

Douglas Family Medicine

"Providing health care for your entire family in Douglas County and the surrounding communities since 1990."

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Welcome To Our Office!

Please help us by legibly printing your information and complete all sections.

PATIENT INFORMATION

Patient Name: Today's Date:
Marital Status: S M D W Do you smoke? (check one) Yes No Quit
Patient Social Security Number:
Street Address: Apartment #:
City: State: Zip:
Date of Birth: Age: Driver's License State & #:
Home Phone Number: Work Phone Number:
Cell/Pager Number: Email Address:
Occupation: Employer:
Employer Address: Suite #:
City: State: Zip:

SPOUSE or PARENT INFORMATION

Name: Relationship:
Street Address: Apartment #:
City: State: Zip:
Date of Birth: Social Security Number:
Employer: Employer Phone/Ext:
Employer Address: Suite #:
City: State: Zip:

FINANCIAL RESPONSIBILITY

Responsible Party: Relationship to Patient:
Street Address: Apartment #:
City: State: Zip:
Phone Number: Social Security Number:
Date of Birth: Occupation:
Employer: Employer Phone:

Note: If you are 18-25 and list a parent as the responsible payor, are you a FULL-TIME student (12 credits or more?) Yes No

METHOD OF PAYMENT TODAY (check one) Cash Check Charge

Emergency Contact: Relationship:
Home Telephone: Work Phone/Ext:
Who referred you to our Office? (check one) Friend Relative Employer
Other/Name:
Who May We Thank for Referring You to Our Practice?

Please complete and sign the next page!

Patient Name: _____

Date of Birth: _____

INSURANCE INFORMATION

Please give your ID card to our receptionist to scan!

Please note: We do not bill "secondary" insurance companies. Use your EOB to submit.

Primary Insurance Company Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Policyholder's Name: _____

Policyholder Social Security Number: _____ **Policyholder's Date of Birth:** _____

Policy Identification Number: _____

Group Number: _____

Benefits Phone Number: _____

Pre-Certification Phone Number: _____

Effective Date of Coverage: _____

PLEASE UPDATE YOUR INFORMATION WITH THE RECEPTION STAFF WHENEVER IT CHANGES!

I AGREE TO PAY for any requested health care provided to me by **Douglas Family Medicine** at the time **any** services are rendered for non-HMO insurance. I understand that managed care HMO's, Point-Of-Service and Preferred Provider Organization health plans may have co-pays that I am responsible for when services are rendered to me and I agree to pay these on the day of service. I authorize payment directly to **Douglas Family Medicine** for my health insurance benefits.

Your Initials Here: _____

I AUTHORIZE Douglas Family Medicine to use, disclose and release my **Protected Health Information (PHI)** for the purpose of carrying out **Treatment, Payment, or healthcare Operations (TPO)** according to The Privacy Rule of our Federal Government during all visits to The Practice. I understand that I have a right to review the Practice's Privacy Notice, request restrictions and to revoke my consent in writing at any time. Additionally, I authorize the physician to discuss my treatment with other doctors and professionals involved in my treatment.

Your Initials Here: _____

AUTHORIZATION TO TRANSMIT MEDICATION INFORMATION ELECTRONICALLY: By signing this, you are agreeing to have medical information regarding your medical care with **Douglas Family Medicine** transmitted electronically in a highly secure and encrypted manner. This information is transmitted using HCFA and HIPPA healthcare guidelines for transmission to the parties authorized by you for your paper or electronic record to receive your health insurance claim.

Your Initials Here: _____

I acknowledge that I received the HIPAA Notice of Privacy Practices for **Douglas Family Medicine**. My questions have been answered to my satisfaction.

Your Initials Here: _____

Date

Patient / Parent Signature as Agreed to Above