APEX | Family | Medicine

REGISTRATION FORM

PATIENT INFORMATION

Patient's last name: First: Middle:			Mr. Mrs. Miss Ms. Other:	Marital status (circle one) Single / Mar / Div / Sep / Wid / Part	
Is this your legal name? Yes No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex/Gender: M / F / TMTF / TFTM / Other
Street address:		Social Security no.:		Home phone no.: ( )	
P.O. box:	City:		State:	ZIP Code:	
Occupation:	Employer:			Employer phone no.: ( )	
Chose clinic because/Referred to clinic by (please check one box):		Dr.	Insurance Plan	Hospital	
Family	Friend	Close to home/work	Yellow Pages	Other:	
Other family members seen here:					

CONTACT INFORMATION

It is permissible to **contact me** at:

Home: _____ Work: _____ Mobile: _____

Email: _____

It is permissible to **leave voice messages** at: ☐Home ☐Work ☐Mobile

It is permissible to leave messages with **other people** who may answer at: ☐Home ☐Work ☐Mobile

IN CASE OF EMERGENCY

Name of local friend or relative	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize APEX Family Medicine or insurance company to release any information required to process my claims.

_____ _____

Patient*/Guardian* ***signature*** *Date*

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Patient & Practice Agreement

PRACTICE AGREEMENT

I, the undersigned, authorize APEX Family Medicine, LLC to obtain any records, reports, and results form any emergency facility at which I may be seen or hospital to which I may be admitted to provide follow-up care at APEX Family Medicine, LLC.

PATIENT FINANCIAL AGREEMENT

I, the undersigned, certify that I have the insurance coverage presented, and assign directly to APEX Family Medicine all insurance benefits, if any, payable to me for serviced rendered. If APEX Family Medicine is contracted with my insurance company, I agree to pay all co-payments at the time of service, and I understand that I cannot be billed for my co-payments. **If I have a deductible I agree to pay $50.00, at the time of service, towards the deductible. I understand that failure to pay my co-pay or deductible payment at the time of service will result in my not being able to be seen in the office on that day.**

I understand that I will be sent a monthly statement for any and all charges incurred at APEX Family Medicine that were not paid at the time of service, including those that my insurance carrier has not responded to within 90 days of billing.

I understand that I am financially responsible for all charges whether or not paid for by my insurance carrier. I hereby authorize APEX Family Medicine to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. If I choose to pay my bill by telephone using a credit card I authorize the use of this signature to authorize such charges. In the event that a collection agency becomes necessary, I agree to pay all collection expenses, attorney fees, and court costs expended in the resolution of the account.

Please be advised that **lab services are billed by an independent lab contracted with your insurance company** and any questions regarding billing should be directed to the telephone number on your invoice.

If you need to cancel or reschedule any future appointments, at least 24 hours notice is required. **A $50.00 administrative fee will be assessed to your account for late or missed appointments.** This does include any appointment made as a "Same Day" appointment. These charges will not be submitted to your insurance company and will be your responsibility.

We look forward to achieving a mutually beneficial patient-provider relationship with you. Again, Thank you for choosing APEX Family Medicine.

Responsible Party Signature	Printed Name	Date

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Wellness Redefined

IMPORTANT INFORMATION REGARDING YOUR INSURANCE COVERAGE AND APEX FAMILY MEDICINE'S APPROACH TO MAINTAINING WELLNESS AND ANNUAL PHYSICALS

APEX has always completed annual physical exams in two parts. Because of its complex nature, the physical exam is basically broken down into two main components; history, screenings, testing/ exam, results and consultation.

The first visit is an OFFICE VISIT and is not considered a preventive visit by insurance companies. We request that you fast the day of this visit in order to appropriately screen for diabetes and heart disease. We also check your kidney function, electrolytes, liver function, and look for infection or immune deficiency, any signs of nutritional deficiency or anemia, and thyroid and HIV testing as needed. It is at this time that we would order additional tests based on your concerns, observations, new health issues or family developments since your last physical. This visit also gives us an opportunity to order other screening tests such as mammograms, prostate cancer screening, or colonoscopies. Lastly we make sure you are protected and recommended for vaccine preventable diseases such as tetanus and hepatitis.

The second visit is the PHYSICAL. This visit allows us to review your tests with your and gives you an opportunity to ask your provider any questions, or voice any concerns. In our opinion this is more effective than receiving an impersonal "test results" phone call or letter. Separating this visit also allows us to complete a more detailed and thorough physical exam and spot potential issues such as skin cancer and treat them early.

