New Patient Packet

Welcome and thank you for choosing Provident Healthcare.

Please complete this packet and bring it with you to your first visit.

For your reference, you may want to write down your appointment time here:

Appointment Date and Time: _____

Provider: _____

Please remember to arrive 15 minutes prior to your appointment time if your paperwork is completed. If you have not completed your paperwork, please arrive 30 minutes prior to your appointment time.

Enclosed in this packet, you will find:

- **Patient Information Sheet**
- **Medical History Form (2 pages)**
- **Review of Systems Form**
- **Office Policies (2 pages)**
- **Release of Healthcare Information**
- **Notice of Nondiscrimination (2 pages)**

When you arrive for your appointment, you will be asked to review our Privacy Practices policy and sign an acknowledgement that you have received it.

If you have any questions before your appointment, please call our office at 303.493.5200. If you prefer, you can ask to speak to the clinic manager.

*Internal Use: Info Entered*_____ *Provider Signoff* _____ *Scan to Patient Information Sheet*

PROVIDENT HEALTHCARE

Patient Information Sheet

Today's Date: _____ **Date of Appointment:** _____

Patient Name: _____

Street Address: _____ **Apt. or Unit #:** _____

City: _____ **State:** _____ **Zip Code:** _____

Social Security Number: _____ **Date of Birth:** _____

(Your Social Security number is used for identification purposes only; you are not required to provide it.)

Which provider are you seeing for your first appointment? _____

How did you hear about us? (circle one)

Physician Friend/ Patient Insurance Company Internet Other

Home Phone Number: (_____) _____

Our computer system has the capability to store several phone numbers for patients. If you would like us to keep an alternate number (other than your work number) on file, please list it here:

(_____)_____ Type of number (e.g. cell phone, pager): _____

Which is the number that you prefer we use most of the time? _____

Please note that our computer system leaves messages reminding you of appointments at your home number.

Email: _____

Would you like to be able to communicate via email with your care team or receive results? Yes / No

Employer: _____ **Work Phone: (_____)_____x_____**

Please give us the name of a relative or friend to contact in case of emergency.

Name and Relationship to you: _____ **Phone: (_____) _____**

Address, if not living with you: _____

City, State and Zip: _____

Insurance Billing: Please be sure to bring your insurance card(s) and prescription cards (if applicable) to your appointment with you.

If you are not the policy holder of your insurance policy, please provide the name of the policy holder here:

_____ Policy holder's date of birth: _____

Responsible Party (the bills for the patient's healthcare will be sent to this person). Do not complete if it is the patient.
Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Internal Use: Info Entered _____ *Provider Signoff* _____ *Scan to Patient Information Sheet*

PROVIDENT HEALTHCARE

Medical History Form

Patient Name: _____ **Date of Birth:** _____

Date of First Appointment: _____

Reason for your visit today: _____ **When did problem first begin** _____

Work/ Accident Related: Yes/ No **If yes, what was the date of the accident/ injury** _____

Please list any chronic illness or diseases that have been diagnosed by a doctor: _____

_____

Please list any operations you have had (include date, type of surgery, name and location of hospital):

_____

_____

List previous hospitalizations (other than operations): _____

_____

Have you ever received a blood transfusion? _____ **yes** _____ **no**

Please list any allergies you have (and the reaction): _____

_____

What pharmacy do you use? _____ **Phone Number:** _____

What medications are you currently taking? (Please include over the counter medications, including vitamins or herbal remedies. If you need more room, please attach a separate page.)

Medication	Dose (strength)	How often	Reason for taking
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Social History and General Questions:

What is your job or occupation? _____

Excessive exposure at home or work to (circle all that apply):

Fumes **Dust** **Solvents** **Airborne Particles** **Noise**

Are you (circle one): **single (never married)** **married** **divorced** **widowed**

Do you have any children? _____ **yes** _____ **no** **How many?** _____

Sons _____ **Ages:** _____ **Daughters** _____ **Ages:** _____

Have you ever been a smoker? _____ **yes** _____ **no** **If you have quit, when?** _____

How much per day? _____ **For how many years?** _____

How much alcohol do you drink? _____ **drinks per** **day** **week** **month** **(please circle one)**

Internal Use: Info Entered _____ *Provider Signoff* _____ *Scan to Health History*

PROVIDENT HEALTHCARE

Medical History Form, continued

Patient Name: _____ **Date of Birth:** _____

Date of First Appointment: _____

What do you do for exercise? _____ **How many days per week do you exercise?** _____

When was your last tetanus shot? _____ **Pneumonia shot ?** _____

Males Only: If you are over the age of 45, when was your last prostate exam? _____

Females Only:

