Patient Registration Form:

Last Name	First Name	**SSN**	Marital Status
Date of Birth			Language

Address: Street	***Zip***	**City**	State
Phone Numbers: please check preferred	Home Phone	Mobile Phone	Work Phone
Email Address			

Preferred Contact Method: please check box	Phone	Mail	Email
Who referred you?			

Driver's License#	Expiration date	State
Employer Name and Address	Occupation	

Primary Insurance Company and Policy Number _____ _____ Effective Date_____CoPay_____	Secondary Insurance Company Name and Policy Number _____ _____ Effective Date_____CoPay_____

If you are covered under the policy of a spouse, parent, or legal guardian, please tell us about them:

Name:	Date of Birth
SSN	Marital Status

Home Phone	Work Phone	Mobile Phone

Address: Street	Zip	City	State
Employer	Occupation		
Emergency Contact Information - Name	Phone Number		

Patient Signature:_____ **Today's Date:**_____

Patient Questionnaire:

Thank you for choosing Comprehensive Endocrinology. Please completely fill out this form to ensure the fastest and best healthcare service. We may ask you to look over this information to make sure it stays up-to-date.

Name of the Medications you are currently taking:	Dose:	Frequency:

Allergies {seasonal and medications):	

Known Medical Diagnoses and Surgeries:	

Patient Signature:_____Today's Date:c_____

TELEMF.DICINE PROGRAM Comprehensive Endocrinology

TELEMEDICINE PATIENT CONSENT FORM

I. (name of patient or parcnt/guardian)_____DOB: _____• agree to participate in a telemcdicine evaluation. By signing this agreement, l authorize the electronic transmission of my medical infonnation and/or videoconlerence session so that it can be viewed by a doctor and other persons involved in my medical care. **[Note:** The likelihood of this transmission being intercepted by persons other than those at the consulting site is extremely sma11].

I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I consider to be inappropriate or am unwilling to have heard by other persons. I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation.

I understand that as with any technology, te)emedicine does have its limitations. There is no guarantee, therefore, that this telemcdicine session will eliminate the need for me to see a specialist in person.

I understand that electronic medical records oftelemedicine services will be kept at Comprehensive Endocrinology.

Signature of patient (or parent/guardian): Date:

Please print the above name:

_____

u **(MARK THIS BOX AND SIGN BELOW FOR WITHDRAWAL ONLY).**
1 have chosen not to participate further in this telemedicine evaluation.

Signature of patient (or parent/guardian)
_____ _____ Date:

Comprehensive Endocrinology, PC

P: 888-418 49880

F: 303-321 3668

4500 E. 9th Avenue, Suite 170

Denver, CO 80220

Financial Policy

This is an agreement between Comprehensive Endocrinology, PC, a Colorado Professional Corporation, as creditor, and the Patient/Debtor named on this form.

In this agreement the words "you," "your," and "yours• refer to the Patient/Debtor. The word "account• refers to any and all accounts established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Comprehensive Endocrinology, PC. By executing this agreement, you are agreeing to pay for all services rendered by our office and employees thereof.

Insurances Accepted: We accept all major insurance payors except for Medicaid, either as primary or secondary insurance. If our office is a participating physician with your insurance plan, we will bill them directly for the care you receive. You are responsible for co-payments at the time of your appointment. You are required to present a *valid insurance card at each visit.* If you do not have your card, we will see you on a fee-for-service basis only, with payment due at the time of the visit (minimum charge of $100). You are responsible for knowing which services are covered under your insurance plan. If we provide a service that we feel is medically prudent and this is a non-covered benefit, you are responsible for payment for that service. It is our ethical responsibility to do what is necessary and correct medically, whether it is financially covered by your individual insurance plan or not.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. Jf you have a co-pay or deductible, that payment is expected at the time of service. It is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company requires a referral and/or preauthorization. you, as the "insured, are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a decreased or zero payment by your insurance company. This means that you are responsible for paying the charges incurred.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. If we are NOT contracted with your insurance company, we wilt bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility, payment rate and benefits. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you as the insured, are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a decreased or zero payment from the insurance company. This means that you are responsible for paying the charges incurred. Your insurance company may send payment for our services directly to you. This means that you are responsible for paying us directly, in full, for all charges incurred. If your insurance company demonstrates that they will consistently pay you and not us directly, payment for our services will be due from you at time of service and we will bill your insurance company, as a courtesy, for your reimbursement.

