

Patricia Sinoway, M.D.
6800 N. 79th St. Suite 202
Niwot, CO 80503
303-652-9222

Patient Name _____ Date of Birth: _____

Medical History

Reason for today's visit _____

Current Medications
(prescription or over the
counter) _____

Drug Allergies/Reactions _____

No known Drug Allergies

Past Medical History- Circle if you have ever had

Anemia	Diabetes	High Blood Pressure	Skin Cancer
Arthritis	Emphysema	HIV	Stroke
Asthma	Hay Fever	Kidney Disease	TB
Bleeding Disorder	Heart Disease	Osteoporosis	Thyroid Disease
Cancer (type): _____	Hepatitis	Rheumatic Fever	Ulcers
Chronic Bronchitis	Fever Blisters	Seizures/Epilepsy	Pacemaker/Defibrillator
High Cholesterol	Hives	Eczema	Lung Disease
Multiple Sclerosis	Psoriasis	Other: _____	

Previous
Surgeries _____

Are you pregnant or planning to be pregnant? ()Yes () No

Has anyone in your immediate family (parent, sister, brother or child) had any of the following?

Skin Cancer Melanoma Unusual Moles None

Do you smoke? ()Yes ()No

Do you use tanning beds? ()Yes ()No

Do you drink alcohol? ()Yes ()No

Do you use illicit drug(s)? ()Yes ()No

We recommend a total body skin exam for all adults to screen for skin cancer and melanoma. We encourage you to schedule this complete exam soon. This exam may take place yearly or as frequently as Dr. Sinoway deems necessary.

Today's date _____

Patient Information (Please print in black ink)

Today's Date ____/____/____

Name _____
Last First MI

Address _____
Street Apt/Unit # City State Zip

Home Phone () _____ Work Phone () _____ Cell Phone () _____

Marital Status S / M / W / D Date of Birth ____/____/____ SS# _____ Sex _____ Age _____

How did you hear about us? _____ Employer/School Attending _____

Primary Care Physician _____ PCP Phone() _____

Other family members that are patients _____

Parent or Legal Guardian (if different from patient)

Name _____ Relationship to Patient _____
Last First

Address: _____
Street City State ZIP Code

Home Phone () _____ Work Phone () _____ Cell Phone () _____

Insurance Information (Please bring card to your appointment)

Primary Insurance Name _____

Policy Holder/Subscriber Name _____ Policy Holder/Subscriber DOB ____/____/____

Relationship to patient _____

Secondary Insurance Name _____

Policy Holder/Subscriber Name _____ Policy Holder/Subscriber DOB ____/____/____

Relationship to patient _____

Contact Information

May we leave personal medical/billing information on your answering machine at Home? YES NO

May we leave personal medical/billing information on your answering machine on your Cell phone? YES NO

Do you give our office permission to discuss your medical/billing information with Family Members? YES NO

If yes, please provide their names, their relationship to the patient, and their date of birth:

Name/Relationship: _____ DOB: ____/____/____

Name/Relationship: _____ DOB: ____/____/____

In case of Emergency, who should be notified? _____

Relationship to patient _____ Phone _____

By signing below I indicate that the information above is accurate and correct to the best of my knowledge and ability.

Patient / Guardian Signature: _____

CONTINUED ON NEXT PAGE

GENERAL CONSENT AND FINANCIAL AGREEMENT

1. CONSENT TO TREATMENT: I, the undersigned, hereby consent to medical treatment. In addition, I give permission to have a biopsy(s), minor surgical procedures and any subsequent treatment as deemed necessary as long as the risks and complications are discussed with me prior to the procedure. I understand that no guarantee has been made as to the results that may be obtained.

2. RELEASE OF INFORMATION: I authorize the release of any or all medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions.

3. FINANCIAL POLICY: In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments, co-insurance, and deductibles will be collected.

4. ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment of medical benefits to the treating physician/practice. I understand that I am responsible for any health insurance deductible, co-payments, co-insurance and non-covered services.

5. ACKNOWLEDGEMENT: My signature below acknowledges that I have read and understand each of the preceding sections 1 through 4.

(Patient or Person Authorized to Consent)

Date: _____

(Print Name if other than Patient)

(Relationship to Patient)

(Witness)

Date: _____

MEDICARE PATIENTS READ AND SIGN BELOW

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature as it appears on Medicare Card

_____/_____/_____
Date

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically “crosses over”, we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature as it appears on Medigap Card

_____/_____/_____
Date

NOTICE OF PRIVACY PRACTICES

Patricia A. Sinoway, M.D., P.L.L.C.

