MOUNTAIN RHEUMATOLOGY
DAVID KORMAN MD
KATHLEEN SROCK MD
4500 E. 9TH AVE SUITE 500S
DENVER, CO 80220
(P) 303-861-2190 (F) 303-355-4435

Dear New Patient,

Please complete the enclosed questionnaire before your scheduled appointment. Please bring your **insurance cards** and **photo ID**. Please arrive at least fifteen minutes prior to your appointment. **All copays are due at the time of service.**

We try to accommodate each patient as best as we can. If for any reason you cannot make your scheduled appointment, please contact our office a minimum of 24 hours to cancel. **PLEASE be on time!** If you are more than ten minutes late to your appointment or later you may be asked to reschedule.

If you **NO SHOW** to your first appointment or do not call our office and cancel, we will **NOT** be able to reschedule the appointment.

It is very important that the physician has copies of your previous medical records for evaluating your condition. **PLEASE** call the doctor who has referred you and have them fax your records. We will need recent office notes, lab results, x-ray reports and other imaging reports. **These can be faxed to us at 303-355-4435.**

We do expect you to be familiar with your insurance coverage. If referrals are required by your insurance policy, it is the patient's responsibility to arrange for a current referral to be sent to us prior to your appointment.

If you have any further questions, please feel free to give our office a call. We look forward to meeting you.

Sincerely,

Mountain Rheumatology

Mountain Rheumatology

Patient Medications / Allergies

Patient Name_____ DOB_____

Current Medications- List any medications that you are taking including aspirin, vitamins, calcium and other supplements. Include the dose and frequency.

Medication	Dose	Frequency

Do you have any allergies to medications _____Yes _____ No

List the names of the drugs. 1)_____ 2)_____
3)_____4)_____ 5)_____

Pharmacy Name_____
Address_____
Phone Number_____

Mail Order pharmacy name_____

Smoking status- Please Circle
Current Former Never

Have you had a pneumonia vaccine? If so, what year? _____

Have you had your seasonal flu vaccine? If yes, when did you have it? _____

Have you had a shingles vaccine? If so, what year? _____

NEW WEB PORTAL

Our office has a new patient web portal that our patient's can log into for:

- office notes
- lab results
- request follow up appointments
- request medication refills
- send messages to our staff

If you're interested, please fill out the following, so we can send you an invitation to our portal. Thank you.

Name: _____
Date of Birth: _____
Email Address: _____

Code needed to create your account will be your year of birth.

MOUNTAIN RHEUMATOLOGY
DR KORMAN AND DR SROCK
4500 EAST 9TH AVENUE # 500S
DENVER, COLORADO 80220

Please print clearly. Please complete ALL information so that your claim can be processed quickly and efficiently. Thank you.

Name (First)_____ MI_____ (Last)_____

Address_____

City, State_____Zip_____

Primary language _____

Your ethnicity: Caucasian (white) Hispanic African American Asian Other:_____

Social Security #_____ Gender M / F Martial Status S M W D

Date of Birth_____Age_____

Employer_____

Insurance_____ID#_____Primary card holder_____

Please list the primary card holders **date of birth** and **social security** number for billing purposes:

_____

Primary card holders address: _____City_____

State_____ Zip code_____ Phone number_____

PHYSICIANS-Please list address, Phone #, and Fax #

Primary Care Physician_____ Phone #_____ Fax #_____

Address_____ City/State/Zip_____

Please list other physicians you are currently seeing and/or want us to send office notes to.

Physician_____ Phone #_____ Specialty _____

Physician_____ Phone #_____ Specialty _____

EMERGENCY CONTACT INFORMATION

Name_____Relationship to patient_____

Address_____ City_____ State_____ Zip Code_____

Phone # _____ Work #_____

I hereby assign, transfer, and set over to Mountain Rheumatology, LLC all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of medical information needed to determine my benefits. This authorization shall remain valid until written notice is given by me revoking this authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I authorize the release of any medical information from other healthcare providers and/or healthcare facilities to Mountain Rheumatology, LLC that is needed during the course of my care. This authorization shall remain valid until written notice is given by me to the office revoking this authorization.

