**As our practice transitions to the final stages of completing our EHR set up we are requiring all patients to sign up for MyChart. Benefits to you include the ability to access lab results, to review previous visit summaries, to look at and print shot records, and to send messages through the system to the providers.**

**MyChart:**

Patient Name:_____ Patient D.O.B_____

Patient Name:_____ Patient D.O.B_____

Patient Name:_____ Patient D.O.B_____

Patient Name:_____ Patient D.O.B_____

Patient Name:_____ Patient D.O.B_____

Parent Name:_____ Parent D.O.B:_____

Parent Email:_____ Zip Code:_____

**Please stop back by the front desk at the end of you visit to pick up your activation letter. If you would prefer the letter to be mailed to you please make sure we have the correct address on file for you.**

Thank You!

-Evergreen Pediatrics

MR #

Today's Date: _____

## PATIENT INFORMATION

Has the patient been seen at any of The Children's Hospital locations? yes no

Patient's full legal name: (last, first, middle) _____

Has patient been seen here under a different name? yes no

If yes, give full name: _____

Date of Birth: ____/____/____ Social Security Number: ____ - ____ - ____

Street address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____

Gender: male female Preferred Language for Visits: _____

**We are asking you questions about your race, ethnicity, and your primary language because we are required to by law since we receive federal funding/assistance. This information will not be used to determine your eligibility for receiving services.**

Race: American Indian or Alaskan Native Asian Black or African American
Native Hawaiian or Other Pacific Islander White More than one race
Refused/Not reported

Who do you take your child to when they are ill or for a regular check up? _____

## PARENT OR LEGAL GUARDIAN #1

Relationship to patient: _____ Gender: male female

Full legal name: (last, first, middle) _____

Date of Birth: ____/____/____ Social Security Number: ____ - ____ - ____

Address: (if different from patient) _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Place of Employment: _____

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

Employment status: full time part time unemployed Occupation: _____

## PARENT OR LEGAL GUARDIAN #2

Relationship to patient: _____ Gender: male female

Full legal name: (last, first, middle) _____

Date of Birth: ____/____/____ Social Security Number: ____ - ____ - ____

Address: (if different from patient) _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Place of Employment: _____

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

Employment status: full time part time unemployed Occupation: _____

## EMERGENCY CONTACT (Besides Parent/Legal Guardian)

Name: (last, first, middle) _____

Relationship to patient: _____ Phone: _____

## INSURANCE INFORMATION

**Primary Insurance (first insurance to be billed):** Name of insurance company: _____

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

Phone: _____ Policy #: _____ Group #: _____

Name of insured (person who carries the coverage): _____ Relationship to patient: _____

Subscriber or Social Security Number: _____ Subscriber Date of Birth: ____/____/____

**Secondary Insurance (second insurance to be billed):** Name of insurance company: _____

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

Phone: _____ Policy #: _____ Group #: _____

Name of insured (person who carries the coverage): _____ Relationship to patient: _____

Subscriber or Social Security Number: _____ Subscriber Date of Birth: ____/____/____

The Children's Hospital
Affiliated with University of Colorado at Denver and Health Sciences Center

**Pre-Registration Form**

Form #686490 3/2009

Evergreen Pediatrics, LLC
30960 Stagecoach Blvd
Suite 120
Evergreen, CO 80439
(303) 674-6671

MR# _____

**Obtain a copy of this Notice of Privacy Practices upon request.**

**Inspect and request a copy of your protected health information for a fee**. We may deny your request under limited circumstances. If we deny you access to health information, you may request that the denial be reviewed by another healthcare professional chosen by someone on our healthcare team. We will abide by the outcome of that review.

**Request an amendment to your health record** if you feel the information is incorrect or incomplete. We may deny your request for an amendment if:

- it is not in writing,
- does not include a reason to support the request,
- the information was not created by our healthcare team,
- it is not part of the information kept by our facility,
- it is not part of the information which you would be permitted to inspect and copy,
- the information already in the record is accurate and complete.

Please note that even if we accept your request, we are not required to delete any information from your health record. If we disagree with your request you have the right to submit a statement of disagreement to be enclosed with future releases of the information in question.

**Obtain a record of the sharing/disclosures of your health information.** The accounting will only list information shared for purposes other than treatment, payment or healthcare operations and will exclude information that was shared because of a valid authorization.

**Request communication of your health information by alternative means or to alternative locations.** We will honor reasonable requests when you provide the alternative address/contact information and information on how payment will be handled.

**Revoke your authorization** to use or share health information except to the extent that action has already been taken.

