

Highlands Health For Life

Please Print all information and use legal name printed on your Insurance Card

PatientName _____
Last First Middle

Birth date: ____/____/____ Age: ____ Social Security #: _____ Sex: M ____ F ____

Address _____
Street Apt City State Zip

Home Phone _____ Cell Phone _____ Email _____

Do you give us consent to text you: Yes ____ or No ____

Drivers License # _____ Drivers License State _____ Drivers License Expiration _____

Marital Status (circle): *Single Married Divorced Widowed Other* _____ Preferred Language: _____

Race (circle): *Black White Asian Hispanic Other*: _____ Ethnicity (circle): *Hispanic Non-Hispanic Other*: _____

How did you hear about us? _____

Pharmacy/Location: _____ Pharmacy Phone: _____

In case of emergency please notify:

Name/Relation: _____ Phone # 1) _____ 2) _____

Next of Kin/Spouse/Parent:

Name/Relation: _____ Phone # 1) _____ 2) _____

Employment Status (circle): *Full-Time Part-Time Retired Unemployed Other* Student (circle): *Full-Time Part-Time*

Employer Name _____ Occupation _____

INSURANCE INFORMATION

I have verified that Dr. Whitney Kennedy is In-Network with my insurance carrier. (Please Initial) Initials _____

Policy Holder (If not patient)

Name _____
Last First Middle Initial DOB Social Security # Relation to Patient

PRIMARY INSURANCE

Carrier Name _____ Policy ID _____ Group/GRP # _____

SECONDARY INSURANCE

Carrier Name _____ Policy ID _____ Group/GRP # _____

Name of Patient: _____

Date of Birth: _____

Highlands Health for Life Notice of Patient Privacy Practices (Condensed Version)

Your Rights- You have the right to:

- Get an electronic or paper copy of your health and claim records, we may charge a cost-based fee for paper copies
- Ask us to correct health and claim records, we may say “no” to your request if it is unreasonable or not accurate based on our determination
- Request confidential communications- direct specific ways that we are to contact you within reason
- Ask us to limit what we use and share- you may ask us to NOT use or share certain health information for treatment, payment or our operations. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer- we are not required to say “yes” to this request if it would affect your care
- Get a list of whom we’ve shared information
- Get a copy of this privacy notice
- Choose someone to act for you such as a medical power of attorney or legal guardian
- File a complaint if you feel that your rights are violated.

Your Choices- For certain health information you can tell us your choices about what we share.

- Share information with your family, close friends or others involved in payment for your care
- Share information in a disaster relief situation
- If you are unable to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious or imminent threat to your health.

Our uses and Disclosures- We typically use or share your information in the following ways:

- Treatment- share with other professionals who are treating you
- Run our organization- We can use and disclose your information to run our organization and contact you when necessary (ie. to help develop better services for you).
- Bill for your services- We can use and share your health information to bill and get payment from health plan plans or other entities
- Help with public health and safety issues- preventing disease, product recalls, reporting adverse reactions to medicines, reporting suspected abuse, neglect or domestic violence
- Preventing or reducing a serious threat to anyone’s health or safety
- Do research
- Comply with the law- we can share your health information if state or federal law requires it
- Respond to organ and tissue donation requests- we may share your information with organ procurement organizations
- Work with a medical examiner or funeral director
- Address workers’ compensation, law enforcement and other government requests
- Respond to law suits and legal actions- in response to a court or administrative order or in response to a subpoena

Our responsibilities-

- We are required by law to maintain privacy and security of your protected health information
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information
- We must follow the duties and privacy practices described in this notice and give you a copy of it
- We will not use or share your information other than is described here unless you give us a signed medical information release form. You may change your mind at any time

For more information please see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Highlands Health for Life endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients’ clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the <CORHIO> HIE, or cancel an opt-out choice, at any time.

Changes to the terms of this Notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website. **Effective date:** March 6, 2017

Highlands Health For Life Privacy Policies

AUTHORIZATION FOR TREATMENT - ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I, the undersigned, here by consent to and authorize all diagnostic and therapeutic treatment performed at Highlands Health for Life considered necessary or advisable by the attending physicians.

