Demographics

First Name	M.I.	Last Name
Primary Contact Number ( )		Secondary Contact Number ( )
Street Address	Apt/Suite #	Date of Birth __ __ / __ __ / __ __ __ __
City	State	Zip Code
If Patient is a Minor; Name of Responsible Party		Social Security Number __ __ __ - __ __ - __ __ __ __
Email (We do not sell, rent or distribute your email address per HIPAA Law)	Gender (circle) Female Male	Marital Status
Employer		Occupation
Work Phone Number/Extension	Employment Status (circle) Full-Time Part-Time Disabled Retired Student Not-Employed N/A	
Race ____White _____Black/African American _____American Indian ____Asian _____Other		
Ethnicity _____Hispanic or Latino _____Not Hispanic or Latino _____Declined to Provide this information		
Preferred Language _____English _____Spanish _____Other:		

Emergency Contact Person	Relationship	Emergency Contact Number

Primary Care Physician	City, State	Phone

Referring Practitioner	City, State	Phone

Name: _____ Date: _____

Primary Insurance Carrier	ID Number	Group Number	
Primary Insurance Carrier Address, City, State, Zip Code			
Name of Insured/Policy Holder	Relationship to Insured	Date of Birth	Gender (circle) Female Male
Secondary Insurance Carrier	ID Number	Group Number	
Secondary Insurance Carrier Address, City, State, Zip Code			
Name of Insured/Policy Holder	Relationship to Insured	Date of Birth	Gender (circle) Female Male
If you have Tricare, Tricare West, Tricare4Life, Sponsor SSN:			

_____TLC The Littleton Clinic cannot guarantee insurance coverage by your insurance carrier. It is your responsibility to verify that your insurance will provide coverage for services received at TLC. The information you provide will assist us in determining if some of the expenses are reimbursable by your HMO or insurance.

_____ I understand that I am financially responsible for all charges whether or not paid by my insurance carrier.

_____ I certify that the information I am providing is true & correct. That I (or my dependent) have insurance coverage and assign directly to TLC The Littleton Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand and agree that I am ultimately responsible for payment that may not be covered.

_____ I authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

(Patient/Responsible Party Signature) (Relationship) Date

Name: _____ Date: _____

Medical History

Past medical history (List any problems that have required recurrent medications or medical supervision, any significant hospitalization or medical event)

_____

_____

_____

_____

Past Surgical History (Any surgery and an estimation of WHEN)

Date_____Surgery_____

Date_____Surgery_____

Date_____Surgery_____

Family History

			Diabetes	High Blood Pressure	Heart Disease	High Cholesterol	Mental Illness	Breast Cancer	Colon Cancer	Other / Specify
Mom	If alive, Age _____	If died, Age _____								
Dad	If alive, Age _____	If died, Age _____								
Other e.g. sister, brother, son, daughter	Relation and Age:									
	Relation and Age:									
	Relation and Age:									
	Relation and Age:									

Do you smoke?

□ Current smoker - Packs per day: _____
How long have you smoked?: _____
□ Former smoker – Last cigarette: _____
□ Nonsmoker

Did you have a drink containing alcohol in the past year?
Yes No

If Yes: How often did you have a drink containing alcohol in the past year?
□ Occasionally □ Weekly/Num: _____ □ Daily/Num: _____
How many times in the past year have you had 6 or more drinks?_____

Allergies to Medication or significant Food Allergy with reaction (i.e. anaphylaxis, rash, vomit):

None <- Circle if none

_____

_____

Medications – We need DOSE and how many times per day Pharmacy:_____

_____ _____

_____ _____

_____ _____

Name: _____ Date: _____

Medical History and Consent for Treatment

I certify that the above information is accurate, complete and true.

I authorize TLC The Littleton Clinic and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

I give my consent for TLC The Littleton Clinic to retrieve and review my medication history. I understand that this will become part of my medical record.

I acknowledge that I have had the opportunity to review TLC The Littleton Clinic Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I authorize TLC The Littleton Clinic to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize TLC The Littleton Clinic to release any information required in obtaining procedure authorization or the processing of any insurance claims.

I understand that TLC The Littleton Clinic will not release my Protected Health Information to any other party (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at its facility and on its website.

