PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. **Please print.** All information will be confidential.

Date ________ Patient Name ________ (FIRST) (MI) (LAST) Patient # ________
SSN ________ ☐ Male ☐ Female Birthdate ________ Home phone ________
Address ________ City ________ State ________ Zip ________
Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Patient's or parent's employer ________ Work phone ________
Business address ________ City ________ State ________ Zip ________
Spouse or parent's name ________ Employer ________ Work phone ________
If patient is a student, name of school/college ________ City ________ State ________
Whom may we thank for referring you? ________
Person to contact in case of emergency ________ Phone ________
In case of a medical emergency, if the patient is of school age 15+, it is all right to treat in my absence.

X ________ Parent or guardian signature

________ Date

Responsible Party

Name of person responsible for this account ________ Relationship to patient ________
Address ________ Home phone ________
Driver's license # ________ Birthdate ________ Financial institution ________
Employer ________ Work phone ________
Is this person currently a patient at our office? ☐ Yes ☐ No

Insurance Information

Name of insured ________ Relationship to patient ________
Birthdate ________ Social Security Number ________ Date employed ________
Name of employer ________ Work phone ________
Address of employer ________ City ________ State ________ Zip ________
Insurance company ________ Group # ________ Union or local # ________
Ins. Co. address ________ City ________ State ________ Zip ________
How much is your deductible? ________ How much have you used? ________ Max. annual benefit? ________

Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following:

Name of insured ________ Relationship to patient ________
Birthdate ________ Social Security Number ________ Date employed ________
Name of employer ________ Work phone ________
Address of employer ________ City ________ State ________ Zip ________
Insurance company ________ Group # ________ Union or local # ________
Ins. Co. address ________ City ________ State ________ Zip ________
How much is your deductible? ________ How much have you used? ________ Max. annual benefit? ________

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X ________ Signature of patient or parent if minor

________ Date

ITEM 16785 © 1998 COLWELL SYSTEMS 1.800.637.1140

Denver Osteopathic Center
Consent for Use and Disclosure of Personal Health Information

This form authorizes us to use and disclose your protected health information (PHI) for the purposes of healthcare operations, treatment and payment activities.

Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your PHI.
For questions concerning our Notice of Privacy Policies, please contact our office.

Patient's Consent

Name: ______________________________

Address: ____________________________

City: ______________________________ State: ________ Zip: ______________

Telephone: (______) ________________ E-mail: ____________________________

____________________________ Social Security #: ________ _____ ________

I, ____, have read your Notice of Privacy Policies and I
(Signature*)
consent to your use of my PHI for the purposes of healthcare operations, treatment and payment activities.
* If this consent is signed by a parent or guardian on behalf of the patient, complete the following:

Parent or Guardian Name: ______________________________________

Relationship to Patient: ______________________________________

Patient's Revocation

By signing below, you revoke your above consent for us to use and disclose your PHI. However, by doing so, we reserve the right to discontinue treatment for you. This revocation also does not negate any of our prior actions while acting under your consent.

Signature: ____________________________________ Date: ______________

If this consent revocation is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ______________________________________

Relationship to Patient: ______________________________________

Acknowledgement of Receipt of Notice of Privacy Policies

I, ____________________________________, have received/reviewed a copy of Denver Osteopathic
Name (Please Print)

Center's Notice of Privacy Policies.

______________________________________ ______________________
Signature Date

This information is intended as advisory in nature and should not be considered as legal advice nor is it a substitute for legal advice. This information does not constitute technical information system/security advice. It is designed to assist you in your own risk management activities. It is not intended to be exclusively relied upon or used as a substitute for your own loss-control program. Accuracy and completeness are not guaranteed.