Within our health care system we are contractually obligated to adhere to very specific rules set forth by your insurance carrier and/or plan. These rules include such items as collecting copays, coinsurances or deductibles, specific medications, office visits for referrals, and so forth. Though we try to keep on top of these hundreds of ever-changing health plans, our training is in medicine. The providers at Apex are all Board Certified. We are your partners in promoting and maintaining your good health. And while we try to be mindful of various health plans and differing plan coverage allowances, ultimately our duty is to provide you the best medicine and guidance both ethically and morally. We choose not to compromise our standard of care for the bottom line. It is the responsibility of you, the patient and policy holder, to be aware of your own medical benefits. By doing so this will limit any "bad surprises" by your insurance company and you can anticipate and prepare for all financial liabilities.

We appreciate you, your family and friends for supporting our philosophy of care at APEX Family Medicine. This is what distinguishes our practice from others. Again, we thank you for being a part of APEX and its success as a medical practice which prioritizes quality of care and individualized medicine.

I have read, understood and agree to the terms listed above.

Signature _____ DATE _____

Print name _____

Jackson Place
300 S. Jackson Street, Suite 100
Denver, CO 80209
Office 303.321.0222 Fax 303.321.6683
Website www.APEXFamilyMedicine.com

APEX | Family | Medicine

Wellness Redefined

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Legal Duty: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on 04/14/03, and will remain in effect until we replace it.
We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.
You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Apex Family Medicine endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. However, you may choose to opt-out of participation in the HIE, or cancel an opt-out choice, at any time. APEX Family Medicine is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices at APEX Family Medicine please contact:

Office Manager
300 S. Jackson Street, Suite 100
Denver, CO 80209
303-321-0222

Effective Date of This Notice: December 1, 2007

I. How APEX Family Medicine may use or disclose your protected health information
APEX Family Medicine collects health information from you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of APEX Family Medicine, but the information in the medical record belongs to you. APEX Family Medicine protects the privacy of your health information. The law permits APEX Family Medicine to use or disclose your health information for the following purposes:

1. **Treatment:** We may use or disclose your health information to a physician or other healthcare providers providing treatment or services to you.
2. **Payment:** We may use or disclose your health information to obtain payment for services we provide for you.
3. **Claims Processing:** In an effort to assist in the insurance claims process and for issues relating to patient safety as deemed by your healthcare provider at APEX Family Medicine, we may access and share information relating to insurance claims to improve safety, healthcare efficiency and our billing/claims process. This information will also shared with our HIPAA bound affiliates such as Western Skies billing Services, pharmacists and other HIPAA regulated institutions and providers involved with your healthcare.
4. **Regular Health Care Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
5. **Information provided to you:** In addition to our use of your health information for treatment, payment or healthcare operations you may give us written authorization to use your health information or to disclose it to anyone

for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
6. **Notification and communication with family:** We may disclose your health information to you, as described in the Patients Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
7. **Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice 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 health information.
8. **Required by Law:** As required by law, we may use and disclose your health information when we are requested to do so by law.
9. **Public Health**: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of the health or safety of others. We are obligated under Colorado Public Health Law CRS 25-4-1401 et seq (HIV/AIDS); CRS 25-4-4 et seq (STD); CRS 25-1-122 (Communicable diseases); CRS 25-1-107 (Communicable diseases); CRS 19-3-304 (Child abuse reporting by CDPHE). The full text of these statutes is available at the Colorado Department of Public Health and Environment Regulations web address:
http://www.cdphe.state.co.us/regulations/diseasecontrol/index.html, or by calling Colorado Department of Public Health, Disease Control and Epidemiology Department at (303) 692-2963.
10. **National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to any authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutional or law enforcement officials having lawful custody of protected health information or inmate or patient under certain circumstances.
11. **Deceased person information:** We may disclose your health information to coroners, medical examiners and funeral directors.
12. **Organ Donation:** We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
13. **Workers Compensation:** We may disclose your health information as necessary to comply with workers compensation laws.
14. **Appointment Reminders:** We may use or disclose your health information to provide you with courtesy appointment reminders (such as voice mail messages, postcards, or letters). If we are unable to reach you personally, it may be necessary to leave general information on your answering machine or with a household member.
15. **Change of Ownership:** In the event that APEX Family Medicine is sold or merged with another organization, your health information/record will become the property of the new owner.

II. When APEX Family Medicine may not use or disclose your health information
Except as described in this Notice of Privacy Practices, APEX Family Medicine will not use or disclose your health information without your written authorization. If you do authorize APEX Family Medicine to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

III. Patient Rights
1. **Access:** You have the right to look at or get copies of your health information with limited exceptions. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice.
2. **Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003.
3. **Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (exception an emergency).

4. **Alternative Communications:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request. You have a right to a paper copy of this Notice of Privacy Practices.
5. **Amendment:** You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.
6. **Electronic Notice:** If you received this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact the Office Manager at 300 S. Jackson St, Suite 100, Denver, CO 80209.