Payments: Unless other written arrangements are approved by us, the balance on your statement is due and payable upon the date the statement is issued, and will be considered as past due if not paid in full after 30 days. If your account becomes past due, we will take the necessary legal steps to collect this debt. If we have to refer your account to a collection agency, you agree to be liable for payment of all collection costs incurred. If we have to refer collection of the balance to a lawyer and or have to pursue payment through the court system, you agree to be liable for payment for all lawyers' fees, court costs and the creditor's loss of income. Please see the **Credit Card and Payment Policy** for more details.

Returned checks: There is a fee (currently $25) for any checks returned by the bank ("bounced checks").

Charges to Account: We shall have the right to cancel your privilege to incur charges against your account at any time. All future visits would then need to be paid at the time of service.

Payment plans: If a payment plan agreement is arranged and signed, payments are expected each month by the arranged due date. You will continue to receive a monthly statement. If you default on the agreed payment plan and the account becomes past due, any courtesy discounts will be rescinded, and your account assigned to our collection agency, for the full amount, as described in the section Payments.

Missed appointment fee: Patients who do not show up for an appointment. or cancel with less than 24 hours notice will be charged a $50 fee. This fee must **be paid** in **full before a new appointment will be scheduled. Patients with two missed appointments will be asked to transfer their records to another doctor.**

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if this account requires litigation in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee if you want to have copies of your records sent to another doctor or organization. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to release all relevant patient and account information, including your payment history.

Co-signature: If this or an additional Financial Policy for this patient account, is signed by another person, that co-signature remains m effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's name: _____

Responsible party

(if not the patient): _____

Signature: _____ Date: _ _ _ _ _ _ _ _ _ _ _ _

Co-Signature: _____ Date: _____

Comprehensive Endocrinology, PC

4500 E. 9th Avenue, Suite 170

P: 888-418 4988

Denver, CO 80220

F: 303-321 3668

Credit Card and Payment Policy

Healthcare benefits and coverage options have become increasingly complex. Insurance plans have numerous differing benefits, co-payments and deductible plans that are often confusing to navigate, not only for the patient, but also medical providers. What you as a patient owe is dependent on a number of things including whether or not you have a plan with a co-payment , co-insurance, deductible, maximum out-of-pocket limits or a combination of all these things.

To make this process more cost effective for everyone, we have the following policy:

1. Payments of copays and deductibles are due at the time of your appointment. If you are a self-pay or cash patient, you will be asked to pay at the time of your visit.
2. **We require all patients to provide us with a credit card at the time of service.** The information is encrypted and securely stored with our payment gateway company, which is 'payment card industry' (PCI) compliant. This is similar to the process that all hotels, mail order pharmacies, gasoline stations, etc use.
3. After your visit **nothing** will be charged to your credit card. Once the Explanation of benefits (EOB) returns from your insurance company and we can determine your responsibility (amount determined by your insurance company minus any copayments or deductible payment made at time of service) we will send you a statement (by e-mail or to your address of records if no e-mail address was provided) with your balance and **we will charge the balance to your credit card on file if you have not paid us within 4 weeks.** This process in no way compromises your ability to dispute your insurance company's determination of payment.
4. We have a 24 hour cancellation policy. You will be charged $50 if you do not cancel in time or simply no-show. The no-show fee will be charged to the credit card on file.

This policy will be an advantage to you, since you will not have to come in or call in with the credit card information or bring In cash to pay the bill. It will be an advantage to us, as It will significantly reduce my time/costs associated with sending out statements from the office as well as collection attempts.
The combination will benefit everyone in helping to keep the cost of healthcare down. As a small medical practice operating with fixed/decreasing reimbursements and rising expenses, we must do everything possible to allow our medical practice to maintain its professional standard of service. Thank you for your cooperation and understanding.