In the event that I am asked to provide a urine and/or blood sample, I voluntarily seek laboratory services and hereby consent to provide a urine and/or blood sample as requested. I have the right to refuse specific tests, but understand this may impact my pain management treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked.

Signed: _____ Date: _____

Parent/Guardian Name (if under 18) _____

Copayments / Coinsurance / Deductible: Copayments, coinsurance, and deductibles for clinic visits and procedures are due at the time of service. If you are unable to make your copayment at the time of service, TLC The Littleton Clinic reserves the right to reschedule your appointment until a time that you are able to make your copayment. Payment for any outstanding balance is due at your appointment.

Missed Appointments and Late Arrivals. If you are more than 15 minutes late we may reschedule your appointment. ("Late" means arriving after the time you are asked to arrive at the clinic.) If you do not show up to your appointment, you will be responsible for a missed appointment fee. Missed appointments are subject to a $50 charge. These charges are your responsibility and will not be billed to any insurance carrier.

I understand and agree to the Financial and Appointment Policy.

Signed: _____ Date: _____

Parent/Guardian Name (if under 18) _____

I acknowledge that I have received a copy of the office's Notice of Privacy Practices. _____

Signed: _____ Date: _____

Parent/Guardian Name (if under 18) _____

Name: _____ Date: _____

Insurance & Financial Polices

INSURANCE

If you have insurance, we will do our best to help you receive your maximum benefits. Insurance is a contract between you and your insurance company. We are not a party to this contract. We will file insurance claims with insurance carrier(s) if you provide us with all of the necessary information. **Our office will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered v. non-covered charges, secondary insurance, "usual and customary" charges, procedures they consider experimental, etc., other than supply factual information as necessary.** You are responsible for the items listed above as well as any services considered "not medically necessary" by your insurance company.

In-Network vs. Out-of-Network

TLC The Littleton Clinic is IN-network with the following carriers/plans:

- Aetna (excluding Aetna Whole Health)
- Aetna Life
- Anthem / BCBS (PAR, PPO, HMO, Blue Priority PPO, Mountain Enhanced, Federal Employee Program)
- Bright Health
- Cofinity
- Coventry
- First Health Network
- Government Employees Hospital Association (GEHA)
- Health Partners
- Humana
- Medicare
- Meritain Health
- Rocky Mountain Health Plans
- State Farm

TLC is IN-network with the follow plans but will be OUT-of-network after 7/1/18:

- Medicaid.
- UHC AARP Medicare Complete
- UMR
- United Healthcare of Colorado
- United Healthcare AARP
- United HealthOne

TLC is IN-network with the follow plans but will be OUT-of-network after 8/1/18:

- All Savers
- CIGNA / Great West (PPO, OAP, HMO)
- Multiplan
- NALC Health Benefit Plan (Cigna OAP)
- PHCS

TLC is IN-network with the follow plans but will be OUT-of-network after 9/1/18:

- Tricare

TLC is currently OUT-of-network with:

- Aetna (Aetna Whole Health)
- BCBS Colorado/Anthem (HMOSelect, Blue Priority, CU Exclusive, Pathway)
- Cigna (Connect, LocalPlus, SureFit)
- Colorado Access HMO
- Denver Health Medicaid Choice
- PreferredOne
- Railroad Retirement Board Health Insurance

The lists above are accurate to the best of our knowledge. However, it is not unusual for carriers to create limited network plans which restrict patients to a very limited set of providers or other plans that might impact in-network access to TLC. If you are on one of these plans, TLC The Littleton Clinic may be out of network even though we are contracted with your carrier. **It is the patient's responsibility to confirm with their carrier whether our clinic is in or out of network. If you don't see your plan listed above or have any reason to doubt our network status, please verify with your carrier.**

Name: _____ Date: _____

Out of network patients will be billed $400/hr, charged in 15 min increments, for office visits. Procedures such as nerve injection and PRP will charged according to a separate price list. Please feel free to ask about the cost prior to receiving these procedures.

It is possible that your insurance payment for your visit to TLC The Littleton Clinic will be sent directly to you. We ask that you please endorse the check over to TLC The Littleton Clinic, and mail it, along with your Explanation of Benefits. By sending such payment you receive directly to the center you avoid the possibility of additional costs for using our facility. Compliance with this request will allow us to process the payment to your account quickly and efficiently, and to make any necessary adjustments.