NEW PATIENT/PHYSICAL HISTORY

NAME ______________________ **DATE** ______________________

PLEASE CHECK ONE: NEW PATIENT ☐ ESTABLISHED PATIENT ☐

Gender M F **Date of Birth** ____________ **Marital Status** S M D Sep **Age** ________

Who lives in your household? **Pets?**

If you are a returning patient and believe we have all this information on file, and there have been *no* changes to your health history, initial here and skip to MEDICAL HISTORY (reverse) Date

FAMILY HISTORY

If any blood relative has suffered any of the following, please circle the number, indicate which relative & the age when they passed away below

1) EPILEPSY	6) THYROID	11) OSTEOPOROSIS	16) ALCOHOLISM
2) MIGRAINE	7) HAYFEVER	12) ARTHRITIS	17) CANCER
3) MENTAL ILLNESS	8) ASTHMA	13) HEART DISEASE	18)
4) GLAUCOMA	9) ANEMIA	14) STROKE	19)
5) DIABETES	10) BLEEDS EASILY	15) HYPERTENSION	20)

HOSPITAL ADMISSIONS/SURGERIES NOT including pregnancies

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

LIST ALL MEDICATIONS YOU ARE NOW TAKING (including non-prescription, vitamins, and herbal supplements)	ALLERGIES

VACCINES - Year of Last		TEST/EXAM	Year of Last	
TETANUS		DENTIST		
FLU		EYE		
PNEUMONIA		COLONOSCOPY		RESULT:
ZOSTIVAX (SHINGLES)		BONE MASS DENSITY		RESULT:

SOCIAL HISTORY

☐ ALCOHOL Drinks per day/week/month ☐ Caffeine (Coffee, Tea, Soda) Cups/day

TOBACCO ☐ Cigarettes packs per day ☐ Chewing Tobacco per day ☐ Cigars per day

Number of years used: Year Quit:

☐ MARIJUANA /day, week, month

☐ ILLICIT DRUG USE (Please describe)

PLEASE LIST ALL OTHER PHYSICIANS YOU ARE ESTABLISHED WITH:

DOCTOR	SPECIALITY	TREATING YOU FOR	LAST SEEN

NEW PATIENT/PHYSICAL HISTORY

MAIN CONCERNS:

PLEASE CHECK ALL THAT APPLY

☐Decreased hearing
☐Ear infections - *frequent*
☐Dizzy spells
☐Failing vision
☐Double or blurred vision
☐Eye infections - *frequent*
☐Nose bleeds - *frequent*
☐Sinus trouble
☐Sore throats - *frequent*
☐Hayfever/Allergies
☐Hoarseness - prolonged
☐Pneumonia/Pleurisy
☐Bronchitis/Chronic cough
☐Asthma/Wheezing
☐Shortness of breath:
on exertion ☐ lying flat ☐
☐Chest pain
☐High blood pressure
☐Heart murmur
☐Swollen ankles
☐Irregular pulse ☐ Palpitations
☐Leg pain (when walking)
☐Varicose veins/Phlebitis
☐Loss of appetite - recent

☐Difficulty swallowing
☐Heartburn ☐Peptic ulcer
☐Persistent nausea/Vomiting
☐Abdominal pain - *chronic*
☐Gall bladder trouble
☐Jaundice/Hepatitis
☐Change in bowel habits
☐Constipation
☐Diarrehea
☐ Diverticulosis
☐Crohn's Disease
☐Bloody or tarry stools
☐Hemorrhoids ☐Hernia
☐Urine infections - *frequent*
☐ Blood in urine ☐ Kidney stones
Urination:
☐Overnight more than twice
☐Painful ☐Loss of control
☐Decrease in force/flow
☐Venereal disease
☐Urethral discharge
☐Chronic fatigue
☐Weight loss ☐Gain-Significant
☐Anemia
☐Bruise easily
☐Cancer Type:

☐Diabetes ☐Thyroid Disease
☐Seizures ☐Stroke
☐Tremor/hands shaking
☐Muscle weakness
☐Numbness/tingling sensations
☐Headaches - *frequent*
☐Arthritis/Rheumatism
☐Back pain - *recurrent*
☐Bone fracture/Joint injury
☐Gout ☐Osteoporosis
☐Foot pain ☐Cold/numb feet
☐Rashes ☐Hives
☐Psoriasis ☐Eczema
☐Sleeping/Concentration difficulty
☐Depression ☐Nervousness
☐Agitation ☐Memory loss
☐Moodiness ☐Suicidal thoughts
☐Phobias ☐Mental illness
☐Feelings of worthlessness
☐Rheumatic fever
☐Scarlet fever
☐Chicken pox ☐Polio
☐Mumps
☐Measles
☐German measles
☐Herpes
☐Tuberculosis

Please list any dietary restrictions or choices:

