About You

Today's Date _____/_____/_____
Name _____ please circle M or F
Name you would prefer to be called: _____ Reason for visit _____ Date of Birth _____ Age_____
SS#_____ Home Address _____
City_____ State _____ Zip Code _____ Home Phone_____ Work Phone _____
Cell Phone _____ e-mail Address _____
Employer _____ How Long _____ Occupation _____
Work Phone _____ Referred by _____

Spouse Information/Emergency Contact

Marital Status (Please Circle One) Single Married Divorced Widowed Other
Spouse or Significant Other Name _____ Home Phone _____ Other Phone _____
Occupation _____ Work Phone _____ In the event of an emergency who should we contact _____
Relation _____ Best Phone # _____ Second best phone # _____

Account Information

Person ultimately responsible for this account Name _____ Relation to patient _____ Billing Address

_____ SS #
_____ DL #
_____ Employer _____
Work Phone _____ Desired Method of payment
_____check _____cash _____credit card

What you need to know

We invite you to discuss openly with us any questions regarding our services. We believe the best health services are based on friendly, mutual understanding between provider and patient.

Our office is a *Fee-For-Service* practice and payment is due at the time treatment is received. We do *not* do any insurance billing, however we would be happy to provide you with an encounter form containing the diagnosis and service/procedure code for you to send into your insurance carrier for possible reimbursement. Please note that it is your responsibility to verify coverage and to submit any claims to your insurance carrier.

Cancellation Policy:

Kindly give us at least **48 hours (weekdays only, not including weekends)** notice if you need to reschedule or cancel your appointment. Other patients are waiting for cancellations so disregard for this request will result in your missed appointment being charged to you. Exceptions will be made on occasion for special circumstance.

I understand the above information and guarantee this form was completed accurately to the best of my knowledge and I understand that it is my responsibility to inform this office of any changes to my medical status, my account or any contact information

Signature of Person Responsible for this account：

_____

Date _____

PATIENT CONSENT FORM

Ilene M. Spector, DO
41425 Lamborn Mesa Rd. • Paonia, CO 81428
phone (970) 349-2095 • fax (877) 599-6551

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used

to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly

- Obtain payment from third-party payers

- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* from time to time and that I may contact Dr. Spector at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:

_____

Signature:

_____

Relationship to Patient if other than self: _____

Date: _____