healthy futures

PATIENT DEMOGRAPHICS

Preferred Name: _____
Last _____ First _____ Middle Initial_____
SS # _____ DOB ____/____/____
Sex at birth: M F Gender Identity: M F Trans Non-binary Other: _____
Preferred Pronouns: She/Her He/Him They/Them Other: _____
Relationship Status: Single Married Divorced Seperated Domestic Partner
Race: American Indian/Alaska Native Asian Asian/Pacific Islander Black/African American
Caucasian Hispanic Native Hawaiian/Other Pacific Islander Other
Ethnicity: Hispanic/Latino Non Hispanic/Latino
Nationality: _____ Primary Language:_____
Street Address: _____
City, State, Zip _____
Email Address: _____
Home Phone # _____ OK to leave message/results?____
Cell Phone # _____ OK to leave message/results? ____
Work Phone # _____ OK to leave message/results?____
Employer Name _____
Emergency Contact/who may we speak to on your behalf? _____
& their relationship to you _____ Phone # _____
Parent/Guardian name (if under 18)_____ Phone # _____

Preferred Pharmacy and Cross-streets/zip code of location: _____
Pharmacy phone number: _____
How did you hear about our office? _____

INSURANCE INFORMATION

PRIMARY INSURANCE:

Name of Insured: _____ Relationship to patient: _____
Insurance Co. Name: _____ Ins. Co, Tel #: _____
Ins. Co. Address: _____ City: _____ State:____ Zip:_____
SSN of Insured: _____ DOB of Insured: ____/____/____
Insurance ID #: _____ Policy/Carrier #: _____ Group #:_____

SECONDARY INSURANCE:

Name of Insured; _____ Relationship to patient: _____
Insurance Co. Name: _____ Ins. Co, Tel #: _____
Ins. Co. Address: _____ City: _____ State:____ Zip:_____
SSN of Insured: _____ DOB of Insured: ____/____/____
Insurance ID #: _____ Policy/Carrier #: _____ Group #:_____

PATIENT OR AUTHORIZED PERSON'S AGREEMENT:

I hereby give consent to the providers and staff of Healthy Futures Colorado, PLLC to render such care and treatment as might be required by my condition. I also authorize my insurance company to pay and provide benefits to my provider. I understand that I am financially responsible for all charges whether or not covered by my insurance. I authorize the release of any medical information necessary to process my insurance claims, and hereby request payment directly to Healthy Futures Colorado, PLLC for services rendered. I also have read and understand the cancellation and no-show policy and agree to those terms. I have been offered a copy of the HIPAA Privacy Policy, which is available to me at the office front desk.

Patients (Authorized Person's) Signature _____ Date_____

healthy futures

Medical History Review **Date**_____

Name _____ **Date of Birth**_____

Do you have any specific health issues today? Yes No

Please explain:_____

_____

_____

_____.

Medical History (please check all that apply): ____Heart disease ____Asthma

____ Diabetes ____COPD ____Hepatitis ____Stroke ____Bleeding Disorder

____ High blood pressure Please list any other conditions: _____

_____

_____.

Please list all medications you are currently taking and dosages:

Name:	Dosages:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Over-the-counter medications, vitamins, herbal supplements, dietary supplements? _____

_____

_____

Past **hospitalizations and surgeries** (please list dates): _____

_____

_____

_____

Social History:

Do you ever drink alcohol? Y/N ____occasinally ____weekly ____daily Number of drinks:____

Do you use tobacco? Y / N / Quit How many pack(s) a day?___ For how long?_____

Do you use recreational/street drugs?_____ Do you smoke marijuana?_____

Stress at home?___ Stress at work?____ Stress about money?____ Abusive relationship?____

Prevention: Number of COVID vaccines and approx dates:_____

Last Flu shot_____ Last eye exam_____

Last pneumonia shot_____ Last dental exam_____

Last tetanus shot_____ Last colonoscopy_____/normal?_____

Last mammogram_____/normal?____ Last dexascan_____/normal?_____

healthy futures

Are you currently experiencing or have concerns with (circle all that apply):

General:	**Head/Neck:**	**Cardiac:**	**Pulmonary:**
Allergies	Ear pain	Chest pain	Cough
High blood pressure	Hearing loss	Shortness of breath	Wheezing
Diabetes	Sore throat	Dizziness	Painful breathing
High Cholesterol	Nasal congestion	Palpitations	Asthma
Fatigue	Vision problems	Fainting	Emphysema
Arthritis	Red eyes	Leg swelling/edema	
Fever	Drainage from eyes	Varicose veins	
Weight Change	Sneezing	Heart Attack	
Memory Problems	Thyroid problems		

Abdominal:	**Orthopedic:**	**Skin:**	**Neurologic:**
Pain	Joint pain	Sore that doesn't heal	Vision changes
Reflux	Back Pain	Rash	Weakness
Constipation	Shooting Pain	Color changes	Slurred speech
Black stools	Injury	Worrisome lesion/mole	Stumbling
Blood in stools	Decrease in height		Seizures
Diarrhea			Choking on food

Mood:			**Urinary:**
Suicidal	Poor concentration	Loss of interest	Increased frequency
Irritability	No motivation	Poor concentration	Increased urgency
Low energy	Sad	Anxiety	Pain with urination
Guilt	Insomnia	Sleeping too much	Incontinence

Females:

Last period_____

Last PAP _____

Abnormal PAP?_____

Pain with sex_____

Birth control_____

Vaginal discharge, sores, rash_____

Changes in periods_____

Breast changes_____

Hot flashes_____

Mood swings_____

Males:

Genital pain, sores rash _____

Discharge from penis _____

Difficulty getting or maintaining an erection_____

Prostate problems_____

Previous Doctors/specialist: _____

_____

_____

_____

Family History: Do any of your direct relatives have any of the medical conditions noted below?