If you have any questions or concerns, please do not hesitate to contact our office at 720-351-2411.

Name: _____ Date: _____

Referrals / Pre-authorizations

If your insurance requires a referral and/or pre-authorization for services, you are responsible for obtaining it. Failure to obtain a referral or pre-authorization may result in a lower or no payment from your insurance company. Know your insurance benefits. You are financially responsible for any unpaid balances on your account.

Worker's Compensation (WC)

We require written approval or authorization by your worker's compensation carrier prior to your initial visit. All necessary information must be provided to file your claim. Our office will not become involved in disputes arising from Worker's Compensation claims. If your WC carrier denies your claim, we will bill your personal health insurance carrier(s) as outlined above. If you have no health insurance coverage, you are responsible for payment in full. All bills will be sent directly to you and it is your responsibility to forward the bills to your attorney if you wish.

Personal Injury

If you are being treated as part of a personal injury lawsuit or claim, we require that you allow us to bill your health insurance carrier pending settlement of your case. In the absence of personal health insurance, other financial arrangements may be made. Payment of your bill remains your responsibility. We cannot bill your attorney for charges incurred due to a personal injury case. If you do involve an attorney you will be required to obtain a Letter of Protection before any other services are rendered,

Responsible Parties of Minors

The parent or legal guardian who signs the "Financially Responsible Party" is responsible for payment of services rendered.

Transferring of Records

If you want copies of your records transferred to another doctor, you must make the request in writing. We reserve the right to charge reasonable copying fees.

Payments and Financial Details

Payments Due at Time of Service: As a result of the contracts we have with our in-network carries, we are required to collect copays and part of the deductible at the time of service. We cannot habitually bill you for your copays they are designated to be collected at time of service.

Same Day Service and Procedure Policy for Insured Patients with Remaining Deductibles

In addition to your "clinic" co-pay, you may be asked to pay a portion of your un-met deductible balance after your service has been performed. Ultimately patients are responsible for deductibles and payments to TLC The Littleton Clinic its providers for services rendered. If you have a remaining deductible we will request 60% of your estimated patient responsibility same day after office visits and or any procedures. The payment will be applied to the charges incurred and you will receive a statement indicating the balance due (if applicable). Your benefits and the status of your current deductible (if applicable) will be verified. If you owe a deposit, you will be asked to pay after your visit is complete. Payments will be requested before some procedures are performed if procedure is performed on same day as original office visit.

Payment of remaining balances are expected to be paid within 30 days of receipt of statement. If you are unable to pay your balance in full please contact our billing department to discuss acceptable payment plan options. A monthly plan is required to keep your account current.

Name: _____ Date: _____

Cancellation /No Show Policy

Late Fee

If you do not pay a required patient responsibility after the first statement cycle. We reserve the right to charge a 6% Late Fee that will be continually billed to your account until the account is brought current.

Statements

Insurance payments on your account are generally received within 14-30 business days after your clinic visit. Once we receive payment from your insurance, a statement will be sent to you if there is a remaining unpaid balance on your account. Your unpaid balance is due upon receipt of your statement, unless other arrangements have been approved by us. Payments may be made by cash, check or credit/debit card. Statements will be sent to the address listed on your registration form. Please notify our office if you want your statements to go to an alternate address.

Returned Check Fee

There is a $25.00 fee for returned checks.

Collections

If your account becomes past due, we will take necessary steps to collect your debt. You will be responsible for all fees associated with debt collection attempts, including but not limited to collection agency and legal fees. If we refer your debt to a collection agency, you will be required to pre-pay for your next visit(s) until the debt is paid.

Patient Balance and Service Payment Policy

All cash balances need to be paid at time of service. If balance is not able to be paid at the time of service a payment
Electronic Funds Transfer (EFT or ACH) arrangement may be made with the billing department.

Payments may be made with cash, personal check, credit card (VISA, MC, AmEx, and Discover), or (EFT/ACH).

If payment cannot be arranged, a non-emergency service would need to be rescheduled, as well as future appointments will have to wait until a payment is received or payment plan is implemented.

A payment plan can be arranged for some of our more expensive services, typically at additional cost. Let us know if this is of interest to you.

If you are unable to keep your scheduled appointment, please call us at least **24 hours in advance** to reschedule/cancel your appointment.

