THE HealthCareClinic OF FORT COLLINS

Patient Questionnaire & General Information

Patient Demographics

Full Name _____ Today's Date _____

Date of Birth_____ Gender: Male / Female SSN# _____

Street Address_____ City_____ State_____ Zip_____

Phone (_____) _____ Can we leave messages regarding your care (i.e. lab results) at this number? Yes / No

Alternate Phone (_____) _____Can we leave messages regarding your care (i.e. lab results) at this number? Yes / No

Email Address _____

- We require a copy of your driver's license with this questionnaire

Employment Information

Employer Name_____ Employer Phone_____

Street Address _____

City_____ State _____ Zip_____

Emergency Contact

Name_____Relationship_____

Phone_____

Primary Care Provider Information

Primary Care Provider_____ Office Number_____

Insurance Information

Do you have Insurance? Y or N If yes, which company_____

ID Number _____ Group Number _____ Plan _____

- We require a copy of your insurance card with this questionnaire

Reasons for Today's Visit: _____

_____

How did you hear about us? _____

I hereby authorize the provider to examine, prescribe for, or treat, the above described patient. I assume responsibility for all charges incurred in the care of this patient. I also understand that these charges will be paid at the time of service and that a deposit may be required for treatment. In the unlikely event that account becomes past due, I agree to pay all service charges, collection fees charges by a collection agency, which may amount to additional 50% of the original balance, a 2% monthly finance charge, and attorney fees to bring my account current.

Signature: _____**Date:**_____

THE HealthCareClinic OF FORT COLLINS

Consent for Treatment

I voluntarily give my permission to the health care providers of The HealthCare Clinic of Fort Collins and such assistants and other health care providers as they may deem necessary to provide medical services to me. I understand by signing this form, I am authorizing them to treat me for as long as I seek care from The HealthCare Clinic of Fort Collins, LLC providers, or until I withdraw my consent in writing. This includes all forms of Tele-Medicine (Telephone and/ or Video).

_____ Initial

Statement of Financial Responsibility/Assignment of Benefits

I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by representatives of The HealthCare Clinic of Fort Collins. I assign and authorize payments to The HealthCare Clinic of Fort Collins. I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law.

_____ Initial

Acknowledgement of Services

I acknowledge that I am about to receive health care services at the HealthCare Clinic of Fort Collins. In the event my insurance company does not reimburse for these services, I agree that I personally owe you, and will make payments within thirty (30) days of this determination for the services rendered for my condition to include Tele-Medicine visits.

_____ Initial

Acknowledgement of Non-Covered Services

I do hereby acknowledge that a certain portion of my treatment/ care may not be covered by my insurance company, PPO, HMO, Medicare or health plan, under the terms of my benefits plan. I understand that if I receive any NON-COVERED services, I will self-pay. I also acknowledge that I have been informed in advance of my treatment, about the portions of my care that I might be responsible to pay for on any future visit. I agree to make financial arrangements with The HealthCare Clinic of Fort Collins to pay these charges myself.

_____ Initial

HIPAA Consent

I acknowledge that I was offered a copy of the HIPAA Notice of Privacy Practices and that copies were readily available to me and/ or I could view and print a copy from the website: www.healthcareclinic.org

_____ Initial

I, _____ (print name) acknowledge that I have read the above information and acknowledge to this fact by initialing after each section. I also acknowledge that the staff asked me if I had any questions about the material and either did not or my questions were answered to my satisfaction prior to treatment.

Signed: _____ Date: _____