**

Patients Name: _____
Last First Middle

Mailing Address: _____
City State Zip

Physical Address: _____

Home/Cell Phone: _____ **Email Address:** _____

Birthdate: _____ **Sex: M F Other:** _____ **SS#:** _____

Insurance: No Insurance Primary: _____ **Secondary:** _____

Ethnicity: **Do you consider yourself to be Hispanic or Latino?** Yes No Declined
Preferred Language _____

Race: Caucasian American Indian or Alaska Native Asian Black or African American Native Hawaiian or Pacific Islander Other Declined

Spouse/Parent/Guardian Name: _____ **Phone #:** _____

Emergency Contact Name: _____ **Phone #:** _____

Employment Status: Not Employed Full-time Part-time Retired Student

Patients Employer: _____ **Phone #** _____

Marital Status: **Single Married Divorced Widowed Legally Separated Significant Other Declined**

May we leave a message containing personal information on your home phone? YES NO
May we leave a message containing personal information on your cell phone? YES NO

Do you give our office permission to discuss your medical information with family members? ___Yes ___No
If yes, please provide names and phone numbers below:

Name _____ **Relationship** _____ **Phone** _____

Name _____ **Relationship** _____ **Phone** _____

Person responsible for payment: _____ (Check if same as patient)

Name _____ **Relationship** _____ **DOB** _____

Mailing address _____

Phone Number _____ **SSN:** _____ **Employer** _____

MY SIGNATURE BELOW CERTIFIES THAT I/WE, THE UNDERSIGNED:

- **CONSENT TO THE EVALUATION AND MEDICAL TREATMENT GIVEN BY IGNACIO FAMILY MEDICINE, INC. _____ (INITIAL)**

- **HAVE RECEIVED AND/OR REVIEWED A COPY OF THE IGNACIO FAMILY MEDICINE, INC. FINANCIAL POLICY. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE. I WILL BE RESPONSIBLE FOR PAYING MY ANNUAL DEDUCTIBLE, CO-PAYMENTS AND CHARGES FOR ANY NON-COVERED SERVICES. I HEREBY AUTHORIZE IGNACIO FAMILY MEDICINE, INC. TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. _____ (INITIAL)**

- **HAVE RECEIVED AND/OR REVIEWED A COPY OF THE IGNACIO FAMILY MEDICINE, INC. NOTICE OF USES AND DISCLOSURES OF PROTECTED MEDICAL INFORMATION (NOTICE OF PRIVACY PRACTICES). _____ (INITIAL)**

- **HAVE RECEIVED AND/OR REVIEWED A COPY OF THE IGNACIO FAMILY MEDICINE, INC. ELECTRONIC HEALTH INFORMATION EXCHANGE NOTIFICATION. _____ (INITIAL)**

- **I AM AWARE THAT IGNACIO FAMILY MEDICINE WILL NOT PRESCRIBE OPIOIDS FOR CHRONIC PAIN AND/OR BENZODIAZEPINES FOR ANXIETY ON A RECURRING BASIS. _____ (INITIAL)**

- **I WILL NOTIFY IGNACIO FAMILY MEDICINE 48 HOURS IN ADVANCE ON ALL MEDICATION REFILLS _____ (INITIAL)**

- **IF I REQUEST A LETTER OR PAPERWORK TO BE FILLED OUT FOR ANY REASON, I AM AWARE THAT I HAVE TO GIVE IGNACIO FAMILY MEDICINE AT LEAST 7 BUSINESS DAYS TO COMPLETE THESE. _____ (INITIAL)**

- **I GIVE IGNACIO FAMILY MEDICINE PERMISSION TO TEXT REMINDERS OF MY APPOINTMENTS. _____ (INITIAL)**

Patient/Parent/Guardian Signature _____ **Date** _____

Revised: 07/13/2023

HEALTH HISTORY FORM
IGNACIO FAMILY MEDICINE, INC.