(Use the following key and circle affected family members for each condition below)

(M=mother, GM=grandmother, S=sister, A=aunt F=father, GF=grandfather, B=brother, U=uncle)

Allergies	M	GM	S	A	F	GF	B	U
Asthma	M	GM	S	A	F	GF	B	U
Bleeding disorder	M	GM	S	A	F	GF	B	U
Brain tumor	M	GM	S	A	F	GF	B	U
Cancer	M	GM	S	A	F	GF	B	U
(type)_____								
Depression	M	GM	S	A	F	GF	B	U
Diabetes	M	GM	S	A	F	GF	B	U
Heart disease	M	GM	S	A	F	GF	B	U
Parkinson's disease	M	GM	S	A	F	GF	B	U
Arthritis	M	GM	S	A	F	GF	B	U
(type)_____								
Epilepsy	M	GM	S	A	F	GF	B	U
Ulcers	M	GM	S	A	F	GF	B	U
Other	M	GM	S	A	F	GF	B	U
(describe)_____								

healthy futures

PRESCRIPTION REFILL POLICY

- No prescription will be refilled on Fridays, Saturdays, Sundays, and holidays.
- We require 72 hours minimum to process prescription renewal and/or pick-up requests.
- The patient is responsible for knowing when medications will need to be refilled (no early refills).
- Prescription phone-in/pick-up: Monday-Thursday during business hours **ONLY** (9:00am-4:30pm).
- Prescriptions will not be filled for unauthorized "walk-in" patients.
- Non-controlled/non-narcotic prescriptions require a follow up appointment every 3-6 months.
- Controlled substances=narcotic and benzodiazepine prescriptions require a follow up appointment every 30-90 days.
- New symptoms and/or events require a clinic appointment. Provider is unable to diagnose via phone.
- No early refills if medications are overused, abused, or misused. Must follow prescription directions.
- NO medication prescription will be replaced if lost, stolen, misplaced, overused, etc. (treat like money!)
- Medications are for the prescribed individual's use only. It is illegal to "share" your medicine.
- Patients must pick-up his/her prescription(s) in person, unless pre-authorized by staff.

These protocols are per recommendations of the Colorado Board of Medical Examiners & DEA.

I understand and accept the protocol listed above. Failure to comply results in immediate termination of prescription medications.

Patient name:_____ Date:_____

Signature:_____

Name of person picking up Rx:_____

Healthy Futures Colorado, PLLC
Financial Agreement for Primary Care Patients

Payment is expected at the time of your visit. We accept cash or credit cards. If you have insurance, then prior to your visit we will collect 1. Any outstanding patient balance from prior visits, 2. The copay for today's visit, and 3. Any amount likely to be attributed to the patient's deductible for today's visit (that amount is typically $75 for a 15 minute visit/1-2 issues or $100 for 30 minutes/3-4 issues), plus any additional services such as blood tests, EKG, or injections. Medicare patients: This serves also as your Advanced Beneficiary Notice. We also require credit card information and patient authorization to cover services unpaid or denied by your insurance plan.

The type of credit card: MasterCard Visa Discover American Express
The number is _____-_____-_____-_____
Expiration date: _____ 3 digit security code: _____

Healthy Futures agrees to promptly reimburse the patient for any value collected from the patient which is then covered by the insurance company.

Patient name, printed: _____
Patient signature:_____ Date: _____

Insurance coverage - We are participating providers with many insurance plans. We will file all of these insurance claims for you. If your insurance company does not pay our clinic within a reasonable period of time, your credit card will be immediately charged. If we later receive payment from your insurer, we will refund any overpayment. Your copayment is a contract between you and your insurance company. It is a requirement of this contract that you pay your copayment at the time of your visit. You are responsible for knowing which services are covered by your insurance plan. If we recommend a service we feel is medically prudent and this is a non-covered benefit of your plan, you are responsible for payment if you choose to accept the treatment.

You are responsible for knowing if our providers are on your insurance plan. If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. Our staff cannot guarantee your eligibility and coverage. Websites used to verify coverage may have erroneous information and are not a guarantee of coverage.

Cancellations or MIssed Appointments - We appreciate your consideration in keeping your appointments when scheduled. We know your time is valuable, as is ours. If you do not cancel your appointment with 24 hours notice, a charge of $35.00 may be assessed the first occurrence, $65 the second occurrence, and $100 the third occurrence. We do realize that some circumstances will arise that you will not be able to give us a 24 hours advance notice, and these will be discussed on a case-by-case basis.

Past due accounts: Your account will be considered past due if we have not received payment in full within 60 days of the balance becoming your responsibility. If payment is not received at the 120 day mark, your account can be turned over to a collection agency, and you may be dismissed from the practice. We understand that sometimes families run into hardships; however, if you find yourself unable to pay your balance, we are willing to work out a budget plan with monthly payment. Please let us know if this is the case with your account.

I understand and agree to this Financial Policy.

Patient signature:_____ Date: _____

healthy futures

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patients rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? **YES** **NO**

May we leave detailed messages on your home or cell phone? **YES** **NO**

May we discuss your medical condition with any member of your family? **YES** **NO**

If YES, please name the members allowed:

_____

Printed name of the Patient:_____

Signature:_____ Date:_____