If you no-show or cancel appointment without calling at least 24 hours in advance or arrive more than 15 minutes after your appointment there will be a $50.00 fee

Name: _____ Date: _____

Cancellation /No Show Policy

We have an appointment policy in place to ensure patient accountability and physician availability. TLC The Littleton Clinic is committed to the highest quality of care!

SIGNATURE BELOW CONFIRMS THAT YOU HAVE BOTH READ AND UNDERSTAND ALL POLICIES AND CONDITIONS.

_____ _____

Patient Name Relationship (if patient is a minor)

_____ _____

Patient (or responsible party) Signature Date

Name: _____ Date: _____

Notice of Privacy Practices

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of TLC The Littleton Clinic's health care operations. The Notice of Privacy Practices also describes my rights and TLC The Littleton Clinic's duties with respect to my protected health information.

TLC The Littleton Clinic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment or viewing on TheLittletonClinic.com.

Signature of Patient or Personal Representative

_____ _____
Name of Patient or Personal Representative Date

_____
Description of Personal Representative's Authority

How Did You Hear About Us? (check all that appy)

- □ Friend or family Who? _____
- □ Healthcare provider. Who? _____

Internet Search

- □ Online Advertising:
- □ Google Ads
- □ Facebook
- □ Instagram
- □ Snapchat
- □ Twitter
- □ Other: _____

Print Advertising:

- □ The Denver Post
- □ Church bulletin
- □ Other: _____

Attach 6 months of Labs

Attach 6 month of X-rays or MRI's

Name: _____ Date: _____

TLC The Littleton Clinic
9200 W. Cross Drive Suite 315
Littleton CO 80123

AUTHORIZATION TO LEAVE TELEPHONE INFORMATION

TLC The Littleton Clinic is committed to ensuring the privacy and confidentiality of your medical/personal information. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). To assist us in protecting your privacy, please complete the following information:

Number to best contact you: _____ Home Cell Work

May we leave a clinical or billing message (i.e. lab results),if no answer? Yes No

May we leave information with someone other than you regarding your medical care (medication changes, laboratory results, billing issues, appointments, etc.)? If so, please list the name(s) in the space(s) below.

Billing Issues: Yes No

Clinical Issues: Yes No

Name: _____ Phone: _____ Relation to patient: _____

Name: _____ Phone: _____ Relation to patient: _____

If Patient is a minor (less than 18 years old):
Age of minor: _____Name of person completing form:_____

If Parent or Legal Guardian is unavailable to accompany minor to appointment, please list authorized caretaker(s):

Name: _____

Name: _____

I am aware that this permission can be revoked by me at any time.

Parent or Legal Guardian Signature: _____ Date: _____

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Name: _____ Date: _____

Medical Records Release

In order for TLC The Littleton Clinic to provide the best care possible, we may need to obtain your prior medical records. Please give this form to any pertinent prior practitioners.

Name _____

Address _____
Street City State ZIP

Home phone _____ **Work phone** _____

Date of birth _____

Please transfer my medical records as follows:

From: _____
_____
_____
_____
Fax: _____

To: TLC The Littleton Clinic
Attn: Medical Records
9200 W Cross Dr, Suite 315
Littleton CO 80123
Fax records to: (877) 673-1592

Records to be released:
_X_ Annual exam and Pap smear / Prostate
_X_ Last full lab profile
_X_ Last progress note
_X_ Pertinent Radiology
_X_ Health Maintenance List
___ All medical records
___ Other _____

I understand that my medical records are protected under state and federal confidentiality regulations. Disclosure of information regarding drug and/or alcohol abuse and treatment, confirmed sexually transmitted infections (including testing or treatment for HIV/AIDS), and diagnosis of mental illness or psychiatric care cannot be released without my written consent.

Please initial below if you **DO NOT** want any of the following records released. All applicable records will be released if nothing is marked.
_____ Drug and/or alcohol abuse, diagnosis or treatment
_____ HIV/AIDS testing and/or treatment
_____ Psychiatric care and/or mental illness
_____ Confirmed STI test results and/or treatment

This consent can be revoked by me at any time unless action has been taken in reliance on it. If not previously revoked, this consent will terminate in 90 days.

_____
Signature

_____
Date