Number of pregnancies: _____ Number of live births: _____

Number of miscarriages: _____ Number of abortions: _____

Date of last menstrual period: _____

When was your last Pap smear? _____ Was it normal? _____yes _____no

When was your last mammogram? _____ Was it normal? _____yes _____no

Family History:

	Age if living	Cause of death (if dead)	Age of death
Father			
Mother			
Brothers **Number Living** **Number Dead**			
Sisters **Number Living** **Number Dead**			

List any other illnesses that run in your family: (hypertension, strokes, diabetes, heart attacks, cancer, thyroid problems):

_____

_____

_____

_____

_____

Internal Use: Info Reviewed _____ *Provider Signoff* _____ *Scan to Health History*

PROVIDENT HEALTHCARE

Review of Systems Form

Patient Name: _____ **Date of Birth:** _____

Date of Appointment: _____

Have you been diagnosed with or are currently having (within the last 6 months) any of the following? If the response is "No" for an entire category, circle "No" on the top line and skip the remaining part of the section.

Constitutional: Do you have the following:
NO – skip to the next section
YES - please indicate below
Insomnia_____ Fever_____
Fatigue_____ Weakness _____

Comments:

Eyes:
Visual Loss: None Right Eye_____Left Eye _____
Corrective Glasses_____Contacts _____

Neurological/ Head, Eyes, Ears, Throat: Do you have the following:
NO – skip to the next section **YES - please indicate below**
Headaches _____

Ears: Hearing Loss _____
Discharge _____

Nose & Sinus: Nasal Congestion _____
Freq. Nose Bleeds _____

Throat: Hoarseness _____
Cold Sores _____
Snoring _____

Comments:

Respiratory: Do you have the following:
NO – skip to the next section
YES - please indicate below
Chest pain with breathing _____Shortness of Breath_____
Wheezing_____ Cough _____

Comments:

Cardiovascular: Do you have the following:
NO – skip to the next section
YES - please indicate below
Chest Pain_____ Swelling in legs/ ankles _____
Palpitations _____

Gastrointestinal: Do you have the following:
NO – skip to the next section **YES - please indicate below**
Abdominal Pain_____ Vomiting of Blood_____ Acid Reflux _____
Diarrhea_____ Indigestion/ Heartburn_____ Constipation _____
Blood in Stool/ Rectal Bleeding_____ Anal Conditions (e.g., hemorrhoids) _____
Comments:

Genitourinary/ GYN: Do you have the following:
NO – skip to the next section **YES - please indicate below**
Urinary frequency_____ Urinary urgency_____ Back Pain _____
Blood in urine_____ Incontinence_____ Foul urine odor _____
Cloudy Urine_____ Frequent Urination at Night _____
Comments:

Male Reproductive: Do you have the following:
NO – skip to the next section
YES - please indicate below
Scrotum/ Testicular Pain_____ Blood in sperm_____ Genital Herpes_____
History of other sexually transmitted diseases:

Musculoskeletal: Do you have the following:
NO – skip to the next section
YES - please indicate below
Bone/Joint Symptoms Back Pain Muscle Aches

Neurological/Psychiatric: Do you have the following:
NO – skip to the next section **YES - please indicate below**
Vertigo_____ Incoordination_____ Gait Disturbance _____
Numbness_____ Dizziness_____ Memory Loss _____
Comments:

Immunological: Do you have the following:
NO – skip to the next section **YES - please indicate below**
Asthma_____ Hay Fever_____ Hives_____ Food Allergies _____
Comments:

*Internal Use: Info Reviewed*_____ *Provider Signoff* _____ *Scan to Health History*

PROVIDENT HEALTHCARE

Provident Healthcare Office Policies

Thank you for choosing Provident Healthcare as your healthcare provider. We receive several questions regarding our office policies and have developed this document to answer some of those questions. If you have any further questions, please ask to speak to our clinic manager.

Missed Appointments: We will assess a charge of $25 for any missed appointment or an appointment that is cancelled with less than 24 hours notice. We ask for 24 hours notice so that we may open that appointment time for other patients that may wish to be seen. This fee must be paid before another appointment can be made. Patients that have more than three (3) no shows or late cancellations may be discharged from the practice.

Health Insurance: We are contracted with most insurance plans as well as Medicare and Medicaid. In order to verify your coverage and keep our records current, we will ask for your insurance card at each visit. If it is your first visit to our office, we will also ask for your picture ID to verify your identity. If you do not have your insurance card, and we cannot verify coverage with the information you give us, we will ask you to pay for your visit in full at the time of service. Please be aware that you are responsible for the charges billed for the services you receive at our office. We bill your insurance as a courtesy to you. If your insurance does not remit payment, we will bill you for those services. If you do not have health insurance, you will be responsible to pay for the visit in full at the time of service, prior to services being rendered.