_____Date_____

Patient Signature

Mountain Rheuamtology
HIPAA CONTACT FORM

Print Name:_____

Date of Birth:_____ Date:_____

Home ( )_____ May we leave a message? ___Yes ___No

Work ( )_____ May we leave a message? ___Yes ___No

Cell ( )_____ May we leave a message? ___Yes ___No

May we fax records to your Home ___Yes ___No or Work ___Yes ___No

Can we email you? ___Yes ___No If yes email address_____

Who may we talk to on your behalf about medical issues?

Name:_____Relationship_____

Phone number_____

Name:_____Relationship_____

Phone number_____

Name:_____Relationship_____

Phone number_____

Who may we or any authorized A/R management company/agent talk to on your behalf about billing issues?

Name:_____Relationship_____

Phone number_____

Name:_____Relationship_____

Phone number_____

Name:_____Relationship_____

Phone number_____

Patient/Guardian Signature:_____

Mountain Rheumatology

Rose Medical Center • Physician Office Building II
4500 E 9th Avenue • Suite 500S • Denver, CO 80220
(303) 861-2190 • (303) 355-4435 FAX

NOTICE OF PRIVACY PRACTICES

Effective Date: September 15, 2013

This notice describes how health information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Each time you visit a physician, or another healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination, test results, a plan for future care or treatment and billing-related information. This notice applies to all the records of your care generated by the office.

OUR RESPONSIBILITIES

We are required, by law, to maintain the privacy of your health information and provide you with a description of our privacy practices. We will abide by the terms of this notice.

If there is a breach of your protected health information, we are obligated to notify you, unless, after completing a risk analysis, it is determined that there is a low probability of protected health information compromise. This risk analysis involves consideration of all of the following factors: 1) the nature and extent of the information involved, 2) the person who obtained the unauthorized access and whether that person has an independent obligation to protect the confidentiality of the information, 3) whether the information was actually acquired or accessed, and 4) the extent to which the risk has been mitigated. If a breach notification is made prior to this risk assessment, a later risk assessment does not need to be conducted.

USES AND DISCLOSURES

The following categories describe examples of the way we use and disclose health information:

For treatment: We may use health information about you to provide treatment or services. We may disclose health information about you to doctors, nurses, technicians, health students, or other practice personnel who are involved in your care at our office (i.e., a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process.) Different departments of the office may also share health information about you in order to coordinate the different things you may need, such as prescriptions, lab work, meals, x-rays, etc.

We may also provide your physician or subsequent healthcare provider with copies of various reports that should assist in treating you.

For Payment: We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company and/or a third party payer (i.e., we may need to give your insurance company information about your surgery so they will pay for the service, or we may tell them about proposed treatment to obtain preauthorization.)

For Health Care Operations: Members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your care and others like it. The results will be used to improve the quality of care based on information about many patients and to evaluate the need for new services or treatments. We may disclose information to doctors, nurses, and students for educational purposes. We may also combine health information we have with that of other offices to see where improvements can be made. We may remove information that identifies you from this set of health information to protect your privacy.

We may also use and disclose health information to business associates we have contracted with to perform agreed upon service(s) and billing for it, remind you about an appointment, tell you about treatment alternatives, tell you about health-related benefits or services, for population-based activities related to improving health or reducing health care costs and for conducting training programs or reviewing competence of health care professionals.

Business Associates: There are some services provided in our organization through contracts with business associates, which are entities that create, receive, store, maintain, or transmit health information on our behalf. These include, but are not limited to: billing services, dictation services, collection services, patient safety organizations, electronic prescribing gateways, and personal health record vendors. When these services are contracted, we may disclose your health information to our business associate so they can perform the job we've asked them to do and bill you, your insurance company, or a third-party payer for services rendered. To protect your health information we require the business associate to appropriately safeguard your information. If a breach of your protected health information is made, the breach notification, if required, may be performed by a business associate.