**Complain about any aspect of our health information practices to us or to the Department of Health and Human Services of the United States.** If you believe your privacy rights have been violated, you may file a complaint with Evergreen Pediatrics or with the US Secretary of the Department of Health and Human Services. To file a complaint with Evergreen Pediatrics, contact the Patient Representative Program at 303-674-6671 (they will forward your complaint to the Privacy and Data Security Officer). There will be no retaliation for filing a complaint.

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facilities, and it will also be posted on our web site at http://www.evergreenconiferpediatrics.

rev. 05-03-2011

Name of Patient (please print)_____

Date of Birth_____

Name of Guardian (please Print)_____

Signature of Guardian_____ Date:_____

MR #_____

PT name_____date_____

I UNDERSTAND AT LEAST 24 HOURS IS NEEDED FOR PRESCRIPTIONS AND ANY PAPER WORK NEEDING A DOCTORS SIGNATURE.

# Financial Agreement

I understand it is my responsibility to call my insurance company and confirm that Evergreen Pediatrics or Kenneth Kutalek M.D. is **"in network"** with my insurance plan and if a claim is denied for **"out of network"** provider, that I am responsible for paying that claim.

I UNDERSTAND THAT MISSED APPOINTMENTS ARE SUBJECT TO A "NO SHOW" CHARGE:
WELL CHECKS $50.00 AND SICK VISITS $25.00-PER CHILD PER VISIT.
TO BE PAID PRIOR TO NEXT APPOINTMENT.
I UNDERSTAND 12 HOURS NOTICE IS REQUESTED FOR ANY CANCELLATIONS **(without penalty.)**

In consideration of treatment by the physician, I the undersigned, jointly and severally, understand and agree:

1) That the preceding information is correct to the best of my knowledge.
2) That I am responsible for all fees relative to the professional services rendered under this agreement, that this may include my children that I authorize, and that this agreement as it relates to my financial responsibility extends to all past, present and future services rendered by the physician and his/her staff to my family I may have authorized, I recognize that insurance is a contract between the patient and the insurance company, and I agree that I will pay all charges under this agreement regardless of my insurance coverage, I may terminate my responsibility under this agreement by paying my account in full and giving written notice to the physician.
3) That I will pay all sums that are due and payable at the time of service. No oral agreements have been made and this agreement cannot be modified orally.
4) That I agree to pay at the rate of 18% annually on all balances over 90 days from the original due date, plus court costs and reasonable attorney's fees, with or without suit, incurred in collection any past due balance, and a collection fee equal to 40% of the outstanding balance.

_____

Responsible Party (please print)

_____

Signature date

_____

Co-Responsible Party (please print)

_____

Signature date

# Request For Outside Medical Records

Patient's Complete Name: Last: _____ First: _____ Middle: _____

Date of Birth _____/_____/_____

| INFORMATION TO BE RELEASED FROM: | INFORMATION TO BE RELEASED TO: |
|---|---|
| _____ Organization | Evergreen Pediatrics Organization / Person |
| _____ Street Address City, State, Zip | 30960 Stagecoach Blvd #W-120 Evergreen, Co. 80439 Street Address Box City, State, Zip |
| _____ Phone Fax | (303)674-6671 (303)674-0031 Phone Fax |

## INFORMATION TO BE RELEASED

**Format for records** ☐ Fax ☐ CD ☐ Mail

**Dates of service for records requested: Beginning** _____ **Thru** _____

- ☐ Complete Medical Record
- ☐ Immunizations
- ☐ Labs/X-Rays

## PURPOSE OF RELEASE

☐ Continuation of Care ☐ Other _____

## AUTHORIZATION FOR GENERAL RELEASE OF INFORMATION

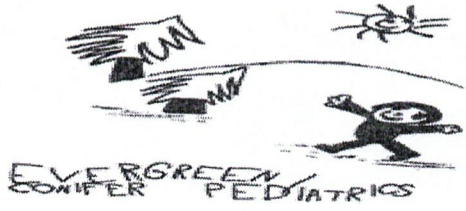
**I understand that:**
(1) My signature on this form is strictly voluntary. (2) I may revoke this authorization at any time in writing, and if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. (3) If the requester or receiver is not a health plan or healthcare provider, the released information may be disclosed by the recipient and may no longer be protected by federal privacy regulations. (4) If I do not sign this form, my healthcare, the payment for my healthcare or my ability to enroll for benefits will not be affected. (5) I may inspect or obtain a copy of the health information that I am being asked to disclose. **Expiration**: Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 180 days from the date hereof, unless otherwise specified _____.

**This form must be filled out completely in order to obtain medical records**

## SIGNATURE OF PATIENT / LEGAL REPRESENTATIVE

_____
Signature of Patient or Legal Representative Date (month/day/year)

_____
Relationship to patient, if not signed by patient




Kenneth Kutalek, M.D. FAAP

Rudolf Schmiedt, M.D. FAAP

Emily Fay, PA-C