I acknowledge the receipt of Highlands Health for Life Notice of Privacy Practices, which describes how my health information can be used or disclosed and to whom.

I hereby acknowledge that I have read Highlands Health For Life's Notice of Privacy Practices. I have read the above statement and by signing this for I understand and agree to what it states.

Patient Signature/ Guardian Signature

Date

CONFIDENTIAL COMMUNICATION AND PHONE MESSAGE CONSENT

In an effort to protect your privacy, we have developed a policy on leaving medical care messages:

- We will NOT leave messages with anyone except the patient or legal guardian.
- We will NOT leave any information on an answering machine/voicemail.

UNLESS...WE HAVE YOUR WRITTEN PERMISSION TO DO SO.

Please read below and consider carefully whom you want to have access to your medical information.

I _____, give Highlands Health for Life my permission to speak with and/or leave phone messages regarding my medical care and/or billing with the person(s) listed below. I fully understand that this consent will remain valid until revoked in writing.

My Cell/Home Phone voicemail: # _____ Initials

My Office/Work Phone voicemail: # _____ Initials

Spouse: _____ # _____ Initials
Name

Other: _____ # _____ Initials
Name/Relation

Other: _____ # _____ Initials
Name/Relation

CONSENTS

PHARMACY MEDICATION HISTORY CONSENT

_____ I give Highlands Health for Life permission to access my medication history electronically from the pharmacy.

_____ I do not give Highlands Health for Life permission to access my medication history electronically from the pharmacy.

Patient Signature/Legal Guardian

Patient Print/Legal Guardian/Relation to Patient

Date

COLORADO HEALTH INFORMATION EXCHANGE (HIE) CONSENT

Highlands Health for Life endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the CORHIO (Colorado Regional Health Information Organization) HIE, or cancel an opt-out choice, at any time.

Colorado is an automatic opt-in state, meaning your providers will be given access to CORHIO HIE, if they participate in the network unless you sign an OPT-OUT form and submit it to CORHIO.

If you choose to opt-out please contact our front desk at 303-381-3700 and they will provide you with the appropriate opt-out form to complete

Please sign below if you understand the above information:

Patient Signature/Legal Guardian

Patient Print/Legal Guardian/Relation to Patient

Date

COLORADO IMMUNIZATION INFORMATION SERVICE (CIIS)

You or your child's shot information is being entered into the Colorado Immunization System (CIIS), a confidential, secure, statewide immunization registry. This is used to help improve communication between providers and give a more accurate history of your immunizations. Colorado is an automatic OPT-IN state, meaning that unless you choose to OPT-OUT of this service, you will automatically be enrolled. To OPT-OUT of this service please contact our front desk at 303-381-3700 and fill out the OPT-OUT form and submit it to the CIIS.

Please sign below if you understand the above information:

Patient Signature/Legal Guardian

Patient Print/Legal Guardian/Relation to Patient

Date

Highlands Health for Life

PATIENT FINANCIAL POLICIES

Thank you for choosing Highlands Health for Life as your physician office. The following is a statement of your Financial Policy, which we require you to sign prior to any treatment. All patients must complete this form prior to seeing the Provider.

We are committed to providing excellent medical care at a fair and reasonable price. Our Staff will be happy to discuss any fees or financial issues in advance or at the time of your visit. We will make every effort to work with you to file insurance claims and timely resolve any outstanding balance. ***Please initial each of the policies, as you read through this document.***

Initials

_____ ***Insurance:*** Insurance coverage is a contract between you and your insurance company. Each insurance policy is individual and it is the patient's responsibility to fully understand their benefits, eligibility dates, and what is covered or not covered by your insurance. Patients are responsible for knowing what their copayments, co-insurance and deductibles are. I hereby authorize Highlands Health for Life to file with my insurance carrier and I assign payment of medical benefits to Highlands Health for Life.