Individuals Involved in Your Care or Payment for Your Care: You may request in writing the release of health information about you to a friend or family member who is involved in your medical care or who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so your family can be notified about your condition, status, and location. After the death of a patient, we may continue to make relevant disclosures to the deceased's family and friends under essentially the same circumstances as were permitted in life (i.e., when these individuals were involved in providing care or payment for care, and the physician is unaware of any expressed preference to the contrary). Fifty (50) years after a patient's death, any HIPAA protection for health information is eliminated.

Research: We may disclose information to researchers when an institutional review board has reviewed the research proposal and established protocols to ensure the privacy of your health information and has approved the research and granted a waiver of the authorization requirement. We may combine conditioned and unconditioned authorizations for research participation, provided that individuals can opt-in to the unconditioned research activity. These authorizations may encompass future research.

Organized Health Care Arrangement: The office and its medical staff members have organized and are presenting you this document as a joint notice. Information will be shared, as necessary, to carry out treatment, payment, and health care operations. Physicians and caregivers may have access to protected health information in their office to assist in reviewing past treatment as it may affect current treatment.

Affiliated Covered Entity: Protected health information will be made available to hospital personnel at local affiliated hospitals, as necessary, to carry out treatment, payment and health care operations. Caregivers at other facilities may have access to protected health information at their locations to assist in reviewing past treatment information as it may affect treatment at this time.

As Required by Law: We may also use and disclose health information to the Food and Drug Administration (FDA), public health or legal authorities charged with preventing or controlling disease, injury or disability, correctional institutions, Worker's Compensation agents, organ and tissue donation organizations, military command authorities, health oversight agencies, and/or funeral directors, coroners, and medical directors, etc.

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid court order, warrant, or subpoena.

State Specific Requirements: Many states have requirements for reporting, including population-based activities related to improving health or reducing health care costs. Some states have separate privacy laws that may apply additional legal requirements and if the state privacy laws are more stringent than federal privacy laws, the state law preempts the federal law. If a state law is in conflict with a HIPAA law, the HIPAA law preempts the state law.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of the healthcare practitioner or offices that compiled it, you have the right to:

Inspect and Copy: You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. Usually, this includes medical and billing records. If you are denied access to health information, you may request the denial to be reviewed. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Copies of Electronic Records: If you request an electronic copy of your electronic health records and other electronic records, they will be provided to you in your requested format, if the records are readily reproducible in that format. Otherwise, the records will be provided to you in another mutually agreeable electronic format. If all readily reproducible electronic formats are rejected, hard copies will be permitted.

Charges for Copies of Records: You may be charged to obtain copies of your records. These costs include labor and supply costs, and we may also impose a separate charge for creating an affidavit of completeness. This cost may not exceed any lower reimbursement rate set by state law.

Emailing Protected Health Information: As transmission security is a risk to maintaining the privacy of your protected health information, we may only send your health information by email if you are informed of this risk, and still request that form of transmission.

Amend: If you feel that health information we have about you is incorrect or incomplete you have the right to request, in writing, an amendment of such for as long as our office keeps the information. We may deny your request for an amendment and if this occurs, you will be notified, in writing, of the reason for the denial.

An Accounting of Disclosures: You have the right to request an accounting of disclosures, that is a list of certain disclosures we make of your health information for purposes other than treatment, payment or health care operations where an authorization was not required.

Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment and health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend (i.e., you could ask that we not use or disclose information about a surgery you had.) We are not required to agree to your request, however if we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. You have the right to request that we do not disclose information about care that you have paid for out-of-pocket to your health plans, excepting treatment purposes or if the disclosure is required by law. We are required to abide by these requests.

Request Confidential Communications: Unless you advise, in writing, that you do not want to be contacted we will mail appointment reminders, test results, or information about the practice to your last known address. We will also leave a detailed message at your home, business, or mobile telephone number about your appointment, normal test results. We will leave a detailed message at the telephone number you request while returning a call about your treatment or billing issue. A message will not be left with a spouse or any other family member, caregiver, or resident of your household unless authorized in writing, by you. The office will grant requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by the office and related correspondence regarding payment for services. We will notify you in accordance with your original request; however, if you fail to respond to any communication from us that requires a response, we reserve the right to contact you by other means, or at another location.