Date_____

Name_____ Date of Birth_____

Chief Complaint (reason for visit): _____
_____

Social History:
Occupation:_____

Marital Status: Single Married Divorced Widowed Legally Separated Significant Other
Declined

Tobacco Use: None Pipe/Cigar Cigarettes _____ Packs/Day
Smokeless tobacco Electronic or E-Cigarette Secondhand smoke exposure

Alcohol Use: None Daily Occasional Trying to cut down In recovery
Amount per week: _____

Caffeine Use: None Daily Occasional Amount per day: _____

Drug Use: None Past Use Current
How many times in the past year have you used recreational drugs or prescription medication for nonmedical reasons?
None One or more
Marijuana Amphetamines Cocaine Designer/Club Opiods
Route: Smoke Inject Ingest Topical

Diet: Well balanced Diabetic Vegetarian Fast food/Fats/Carbs

Exercise/Activity Level: Sedentary Strength/Wt. Training Stretch/Balance Aerobic/Cardiac
How often/long?: _____

Sexual Activity: Not Active Active Number of lifetime sexual partners: _____
Men Women Both

Do you have a caregiver? Yes No
Name: _____ Relationship: _____

Do you: Use a seatbelt Use a helmet Have guns in home Have a smoke detector in home

Abuse:
I feel safe at home: Yes No
Is there anyone you are afraid of? Yes No
Do you have a history of abuse? Yes No

Travel
In the last 30 day, have you traveled to any foreign countries? Yes No List: _____
_____

Family History:

		Living	Deceased	Major illness or cause of death
Spouse		____	____	_____
Mother		____	____	_____
Father		____	____	_____
Brothers	Number	____	____	_____
Sisters	Number	____	____	_____
Children	Number	____	____	_____
Maternal Grandmother		____	____	_____
Maternal Grandfather		____	____	_____
Paternal Grandmother		____	____	_____
Paternal Grandfather		____	____	_____

Surgical History:

Please list surgeries/procedures and add notes as needed.

Year	Surgery/Procedure	Hospital/Location	Complications/Comments

Hospitalizations: (Please list)

Year	Reason	Hospital/Location	Comments

Medications: None

Please list any medications you are taking (including aspirin, vitamins, supplements, or any other over the counter medication).

Name of Medication	Dose	How often do you take	Reason for taking medication

Preferred Pharmacy: _____ **Phone Number:** _____

Allergies: (Please list) No Known Drug Allergies
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Other (latex, adhesive, food, environment): _____
Other (latex, adhesive, food, environment): _____

Immunizations:
Please provide any known dates or full immunization record(s).

Tetanus or Tetanus/Pertussis: _____ (mm/dd/yy) Influenza: _____ (mm/dd/yy) Shingles: _____ (mm/dd/yy)

Hepatitis A: _____/_____ (mm/dd/yy / mm/dd/yy) Hepatitis B: _____/_____ (mm/dd/yy / mm/dd/yy)

HPV: _____/_____/_____ (mm/dd/yy / mm/dd/yy / mm/dd/yy) Pneumococal 13 or 23: _____ (mm/dd/yy)

COVID 19: _____/_____ (mm/dd/yy / mm/dd/yy) (Moderna/Pfizer/Johnson & Johnson)

Advance Directive
Do you have a Living Will/DNR? Yes No
Do you have a Durable Power of Attorney? Yes No
If yes: _____
(Please Print Name) (Phone Number)

Would you like information regarding Advance Directive? Yes No

Female Patients Only
Number of pregnancies: _____ Deliveries: _____ Elective Abortions: _____ Miscarriages: _____
Form of Contraception (if any): _____ Age of 1st period: _____
Date of last menstrual period: _____ Currently pregnant: _____
Currently breast feeding: _____
Last Pap Smear: _____ Age of menopause: _____
Last mammogram: _____

Personal Medical History

Please check all diagnoses that apply to you and add notes as needed.