Payment for services:

- Copayments are due at the time of service. If you do not pay your copayment at time of service, a "copayment service fee" of $10 will be added to your account.
- If you have a deductible with your health insurance policy that you have not met yet, you will be asked to make a down payment toward your deductible at the time of your visit. The amount of that down payment depends upon the services you are expected to receive, as well as the amount of your deductible. Our billing department can tell you the amount of this down payment in advance, if you prefer. Other payment arrangements can be made with our billing department.
- If you have a balance due on your account, for claims that have already been processed by your insurance company, you will be asked for payment at your next visit, even if you have not received a statement yet. You will be provided a summary bill at that time.
- If you have an outstanding balance due, you will receive a statement in the mail. Payments are due within thirty (30) days of the statement date. We will send one statement as a courtesy for the balance due. If the account is not paid within thirty (30) days, a "Statement Mailing Fee" of $10.00 will be added to your account for additional statements that we send for the same amount.
- If the account is not paid within sixty (60) days, it is considered past due and may be sent to our collection agency. A service fee of $25 will be added to your account if we send the account to collections.

- If your account is sent to our collections agency, payment in full is required before you can return to the practice. Additionally, you will be required to keep a credit card on file or pay a security deposit if you cannot or wish not to give us a credit card. Additionally, if your account goes past due more than twice in a calendar year, you will be required to keep a credit card on file for future payments.

Services not covered by your insurance: We make every effort to order tests that meet "medical necessity" guidelines set by Medicare/ Medicaid and insurance plans. However, it is not possible for us to know what is covered under every plan. If your insurance does not cover certain services, you will be responsible for those charges. If you prefer, you do have the option of calling your insurance to check your individual coverage prior to receiving services. If one of our providers is not listed as your primary care provider on your insurance card, we may ask you to sign a waiver or refuse to treat you. It is your responsibility to make the change with your insurance company. Insurance companies DO NOT allow us to make these changes. Please make this change so that we can treat you and so that your services will be reimbursed by your insurance company.

Medication refills: Our refill policy is posted in every exam room and you are encouraged to review it. In certain cases, we may require an office visit before we will refill a medication.

Lab Results: If your provider orders labs or other testing for you, we may ask you to return for an appointment to discuss those results. Also, it is not our policy to send normal lab results to patients. We will send them, upon request via our secure patient portal. If you would like to enroll in that **FREE** service, please ask any staff member. We do not mail results due to increasing overhead and postage costs.

Paperwork Reduction: We do provide a free service where we will keep your credit card on file for your account balances. This gives you peace of mind knowing that your account is paid. We will give you a courtesy call prior to charging the card. If you would like to sign up for this service, please ask for a form.

I have read and understand these policies and agree to abide by them. I understand updates to this document are available on the website.

Patient Signature :_____ **Date:** _____

Patient Name:_____ **Patient Date of Birth:** _____

PROVIDENT HEALTHCARE

Phone 303-493-5200
Fax 720-570-2012

Authorization/Release for Protected Health Information

Name: (Last, First, MI)	**Date of Birth:** (MM/DD/YYY)

Other Names Used: _____

I request and authorize: _____ to release Healthcare information of the above patient to:

Provident Healthcare
P.O. Box 60
Englewood, CO 80151

This request applies to: (select one)

☐ My Entire Medical Record (All Dates)

OR

☐ My Medical Record From: _____ to _____

Purpose: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above

Expiration or revocation of authorization: I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based upon this authorization.

Signature of Patient/Legal Guardian: _____ Date: _____

THIS AUTHORIZATION EXPIRES UPON FULFILLMENT OF REQUEST

Discrimination is Against the Law

Provident Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Provident Healthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Provident Healthcare provides free aids and services to people with disabilities to communicate effectively with us, such as:

Qualified sign language interpreters

Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as: Qualified interpreters

Information written in other languages

If you need these services, contact the Clinic Manager.

If you believe that Provident Healthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Cori Tiffany, Administrative Coordinator, 701 E. Hampden Ave., Suite 370, Englewood, CO 80113, 303-493-5200, fax 720-570-2012, info@providentsh.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Cori Tiffany, Administrative Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-303-493-5200.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-303-493-5200.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-303-493-5200。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-303-493-5200번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-303-493-5200.

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-303-493-5200.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1--303-493-5200.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-303-493-5200.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-303-493-5200.

ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-303-493-5200 ।

Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-303-493-5200.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-303-493-5200.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-303-493-5200まで、お電話にてご連絡ください。

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-303-493-5200 تماس بگیرید.

Dè dɛ nìà kɛ dyédé gbo: Ɔ jǔ ké m̀ [Ɓàsɔ́ɔ̀-wùdù-po-nyɔ̀] jǔ ní, nìí, à wudu kà kò dò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Đá 1-303-493-5200