# Patient Consent Form and acknowledgement For Notice of Privacy Practices

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## Berenbeim Osteopathic, PC

**Berenbeim Osteopathic, PC, 1780 S. Bellaire St., Suite 701, Denver, CO 80222**
**720-943-3001**


Berenbeim Osteopathic's written Notice of Privacy Practices provides detailed information on how they may use and disclose my protected health information. By signing this form, I acknowledge that I have received the Notice of Privacy Practices and I am in agreement with their use and disclosure of my protected health information for treatment, payment and operations of the practice.

I understand that I may request, in writing, restrictions to the use or disclosure of my protected health records, and that I am able to provide access to my personal health information by written authorization as specified in Berenbeim Osteopathic's Notice of Privacy Practices. I also understand that Berenbeim Osteopathic may charge a fee for the costs of copying, mailing and supplies associated with any request for copies of my information.

_____ _____

Printed Name Date of Birth

_____

Signature of Patient or Authorized Representative Date_____

# Consent to Leave Messages
# How can we reach you?

**Berenbeim Osteopathic**, at times may need to contact you about test results, appointments, referrals or other information. By filling out the information below, we will be better able to serve you. In an effort to protect your privacy and follow federal guidelines, we have developed a form on leaving medical care messages.

**Unless we have written permission to do so:**

- We will not leave massages with anyone except the patient or legal guardian
- We will not leave messages on voice mail or answering machines
- We will not send faxes

Please read below and carefully consider who, if anyone, you want to have access to your medical information.

I _____ give my permission for Berenbeim Osteopathic to leave phone messages and or fax messages regarding my medical care. I fully understand that this consent will remain valid until revoked in writing by me.

**Patient Name:** _____

**Date of Birth:** _____

**Signature:** _____

**Date:** _____

**How would you prefer to receive normal test results?**

□ Fax Fax Number: _____

□ U.S. Mail Address: _____

**May we leave a phone message to inform you that test results are available and to contact our office for those results?**

Home Phone: _____ □ Yes □ No

Work Phone: _____ □ Yes □ No

Cell Phone: _____ □ Yes □ No

**Who else may we share your test results with on your behalf?**

Spouse/Partner: □ Yes □ No If yes, name: _____

Son/Daughter: □ Yes □ No If yes, name: _____

Other: □ Yes □ No If yes, name: _____

Special Instructions, if any: _____

4/25/15

Patient consent form

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# Berenbeim Osteopathic, PC

**1780 S. Bellaire St., Suite 701, Denver, CO 80222**
**720-943-3001**

## Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Berenbeim Osteopathic, PC** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

(The Notice of Privacy Practices provided by **Berenbeim Osteopathic, PC** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.
**Berenbeim Osteopathic, PC** reserves the right to revise its Notice of Privacy Practices
at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Susan Berenbeim**, Office Manager and Privacy Officer, Berenbeim Osteopathic, PC, 1780 S. Bellaire St., Suite 701, Denver, CO 80222.**

With this consent, **Berenbeim Osteopathic, PC** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Berenbeim Osteopathic, PC** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **Berenbeim Osteopathic, PC** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Berenbeim Osteopathic, PC** restrict how it uses or discloses my PHI to carry out TPO.

The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Berenbeim Osteopathic, PC** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Berenbeim Osteopathic, PC** may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable

# Patient Information

| **First Name** | | | **MI** | **Last Name** |
|---|---|---|---|---|
| **Date of Birth** | **Gender** | **Marital Status** | | **Employer** |
| **Address** | | | **Work Number** | |
| **City** | **State** | **Zip** | | **Cell Number** |
| **email** | | | | |
| **Guarantor (if patient is minor)** | **Guarantor Home Phone** | **Guarantor work Phone** | | |
| **Emergency Contact** | **Emergency Phone** | | | |

**Insurance:** Dr. Berenbeim is not contracted with any insurance carrier therefore **full payment is expected at time of service.** However, we will be happy to give you a copy of the bill to submit to your insurance for possible reimbursement to you. Return checks will be discharged a $10 return check charge.

**Missed appointments:** Our policy is to charge $50 for missed appointments not **canceled at least 24 hours in advance.** Additionally if you arrive late for a scheduled appointment, we reserve the right to ask you to reschedule. Please help us to serve you better by keeping scheduled appointments.

**After-hours call:** Dr. Berenbeim are available after-hours for urgent situations. If it is an emergency you should call 911 or go to the nearest emergency room.

**Prescription refills:** Please plan ahead for prescription refills. We ask that you contact your pharmacy at least 3 days prior to needing a refill. Even if you are out of refills your pharmacy will contact our office for physician approval. **Please note: We will NOT refill narcotic prescriptions after hours**.

**Calls to Medical Personnel:** Our primary goal at Berenbeim Osteopathic is to provide our patients with the best possible care. Our medical staff is devoted each day to our regularly scheduled patients. Therefore, please understand when calling, we may be unavailable to immediately respond to your call. **All non-urgent calls will be returned within 24 hours.**

**Medical treatment by phone:** In order to maintain the highest health standards at Berenbeim Osteopathic, our **medical staff will NOT diagnosis, treat or prescribe medication over the phone**. If you require the above, we will make every effort to schedule you as soon as possible.

**Osteopathic Manipulative Medicine:** The application of osteopathic philosophy, structural diagnosis and use of OMT in the diagnosis and management of the patient.

**Osteopathic Manipulative Therapy/Treatment:** the therapeutic application of manually guided forces by an osteopathic physician to improve physiological function and homeostasis that has been altered by somatic dysfunction.

**I understand that I am responsible and agree to pay for all medical services to Berenbeim Osteopathic at the time of service. I voluntarily consent to all treatment, including Osteopathic Manipulative Therapy for myself and or my dependant(s). I have read the Office Policies and my questions have been answered satisfactorily. I understand this is a contract and I agreed to these Policies.**

**Signature: _____Date: _____**

**For Minors:**

**I _____, (_____ relationship to patient), authorize Berenbeim Osteopathic, PC to provide medical care to my child(ren) listed below.**

Name: _____ Date of Birth _____

Name: _____ Date of Birth _____

**I authorize Berenbeim Osteopathic, PC to provide medical care to my child(ren) listed above without myself or another guardian present. Circle one: yes no**

**Signature: _____Date: _____**

9/24/2015