Gastrointestinal			**Genitourinary**		
Diverticulitis/Colitis	Yes	No	Kidney Stones	Yes	No
GERD (Heartburn)	Yes	No	Chronic Kidney Disease	Yes	No
Hiatal Hernia	Yes	No	Recurrent UTIs	Yes	No
Gastrointestinal Bleeding	Yes	No			
Ulcers	Yes	No			
Irritable Bowel Syndrome (IBS)	Yes	No	**Musculoskeletal**		
Colon Polyps	Yes	No	Scoliosis	Yes	No
			Fibromyalgia	Yes	No
Cardiovascular			Arthritis Type	Yes	No
Arrythmias/Atrial Fibrillation	Yes	No	Back Pain	Yes	No
Palpitations	Yes	No	Osteoporosis	Yes	No
Heart Attack (MI)	Yes	No	Chronic Pain	Yes	No
Heart Surgery	Yes	No	Restless Leg Syndrome	Yes	No
Heart Failure	Yes	No			
Heart Murmur	Yes	No	**Pulmonary**		
Chest Pain (Angina)	Yes	No	Sleep Apnea	Yes	No
Peripheral Vascular Disease	Yes	No	Oxygen Use	Yes	No
Hypertension	Yes	No	Asthma	Yes	No
Hyperlipidemia (High Cholesterol)	Yes	No	COPD/Emphysema	Yes	No
DVT Pulmonary Embolism (Blood Clots)	Yes	No			
Anemia	Yes	No	**Psychological**		
			Anxiety	Yes	No
Neurological			Depression	Yes	No
Vertigo/Dizziness	Yes	No	Bipolar Disorder	Yes	No
TIA/Stroke	Yes	No	Other	Yes	No
Seizures	Yes	No			
Migraines	Yes	No	**Other Conditions**		
Head Injury/Concussion	Yes	No	Autoimmune Disease Type		
			Cancer Type		
Endocrine			Hepatitis Type		
Thyroid Problems	Yes	No	HIV/AIDS	Yes	No
Diabetes Type	Yes	No			
ENT			Date of last dental exam:		
Glaucoma	Yes	No	Date of last eye exam: Glasses/Contacts	Yes	No
Macular Degeneration	Yes	No	Date of last colonoscopy:		
Hearing Loss	Yes	No	Date of last Chest X-Ray		
			Date of last EKG/Stress Test		
			Date of last DEXA Scan		

IGNACIO FAMILY MEDICINE, INC.
Dixie Melton, CFNP
FAMILY PRACTICE

P.O. BOX 707
115 CEDAR STREET
IGNACIO, CO 81137
Telephone (970) 563-9388
Fax (970) 563-9398

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Date of Request:_____

Patient Name: _____ DOB: _____

I hereby authorize: _____

Address:_____

_____
City State Zip

To furnish to: _____

Address: _____

_____
City State Zip

Type of Information to be released:

_____Medical Records (All)	_____Consultations	_____Lab Findings
_____Progress Notes	_____X-Rays	_____Testing Records
_____Evaluations/Assessments	_____HIV/AIDS	_____Alcohol/Drug Treatment
_____Discharge Summary	_____Other _____	

Purpose(s) for which information is to be used:

_____Changing Providers	_____Moving	_____Insurance/Payer Claim
_____Worker's Comp.	_____Legal Action	
_____On-going Care	_____Referral: _____	
_____Other: _____		

This is subject to revocation by the undersigned at anytime except to the extent that action has been taken in reliance hereon, and if not earlier revoked, it shall be terminated 90 days from the date signed without express revocation.
Exception: Exchange of information is valid while case is active, but not to exceed one year.

Patient Signature: _____Date: _____

Guardian/Parent Signature: _____Date: _____

Staff Signature: _____Date: _____

CORHIO
COLORADO REGIONAL HEALTH INFORMATION ORGANIZATION

ELECTRONIC HEALTH INFORMATION EXCHANGE

NOTIFICATION

Ignacio Family Medicine, INC. endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the CORHIO HIE, or cancel an opt-out choice, at any time.

IGNACIO FAMILY MEDICINE
FINANCIAL POLICY

We are committed to providing you with the best possible care. In order to achieve these goals, we need your assistance and understanding of our payment policy. Payment is due at the time of service. If you have medical insurance, we are happy to help you receive your maximum allowable benefits.

~Unless other arrangements have been made in advance by either you or your insurance carrier, **full payment is due at the time of service, including any Medicare deductibles or co-payments.** We accept cash, personal checks, VISA, Mastercard, Discover, Diners Club, JCB, American Express, and Flexible Spending cards.

~If we are a participating provider with your insurance, we will complete the necessary forms to bill your insurance. We will, however, require you to pay a co-payment, co-insurance, and/or deductible at the time of service.