☐Regular exercise
Are you fasting for bloodwork today?
☐Yes ☐No

FEMALES - *Please Complete*
Menstrual Flow:
☐Reg ☐Irreg ☐Pain/Cramps
Days of Flow ___ Cycle Length _____
Start date of last period ____________
☐Pain/bleeding during/after sex
☐Menopausal Since ________
Number of:
Pregnancies ____ Abortions___
Miscarriages___ Live Births___
Birth Control Method__________
B.C. pill (name)_____________
☐Heat flashes/flushing
Date of Last PAP test_________
☐Normal ☐Abnormal
Date of Last Mammogram______
☐Normal ☐Abnormal

ARE THERE ANY PROBLEMS OR CONCERNS WE SHOULD BE AWARE OF?

HOW DO YOU PREFER WE CONTACT YOU WITH ANY RESULTS?

MAY WE LEAVE A DETAILED MESSAGE FOR YOU? ____________________
MAY WE LEAVE A DETAILED MESSAGE WITH SOMEONE ELSE? ____________________
IF SO, WITH WHOM? ____________________

Denver Osteopathic Center, P.C.

Joel B. Cooperman, D.O. • Christopher M. LaFontano, D.O. • Julie V. Lafontano, D.O.

Phone/Message Consent

I, ______________________________, give Denver Osteopathic Center, PC, its providers and medical assistants, permission to leave the following information:

_____ Lab results i.e. bloodwork results

_____ P athology results i.e. biopsies and pap smears

_____ I maging results i.e. MRI, CT, and X-Rays

_____ A nswers to questions that I called to ask

_____ Other: ______________________________

On the following phone answering machine/voice messaging phone number(s):

____

Or with the following person(s) (name and relationship): ______________________________

____

____

Signed: ______________________ Printed: ______________________

Date: ______________________

10555 E. Dartmouth Ave., Suite 200, Aurora, CO 80014 • Ph. 303.991.4651 • Fax 303.991.3300 • denverosteoctr@aol.com

Denver Osteopathic Center, P.C.

Joel B. Cooperman, D.O. • Christopher M. LaFontano, D.O. • Julie V. Lafontano, D.O.

Denver Osteopathic Center
Billing Policies

Please Read

- Copays are due at the time of visit. If the copay is not paid at the time of your visit, there will be a $10.00 administrative fee added to the copay amount.

- If you do not have insurance, you will be expected to pay your balance in full at the time of your visit.

- If at any time a patient balance is accrued, you will be sent a monthly statement from our office. We expect payment to be made in full at that time, or you may contact us to set up payment arrangements. When a patient balance remains unpaid after 90 days, you will be sent a 30-day notice; if that goes unanswered, a 10-day notice will be sent. If all attempts fail and payment is not made in a timely manner, we reserve the right to send your account to collections, and you will be responsible for any additional collection agency fees/charges incurred, including, if necessary, reasonable attorney costs.

We accept most forms of payment.

Thank You.

I have read and understand the above information:

Signature Date

10555 E. Dartmouth Ave., Suite 200, Aurora, CO 80014 • Ph. 303.991.4651 • Fax 303.991.3300 • denverosteoctr@aol.com

Denver Osteopathic Center

Joel B. Cooperman, D.O. Christopher M. LaFontano, D.O. Julie V. LaFontano, D.O.

Notice of Privacy Policies

The information provided below illustrates the manner your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Managing the privacy of your protected health information is extremely important to Denver Osteopathic Center.

Denver Osteopathic Center's Legal Responsibilities: As mandated by Federal and State legal requirements your protected health information must be protected. As part of these regulations we are required to ensure you are aware of privacy policies, legal duties and your rights to your protected health information. This notice of privacy policies, outlined below, will be in effect for the duration and must be followed by our practice. This notice will be in effect until it is replaced and becomes effective 02/01/2003.

We reserve the right to modify our privacy policies and the terms of this notice at any time, and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all protected health information that we maintain, including protected health information we created or received before the changes were made. Changing this notice will precede all significant modifications. This notice will be available upon request.

Copies of this notice are available at your request. For your convenience information regarding how you can contact us is at the bottom of this notice.

PROTECTED HEALTH INFORMATION USE AND DISCLOSURE: Information regarding your health may be used and disclosed for the purpose of treatment, payment and other healthcare operations. Examples cited below further explain the use and disclosure process.

