

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 _____ 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 _____

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.

HEALTH HISTORY

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

Patient Name _____ Birthdate _____ Date: _____
 Patient # _____

Chief Complaint: _____

History of present illness:

Location: _____
 (Where is the pain/problem?)

Severity _____
 (How severe is the pain/problem on a scale of 1-5 with 5 being the most severe?)

Timing _____
 (Does the pain/problem occur at a specific time?)

Associated signs/symptoms _____
 (What other associated problems have you been having?)

Quality _____
 (Example: normal versus abnormal color, activity, etc.)

Duration _____
 (How long have you had this pain/problem?, or, When did it start?)

Context _____
 (Where were you at the onset of this pain/problem?)

Modifying factors _____
 (What makes the pain/problem worse or better?, or, Have you had previous episodes?)

Past Medical History

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles	no	yes	Anemia	no	yes	Back trouble	no	yes	Hepatitis	no	yes
Mumps	no	yes	Bladder Infections	no	yes	High Blood Pressure	no	yes	Ulcer	no	yes
Chickenpox	no	yes	Epilepsy	no	yes	Low Blood Pressure	no	yes	Kidney Disease	no	yes
Whooping Cough	no	yes	Migraine Headaches	no	yes	Hemorrhoids	no	yes	Thyroid Disease	no	yes
Scarlet Fever	no	yes	Tuberculosis	no	yes	Date of last chest x-ray			Bleeding Tendency	no	yes
Diphtheria	no	yes	Diabetes	no	yes	Asthma	no	yes	Any other disease	no	yes
Smallpox	no	yes	Cancer	no	yes	Hives or Eczema	no	yes	(please list):		
Pneumonia	no	yes	Polio	no	yes	AIDS or HIV+	no	yes	_____		
Rheumatic Fever	no	yes	Glaucoma	no	yes	Infectious Mono	no	yes	_____		
Heart Disease	no	yes	Hernia	no	yes	Bronchitis	no	yes	_____		
Arthritis	no	yes	Blood or Plasma Transfusions	no	yes	Mitral Valve Prolapse	no	yes	_____		
Venereal Disease	no	yes				Stroke	no	yes	_____		

Previous Hospitalizations/Surgeries/Serious Illnesses

When?

Hospital, City, State

Medications: (Include nonprescription) _____

Have you ever taken Fen-Phen/Redux? no yes

Patient social history:

Marital status Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____
 Use of alcohol: Never: _____ Rarely: _____ Moderate: _____ Daily: _____
 Use of tobacco: Never: _____ Previously, but quit: _____ Current packs / day: _____
 Use of drugs: Never: _____ Type/Frequency: _____
 Excessive exposure at home or work to: Fumes: _____ Dust: _____ Solvents: _____ Air-borne Particles: _____ Noise: _____

Family medical history:

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Review of Systems: Please indicate any personal history below:

Constitutional Symptoms

Good general health lately No Yes
 Recent weight change No Yes
 Fever No Yes
 Fatigue No Yes
 Headaches No Yes

Eyes

Eye disease or injury No Yes
 Wear glasses/contact lenses No Yes
 Blurred or double vision No Yes

Ears/Nose/Mouth/Throat

Hearing loss or ringing No Yes
 Earaches or drainage No Yes
 Chronic sinus problem or rhinitis No Yes
 Nose bleeds No Yes
 Mouth sores No Yes
 Bleeding gums No Yes
 Bad breath or bad taste No Yes
 Sore throat or voice change No Yes
 Swollen glands in neck No Yes

Cardiovascular

Heart trouble No Yes
 Chest pain or angina pectoris No Yes
 Palpitation No Yes
 Shortness of breath w/walking
 or lying flat No Yes
 Swelling of feet, ankles or hands No Yes

Respiratory

Chronic or frequent coughs No Yes
 Spitting up blood No Yes
 Shortness of breath No Yes
 Wheezing No Yes

Gastrointestinal

Loss of appetite No Yes
 Change in bowel movements No Yes
 Nausea or vomiting No Yes
 Frequent diarrhea No Yes
 Painful bowel movements
 or constipation No Yes
 Rectal bleeding or blood in stool No Yes
 Abdominal pain No Yes

Genitourinary

Frequent urination No Yes
 Burning or painful urination No Yes
 Blood in urine No Yes
 Change in force of strain
 when urinating No Yes
 Incontinence or dribbling No Yes
 Kidney stones No Yes
 Sexual difficulty No Yes
 Male - testicle pain No Yes
 Female - pain with periods No Yes
 Female - irregular periods No Yes
 Female - vaginal discharge No Yes
 Female - # of pregnancies _____
 Female - # of miscarriages _____
 Female - date of last pap smear _____

Musculoskeletal

Joint pain No Yes
 Joint stiffness or swelling No Yes
 Weakness of muscles or joints No Yes
 Muscle pain or cramps No Yes
 Back pain No Yes
 Cold extremities No Yes
 Difficulty in walking No Yes

Integumentary (skin, breast)

Rash or itching No Yes
 Change in skin color No Yes
 Change in hair or nails No Yes
 Varicose veins No Yes
 Breast pain No Yes
 Breast lump No Yes
 Breast discharge No Yes

Neurological

Frequent or recurring headaches No Yes
 Light headed or dizzy No Yes
 Convulsions or seizures No Yes
 Numbness or tingling sensations No Yes
 Tremors No Yes
 Paralysis No Yes
 Head injury No Yes

Psychiatric

Memory loss or confusion No Yes
 Nervousness No Yes
 Depression No Yes
 Insomnia No Yes

Endocrine

Glandular or hormone problem No Yes
 Excessive thirst or urination No Yes
 Heat or cold intolerance No Yes
 Skin becoming dryer No Yes
 Change in hat or glove size No Yes

Hematologic/Lymphatic

Slow to heal after cuts No Yes
 Bleeding or bruising tendency No Yes
 Anemia No Yes
 Phlebitis No Yes
 Past transfusion No Yes
 Enlarged glands No Yes

Allergic/Immunologic

History of skin reaction or other adverse
 reaction to:
 Penicillin or other antibiotics No Yes
 Morphine, Demerol,
 or other narcotics No Yes
 Novocain or other anesthetics No Yes
 Aspirin or other pain remedies No Yes
 Tetanus antitoxin
 or other serums No Yes
 Iodine, Merthiolate or
 other antiseptic No Yes
 Other drugs/medications: _____

Known food allergies: _____

Environmental allergies: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

 Signature of Patient, Parent or Guardian

 Date

Doctor's Review

 Signature of Doctor

 Date



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

___ Pathology results i.e. biopsies and pap smears

___ Imaging results i.e. MRI, CT, and X-Rays

___ Answers 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: _____



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 _____

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 your 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 your 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