_____ . _____

Authorization to charge my credit card for all 'patient responsibility'

portions of my insurance payment &/or no-show fee

I authorize Comprehensive Endocrinology to charge my credit card with the balance due (patient responsibility) portion of my insurance explanation of benefits (EOB) or other outstanding charges I may owe the practice. I understand that I can dispute the charge at any time with my credit card company; the actual amount of the charge can only be disputed with my insurance company. Any subsequent change in the EOB by the insurance company will be reflected as a credit or additional charge on my credit card.

Patient's name:_____

Signature:_____ Date: _____

PATIENT PORTAL AUTHORIZATION FORM

Patient Name:

DOB:

E-mail Address:

By signing this form,/ authorize Comprehensive Endocrinology (Comp Endo) to communicate via personal, secured access Patient Portal with me for my medical care and treatment. Comp Endo will provide notices via your personal e-mail that information can be found in your Patient Portal. No personal health information is transmitted via or into your personal e-mail. I understand the following types of protected health information may be used, disclosed and retained by health care providers of Comp Endo as a result of the communications:

1. my personal health information
2. laboratory test results
3. pathology reports
4. other medical records

We **want** your records to be complete and correct. let us know if there is any problem with your records. Sometimes we may use medical jargon or make mistakes and it can lead to confusion. If something doesn't make sense let us know.

You can access the portal day or night, but we don't have 24 hour presence therefore the portal should not be used for pressing issues. The portal is not intended for "web visits" or new problems. If a message takes a long time to write, it's probably something better done in person at an office visit.

Signature:_____ Date _____

Once you have signed up you can access the site through our website or at www.gotomyclinic.com/comp-endo

User Name:

COMPRENSIVE ENDOCRINOLOGY, 4500 E. 9th Avenue, Suite 170, Denver CO 80220

Notice of Privacy Practices and Terms and Conditions

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Comprehensive Endocrinology]. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purposes other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes when financial remuneration is involved. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

Privacy Policy and Terms of Services:
Usage of SMS/Texting for communication:

Comprehensive Endocrinology uses text messaging to communicate with patients. This service is voluntary.

Patients have to opt-in to receive messages and can opt-out at any time by notifying Comprehensive Endocrinology.

Phone number: _____

I hereby agree to receive text messages to remind me of upcoming appointments and to receive reminders of pending payments. My opt-in information will never be shared with third parties for marketing purposes.

Terms of Services:
Text messages will only be used for reminders of appointments and outstanding balances. To opt out of this service please contact Comprehensive Endocrinology by a written notice through the Patient Portal.
Message and Data rates may apply. This Privacy and Terms of Serviced can be reviewed at www.comp-endo.com

Name: _____ Date:_____

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find interesting.

We may also send you information describing other health-related products and services that we believe may interest you.

Fundraising. Unless you request us not to, we will use your name and address to support our fund-raising efforts. If you do not want to participate in fund-raising efforts, please check off the following box.

0 Please do not use my information for fund-raising purposes.

Marketing. Unless you request us not to, there are some marketing activities for which we may use your name and address, to provide you with information about services available at our practice. If you'd rather not receive marketing communication from our practice, please check off the following box:

0 Please do not use my information for marketing purposes

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Comprehensive Endocrinology Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices outlined in this notice. In the event of a breach of unsecured protected health information, if your information has been compromised it is our duty to notify you.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices *may* be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit.

The revised policies and practices will be applied to all protected health information we maintain.

COMPRENSIVE ENDOCRINOLOGY, 4500 E. 9th Avenue, Suite 170, Denver CO 80220

Requests to Inspect Protected Health Information

You *may* generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our office staff. Your request will be reviewed and wiH generally be approved unless there are legal or medical reasons to deny the request. Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Comprehensive
Endocrinology
4500 E. 9th **Ave,** Suite 170
Denver, Co 80220

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the parson you may contact for further information concerning our privacy practices is:

Comprehensive
Endocrinology
4500 E. 9th **Ave,** Suite 170
Denver, Co 80220
[Privacy officer telephone number: **8884184988]**

This notice is effective on or after August, 10th 2015.

Acknowledgment of Notice of Privacy Practices

Comprehensive Endocrinology reserves the right to modify the privacy practices outlined in the notice.

_____
Signature

☐ I have received a copy of the notice of privacy practices for Comprehensive Endocrinology.

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative

(Required if the patient **is a** minor or an adult who is unable to sign this form)

_____
Relationship of Patient Representative to Patient