_____ ***Demographic Information & Insurance Cards:*** It is extremely important that we have updated demographic data so that we will be able to contact you in the future. We also must have a current copy of your insurance card and a photo ID on file at all times. If your insurance changes, it is your responsibility to let us know as soon as possible and to inform us of the effective dates for your new policy. If prior encounters need to be refilled to a different Insurance, you must notify us immediately due to timely filing requirements by your insurance. If we do not have your updated insurance information, then your claims may be denied for untimely filing by your insurance and those claims would become your financial responsibility.

_____ ***Network Providers:*** It is your responsibility to know if your physician is considered "In-network" by your insurance. Please call your insurance to verify if there is a question regarding network eligibility.

_____ ***Co-pays, Co-Insurances & Deductibles:*** I understand that any co-payments, deductibles and co-insurances are due at the time of service. I understand that I am responsible for any balance not covered by my insurance. We are required by all insurance carriers to collect all co-pays, co-insurances, and deductibles.

_____ ***Non-covered Services:*** It is possible that your Insurance may not cover certain procedures, treatments or labs for certain diagnoses. Please be aware that you will be responsible for any non-covered services.

_____ ***Returned Checks:*** I understand that I will be charged an additional fee of \$25 for any returned check.

_____ ***Cancellation of Appointments:*** We understand that unplanned things happen and extenuating circumstances occur, as a courtesy to other patients and the providers; we would appreciate a call at least 24 hours in advance to cancel an appointment. This will allow us to use the time for others who need to be seen. All no show late/cancellations will be charged a \$50 fee. Insurance companies will not pay this fee. You will be responsible to pay this prior to scheduling your next appointment. We allow 2 no shows /late cancellations in the preceding 12 months; on a 3rd no show or late cancellation within a year, we may decide to terminate the doctor-patient relationship.

_____ ***Payment:*** We accept Cash, Check, MasterCard, Visa, American Express, Discover and Debit Cards for payment. Payments can be made in the office, mailed in, through the patient portal, as well as over the phone. You may be contacted by our office at any of your contact numbers listed to attempt to resolve any outstanding balances. In the event that the account is not resolved, I understand that my account may be turned over to a collection agency and I may be terminated as a patient of Highlands Health for Life.

_____ ***Outside Lab Services:*** As a courtesy to our patients, we draw labs here on site, and we utilize outside lab companies. Charges for these services are not controlled by Highlands Health for Life. Patients are responsible for knowing whether their insurance plan covers laboratory services and for making arrangements for payments with the servicing lab.

_____ ***Medicare Assignments of Benefits/Authorization:*** I request that payment of authorized Medicare and/or any other government sponsored insurances of which I may be covered, be made on my behalf to Highlands Health for Life. I also assign any Medigap benefits to be paid directly to my provider. I permit a copy of this authorization to be used in the place of the original.

I authorize the release of any medical or other information necessary to process claims on my behalf. I agree to be fully responsible for all lawful debts incurred by myself for services.

Patient Signature/Legal Guardian Patient

Print patient name and Legal Guardian/Relation to Patient

Date

HIGHLANDS HEALTH FOR LIFE

THE PATIENT PORTAL!

The Patient Portal is a secure web portal on our web site home page that gives patients a new and efficient internet-based method of communicating with their doctor's office. Patients can log on to www.highlandshealthforlife.com and:

- Send and receive secure and confidential messages with our office
- Request Appointments
- Request Prescription Refills
- View Upcoming Appointments
- Update Your Personal Information
- Print Useful Paperwork and Forms
- SEE LAB RESULTS

IT'S SIMPLE AND EASY TO ACCESS YOUR PATIENT PORTAL:

Look for an invite from Highlands Health for Life on your email and follow instructions

-OR- once you have scheduled with us

1. Log onto our website at: www.highlandshealthforlife.com
2. Click on the Patient Portal link
3. Register. Make sure to use your primary phone number that we have in your chart when registering
4. Login and follow the directions

(If you experience difficulty when registering, please call our office at 303-381-3700 during normal business hours for assistance.)