NAME:____ DATE: ____________________
Last First Middle

PHONE: (H)______________________(W)_______________________(C) ______________________

BILLING ADDRESS: ____
Street Address City State Zip Code

DATE OF BIRTH:______/______/______AGE:________SSN:________________________SEX: M☐ F☐

IS IT OK TO CONTACT VIA EMAIL? ☐ Yes ☐ No Email Address: ______________________________________

☐ Married ☐ Single ☐ Widowed ☐ Divorced SPOUSE NAME: __________________

EMPLOYER: ____________________________________ ☐ Retired ☐ Not Employed/Stay at Home ☐ Student

PRIMARY CARE PHYSICIAN:______________________ *REFERRED BY*: _____________________________

EMERGENCY CONTACT:______________RELATIONSHIP:_________________PHONE: _________________

May we leave a message about medical issues on voicemail or a home answering machine? ☐ Yes ☐ No

May we leave a message for you at work to call us? ☐ Yes ☐ No

May we discuss your medical condition with another person? ☐ Yes ☐ No. Phone number: ______________
If yes, whom?____________________________________ Relationship: ______________________

RECEIPT OF NOTICE OF PRIVACY PRACTICES AND NOTICE OF NON-DISCRIMINATION: My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Privacy Practices and Notice of Non-Discrimination.

INITIALS: __________

PAYMENT POLICY: I will be responsible for paying my annual deductibles, copayment and charges for any non-covered medical and cosmetic services at time of service. I understand that I am responsible for any deductibles, coinsurance, co-pays and services deemed not medically necessary by my insurance carrier.

> **I understand that if I do not show up for my scheduled appointment or do not call within 24 hours to reschedule, I will be assessed a $25.00 no show fee.**
>
> **I further understand that if I present a check that is returned to FRDA for insufficient funds, I will be assessed at $45.00 insufficient funds fee.**

INITIALS: __________

OUTSIDE LAB CHARGES: If your provider takes a biopsy or culture, this specimen will be sent to an outside laboratory for processing and testing. If that is the case, you will receive a bill from that lab. Those charges would be in addition to your treatment costs and would be due and payable to the lab that is chosen.

I understand that all outside lab charges will be billed to me separately.

INITIALS: __________

AUTHORIZATION TO USE CELL NUMBER AND EMAIL ADDRESS FOR APPOINTMENT REMINDER INFORMATION:
By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment or overdue wellness exam. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.

INITIALS: __________

PATIENT OR RESPONSIBLE PARTY____ **DATE:** ___________________

Now Serving Northern Colorado in 4 Locations:

6801 West 20th Street, Suite 208; Greeley, CO
2923 Ginnala Drive; Loveland, CO
500 Main Street; Fort Morgan, CO
4038 Timberline Road, Suite 100; Fort Collins, CO