Treatment: Use and disclosure of your protected health information may be provided to a physician or other healthcare provider providing treatment to you.

Payment: Your protected health information may be used and disclosed to obtain payment for services we provided to you.

Healthcare Processes: We may use and disclose your protected healthcare information in relations with our healthcare process. These processes include an assessment, improvement activities, reviewing the competence or qualifications of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: At any time you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization it will not affect any use or disclosure prior to the revocation.

Your protected health care information may be used and disclosed to you, as described in the patient rights section of this notice. In addition, your protected health information may be used and disclosed to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but only with your authorization.

Person Involved in Care: In order to accommodate the notification of your location, your general condition, or death, your protected health information may be used or disclosed to a family member, your personal representative or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information you may do so. To the extent you are incapacitated or emergency circumstances exist, we will disclose protected health information using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your healthcare. We will use our professional judgment and our experience with common practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of protected health information.

Marketing Health-Related Services: The use of your protected health information for the purpose of marketing communications is prohibited without you're written authorization.

Required by Law: Your protected health information may be used or disclosed if required by law.

Abuse or Neglect: As required by law, if we have reason to believe that you are the victim of possible abuse, neglect or domestic violence or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If we have reason to believe the use or disclosure of your protected health information will prevent a serious threat to your health or safety or the health or safety of others we may have to provide the necessary protected health information.

National Security: Under some circumstances the military may require disclosure of health care information for armed forces personnel. For the purpose of national securities activities, counter intelligence and lawful intelligence, authorized federal authorities

may require disclosure of protected health information. Protected health care information disclosure may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information.

Appointment Reminders: Your protected health care information may be used to assist you with appointment reminders in the form of voicemail messages, postcards, or letters.

PATIENT RIGHTS

Access: At all times you have the right to review your protected health information, with limited exceptions. At your request, we will provide your information in a format other than photocopies. If we are able to do so we will accommodate your request.

Your request to obtain access to your information must be in writing. You may obtain a *Protected health information Access Form* by using the contact information at the end of this notice. We may need to charge you a reasonable cost-based fee for expenses including copies and staff time. You may also request access for submitting a letter using the information at the bottom of this notice. If you request copies there may be a charge for staff time to locate and copy your protected health information. Postage will be included if you wish to have your information mailed. If you request a format option, which is different, we will charge a cost based fee for that format. An explanation of fees can be made available.

Disclosure Accounting: Your rights include the choice to receive a review of every time we or our business associates disclosed your protected health information for reasons other than treatment, payment, healthcare information and certain other activities for the last six years but not before April 14, 2003. Additional reasonable cost based fees may be extended if your requests for such information are more than one time per year.

Restrictions: You may request we apply additional restrictions to any disclosure of your health care information. We are not required to respond to the application of these additional restrictions. If we agree to follow your request regarding additional restrictions we will follow the agreed restrictions unless an emergency situation dictates otherwise.

Alternative Communication: Your rights include the instruction to request how you are communicated to regarding your protected health information. Your request must be in writing and can spell out other ways or others locations regarding your protected health information communication. You must identify agreed upon explanations of payment arrangements under alternative communications.

Amendment: You can initiate a written request to amend your protected health information. Included in the amendment must be an explanation why information should be amended. Certain conditions may exist where we may reject you request.

Electronic Notice: If you receive a notice electronically, you are entitled to receive the notice in writing as well.

QUESTIONS AND COMPLAINTS

More information is available to you regarding our privacy policies, please contact us.

If at any time you are unsure or concerned that your protected health information has not been protected or if you believe an error was made in the decision we made about accessing your protected health information; or in the response to a request you made to amend the use or disclosure of your protected health information; or to have us communicate to you by an alternative means or at an alternative locations, you have the right to bring this issue forward. You may make a complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U. S. Department of Health and Human Service at your request.

Privacy of your protected health information remains extremely important; we are committed to ensure your privacy. If you file a concern with the U.S. Department of Health and Human Resources we will not retaliate in anyway. We are available to assist you with any questions, concerns or complaints.

Contact Person's Name: Joel B. Cooperman, D.O.

Telephone: (303) 991-4651

Fax: (303) 991-3300

E-Mail

Address: 10555 E. Dartmouth Ave. Suite 200

City, State, Zip: Aurora, CO 80014