A Paper Copy of this Notice: You have the right to a paper copy of this notice, even if you have agreed to receive it electronically, and may ask us to give you a copy of this notice at any time.

To exercise your rights, please obtain the required forms from the Privacy Official and submit your request in writing.

Changes to this Notice: We reserve the right to change this notice. The revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the office and include the effective date. In addition, each time you visit the office for treatment or healthcare services we will offer you a copy of the current notice in effect.

Complaints: If you believe your privacy rights have been violated you may file a complaint with the office by following the process outlined in the office's Patient Rights documentation. You may also file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Health Information: Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your permission, and we are required to retain records of the care we provided to you.

I, THE UNDERSIGNED, HAVE READ THE NOTICE OF PRIVACY PRACTICES AND FULLY UNDERSTAND MY RIGHTS AND HOW MY MEDICAL INFORMATION CAN BE USED AND DISCLOSED, AND HOW I CAN GAIN ACCESS TO THIS INFORMATION.

SIGNATURE: _____ **DATE:** _____

Printed Legal Name: _____ Date of Birth: _____

OFFICE POLICIES REGARDING HEALTH INSURANCE AND PAYMENTS

I understand it is the policy of this office to collect insurance co-payments prior to being seen by the doctor. Unless I have made prior specific arrangements with the office's billing staff, I understand I am responsible for payment of all known charges not covered and/or paid by my insurance plan, and that these charges are payable at time of service.

If I am late for my appointment, and as a result, the doctor is unable to see me, or if I do not cancel my appointment with twenty-four (24) hours' advance notice, I understand that I may be charged a fee.

I am responsible for payment of charges assessed for return of any payment for any reason, including but not limited to Non-Sufficient Fund charges. I further understand that if payment is returned by your bank for any reason, checks will no longer be accepted. In the event any balance is not paid as agreed, I agree to pay all charges brought about by the collection company, including but not limited to interest and/or attorney fees if required.

I understand that I bear ultimate financial responsibility for my health care. Any benefits paid by my health insurance company are a result of a contract between my health insurance company and myself. It is my responsibility to know and understand my own insurance benefits.

I understand this office will act as a third party in good faith in insurance billing matters. Furthermore, I understand this service is provided as a courtesy, and I do not expect this office to become involved in prolonged negotiations with my insurance provider, as the ultimate responsibility for payment of charges is mine. I will provide any and all information, including but not limited to, my insurance card(s), which are required to bill my health insurance company. By my signature, I hereby authorize payment of benefits to the treating physician for all services rendered today and in the future.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize this office to release my medical information, including test results, radiology and procedure reports, diagnoses, and any other necessary records pertaining to recommended treatments or procedures to my insurance carrier in order to bill for services rendered or to obtain authorization for certain tests, procedures, or prescription medications.

I also authorize the release of information to another physician or facility where continuing care will be rendered. This information is confidential and it is expressly understood that any person, office, or organization that receives this information is not authorized to release it in any form to anyone else without my further written authorization directly to that entity. A copy of this authorization shall be valid as the original.

This authorization does not permit release of any information (medical or billing) to any other party, including but not limited to my spouse, my parent(s), or my child(ren), with the exception of my insurance carrier or another treating health care provider. This release may be revoked only by a written, signed request.

I, THE UNDERSIGNED, HAVE READ THIS AUTHORIZATION, UNDERSTAND ITS CONTENTS, AND AGREE WITH ITS CONDITIONS.

SIGNED:_____ **DATED:** _____
(Patient)

Printed_____ LegalName:_____

SSN: _____ Date of Birth: _____

SIGNED:_____ **DATED:** _____
(Parent, Legal Guardian, Durable Power of Attorney, or other legally responsible party)