IV. Questions and Complaints

1. If you want more information about our privacy practices or have questions or concerns, please contact us.
2. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

3. You may also address your complaint to one of the regional Offices of Civil Rights. A list of these offices can be found online at http://www.hhs.gov/ocr/regmail.html.
4. We support you right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Acknowledgement of Receipt of Notice of Privacy Practices:

I acknowledgement that I have received and read the above Notice of Privacy Policy and Procedures and that I have had any questions regarding this notice answered to my satisfaction. By signing this notice, I give Apex Family Medicine permission to share my PHI through means outlined and grant Apex permission to submit electronic Prior Authorizations on my behalf

_____ _____

Patient/Representative Signature Date

_____ _____

Print Name APEX Representative & Title

300 S. Jackson Street, Suite 100
Denver, CO 80209
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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):*	**DOB:**
Marital status: Single Partnered Married Separated Divorced Widowed	**Sex/Gender:** M / F / TMTF / TFTM / Other:
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness:	Measles Mumps Rubella Chickenpox Rheumatic Fever Polio	
Immunizations and dates:	Tetanus	Pneumonia
	Hepatitis	Chickenpox
	Influenza	MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	Yes	No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	Sedentary (No exercise)					
	Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				Yes	No
	If yes, are you on a physician prescribed medical diet?				Yes	No
	# of meals you eat in an average day?					
	Rank salt intake	Hi	Med	Low		
	Rank fat intake	Hi	Med	Low		
Caffeine	None	Coffee	Tea	Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				Yes	No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				Yes	No
	Have you considered stopping?				Yes	No
	Have you ever experienced blackouts?				Yes	No
	Are you prone to "binge" drinking?				Yes	No
	Do you drive after drinking?				Yes	No
Tobacco	Do you use tobacco?				Yes	No
	Cigarettes – pks./day		Chew - #/day	Pipe - #/day	Cigars - #/day	
	# of years	Or year quit				
Drugs	Do you currently use recreational or street drugs?				Yes	No
	Have you ever given yourself street drugs with a needle?				Yes	No

Sex	Are you sexually active?	Yes	No
	If yes, are you trying for a pregnancy?	Yes	No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	Yes	No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	Yes	No
Personal Safety	Do you live alone?	Yes	No
	Do you have frequent falls?	Yes	No
	Do you have vision or hearing loss?	Yes	No
	Do you wear a seatbelt when riding/driving a motorcycle/vehicle?	Yes	No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	Yes	No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	M F	
Mother				M F	
Sibling	M F			M F	
	M F			M F	
	M F		**Grandmother** *Maternal*		
	M F		**Grandfather** *Maternal*		
	M F		**Grandmother** *Paternal*		
	M F		**Grandfather** *Paternal*		
Family History of Cancers?	Breast, ovarian, prostate, colon, etc.		**Hereditary metabolic diseases?**	Stroke, diabetes, heart disease, high blood pressure, etc.	

MENTAL HEALTH

Is stress a major problem for you?	Yes	No
Do you feel depressed?	Yes	No
Do you panic when stressed?	Yes	No
Do you have problems with eating or your appetite?	Yes	No
Do you cry frequently?	Yes	No
Have you ever attempted suicide?	Yes	No
Have you ever seriously thought about hurting yourself?	Yes	No
Do you have trouble sleeping?	Yes	No
Have you ever been to a counselor?	Yes	No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every days		
Heavy periods, irregularity, spotting, pain, or discharge?	Yes	No
Number of pregnancies Number of live births		
Are you pregnant or breastfeeding?	Yes	No
Have you had a D&C, hysterectomy, or Cesarean?	Yes	No
Any urinary tract, bladder, or kidney infections within the last year?	Yes	No
Any blood in your urine?	Yes	No
Any problems with control of urination?	Yes	No
Any hot flashes or sweating at night?	Yes	No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	Yes	No
Experienced any recent breast tenderness, lumps, or nipple discharge?	Yes	No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	Yes	No
If yes, # of times		
Do you feel pain or burning with urination?	Yes	No
Any blood in your urine?	Yes	No
Do you feel burning discharge from penis?	Yes	No
Has the force of your urination decreased?	Yes	No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	Yes	No
Do you have any problems emptying your bladder completely?	Yes	No
Any difficulty with erection or ejaculation?	Yes	No
Any testicle pain or swelling?	Yes	No
Date of last prostate and rectal exam?		

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

Skin	Chest/Heart	Recent changes in:
Head/Neck	Back	Weight
Ears	Intestinal	Energy level
Nose	Bladder	Ability to sleep
Throat	Bowel	Other pain/discomfort:
Lungs	Circulation	