~For billing purposes, at each visit you will be required to provide a current insurance card and updated driver's license as well as a current address and phone number. If you do not have current insurance information at the time of your visit, you will be given 7 days to provide our office with this information, otherwise your insurance will not be billed, and you will be responsible for the full amount.

~For identification and billing purposes, we require your social security number. In the current atmosphere of identity theft, we realize that some patients are concerned about providing this information. We appreciate your concerns about this issue and take every precaution against this or any personal information getting into the wrong hands.

~This office reserves the right to refuse service, if the above information is not provided to our staff.

~If a balance on any account remains unpaid after 90 days; that account will be sent to a collection agency. All outstanding balances must be paid in full before you or your immediate family may be seen for a visit or any prescriptions are refilled.

~The fee for a check returned by the bank for insufficient funds is $20.00 plus any other charges incurred with the check.

~**Minor patients:** For all services rendered to minor patients (under 18 years of age), we will look to the adult accompanying the patient for payment. Custody agreements are not a consideration of this practice.

~If your account has a credit, we will be happy to refund this to you or apply it to future office visits.

~Please help us to better serve you by keeping all your scheduled appointments. You may be charged for missed appointments, if advance notice is not given to our office.

If you have any questions about our financial policy or any uncertainty regarding your insurance coverage, please do not hesitate to ask us. We are here to help you!

NOTICE OF PRIVACY PRACTICES
IGNACIO FAMILY MEDICINE, INC.

This information describes how medical information about you may be used and disclosed and how you can get access to this information. Please read carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practice with respect to protected health information.

As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

How Ignacio Family Medicine, Inc. May Use or Disclose Your Health Information

Ignacio Family Medicine, Inc. collects health information from you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of Ignacio Family Medicine, Inc., but the information in the medical record belongs to you. Ignacio Family Medicine, Inc. protects the privacy of your health information. The law permits Ignacio Family Medicine, Inc. to use or disclose your health information for the following purposes:

- **Treatment:** means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may share information about you with your pharmacist who needs to dispense medication to you; or we may disclose information to other healthcare providers who are involved in your care.
- **Payment:** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health Care Operations:** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates", such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information.
- **Appointment Reminders:** We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.
- **Notification and Communication with Family:** We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts.
- **Required by Law:** As required by law, we may use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse,

neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

- **Public Health:** As required by law, we may disclose your health information to public health authorities for purposes related to preventing or controlling disease, injury, or disability; reporting child, elder or other abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.
- **Law Enforcement:** We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.
- **Deceased Person Information:** We may disclose your health information to coroners, medical examiners and funeral directors
- **Organ Donation:** We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.
- **Public Safety:** We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
- **Proof of Immunization:** We will disclose proof of immunization to a school that is required to have it before admitting a student if you have agreed to the disclosure on behalf of yourself or your dependent.
- **Specialized Government Functions:** We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
- **Change of Ownership:** In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Breach Notification: In the case of a breach of unsecured protected health information, we will notify you in writing as required by law. In some circumstances our business associate may provide the notification.

Your Health Information Rights

You have the following rights with respect to protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- You have the right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- You have the right to receive your health information through a reasonable alternative means or at an alternative location.
- You have the right to inspect and copy your health information with limited exceptions. We may charge a reasonable fee for copies.
- You have the right to request that Ignacio Family Medicine, Inc. amend your protected health information.
- You have the right to receive an accounting of disclosures of protected health information.
- You have the right to obtain a paper copy of this notice from us upon request.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the *Notice of Privacy Practices* currently in effect. We reserve the right to change the terms of our *Notice of Privacy Practices* and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised *Notice of Privacy Practices from this office.*

Complaints

Complaints about this Notice of Privacy Practices or how Ignacio Family Medicine, Inc. handles your health information should be directed to:

Dixie A. Melton, CFNP
Ignacio Family Medicine, Inc.
PO Box 707
115 Cedar Street
Ignacio, CO 81137
(970) 563-9388

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

You may also address your complaint to one of the regional Offices for Civil Rights. A list of these offices can be found online at http://www.hhs.gov/ocr/regmail.html, or you may also submit your complaint electronically by visiting http://www.hhs.gov/ocr/privacy/index.html

You will not be penalized for filing a complaint.

Revised May 9, 2013