This notice describes how medical information about you may be used and disclosed and how you may get access to this information. Please read it carefully.

This Practice is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. This Practice is required by law to abide by the terms of this Notice.

How Your Medical Information Will Be Used and Disclosed:

Treatment, Payment, Healthcare Operations. We will use your medical information as part of rendering patient care, to obtain payments, and for the operation of the Practice. For example, your medical information may be used by the provider or nursing staff treating you, by the business office to process your payment for the services rendered and by administrative personnel reviewing the quality of care you receive.

We may also use and/or disclose your information in accordance with federal and state laws for the following purposes:

Appointment Reminders. We may contact you to provide appointment reminders.

Treatment Information. We may contact you with information about treatment alternatives or other health related benefits and services that may be of interest to you.

Disclosure to Department Health and Human Services. We may disclose medical information when required by the United States Department of Health and Human Services as part of an investigation or determination of our compliance with relevant laws.

Family and Friends. Unless you object, we may disclose your medical information to family members, a personal representative or another person involved in your care, of your location, general condition or death.

Disaster Relief. We may disclose your medical information to a public or private entity, such as the American Red Cross, for the purpose of coordinating with that entity to assist in disaster relief efforts.

Public Health and Health Oversight Activities. We may use or disclose your medical information for public health activities, including the reporting of disease, injury, vital events and the conduct of public health surveillance, investigation and/or intervention. We may disclose your medical information to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions, administrative and/or legal proceedings.

Abuse or Neglect. We may disclose your medical information when it concerns abuse, neglect or violence to you in accordance with federal and state law.

Legal Proceedings. We may disclose your medical information in the course of certain judicial or administrative proceedings.

Law Enforcement. We may disclose your medical information for law enforcement purposes or other specialized government functions.

Coroners, Medical Examiners and Funeral Directors. We may disclose your medical information to a coroner, medical examiner or funeral director.

Required Law: We may disclose your medical information as required by law or a court order.

Organ Donation. If you are an organ donor, we may disclose your medical information to an organ donation and procurement organization.

Research. We may disclose your medical information for certain research purposes if an Institution Review Board or a privacy board has altered or waived individual authorization, the review is preparatory to research or the research is on only decedent's information.

Public Safety. We may use or disclose your medical information to prevent or lessen a serious threat to the health or safety of another person or to the public.

Worker's Compensation. We may disclose your medical information as authorized by laws relating to worker's compensation or similar programs.

Business Associates. We may disclose your health information to a business associate with whom we contract to provide services on our behalf. To protect your health information, we require our business associates to appropriately safeguard the health information of our patients.

Authorizations: We will not use or disclose your medical information for any other purpose without your written authorization. Once given, you may revoke your authorization in writing at any time. To request a Revocation Of Authorization form, you may contact our Privacy Officer at 6800 79th Street, Suite 202, Niwot, CO 80503; (p) 303-652-9222; (f)303-652-9333.

Your Rights Regarding Your Medical Information:

You have the following rights with respect to your medical information:

*You may ask to restrict certain uses and disclosures of your medical information. We are not required to agree to your request, but if we do we will honor it.

*You have the right to receive communication from us in a confidential manner or in certain circumstances by alternative means or at alternative locations upon request..

*Generally, you may inspect and copy your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records.

*You may ask us to amend your medical information. We may deny your request for certain specific reasons. If we deny your request, we will provide you with a written explanation for the denial and information regarding further rights you may have at that point.

You have the right to receive an accounting of the disclosures of your medical information made by the Practice during the last 6 years, except for disclosures for treatment, payment, or healthcare operations, disclosures which you authorized and certain other types of disclosure.

*You may request a paper copy of this Notice of Privacy Practices for Protected Health Information.

*You have the right to complain to us and/or the United States Department of Health and Human Services if you believe that we have violated your privacy rights. If you choose to file a complaint, you will not be retained against in any way. To complain to us, please contact our Privacy Officer at: 6800 79th Street, Suite 202, Niwot, CO 80503; (p) 303-652-9222; (f) 303-652-9333.

Change of Notice: We may change the terms of our notice at any time. The new notice will be effective for all medical information that we maintain at that time, as well as new information after the change occurs. Before we make a significant change in our policies, we will change our notice and post the new notice in the office.

ACKNOWLEDGEMENT:

I hereby acknowledge that I have received and had an opportunity to ask questions concerning this Notice of Privacy Practices provided to me by Patricia A. Sinoway, M.D., P.C. I hereby consent to the use and disclosure of my medical information as described in the Notice of Privacy Practices..

Patient or Patient's Representative

Date

Representative's Relationship to Patient