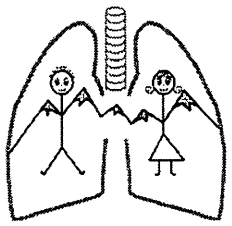

Helping your child...with inspiration!

Rocky Mountain Pediatric Pulmonology
4545 E. 9th Ave., Suite 504
Denver, CO 80220
Tel: 303-831-9853 Fax: 303-832-3533

With Colorado satellite offices in Lone Tree, Castle Rock, Louisville, Ft Morgan and Co Springs

Doctor (please check one): Lee S. Rusakow, M.D. _____ Margarita Guarin, M.D. _____

Today's Date: _____ **Specific Reason for Visit:** _____
(Example: Asthma, Cough, Shortness of Breath)

Patient Information

First Name: _____ M.I. _____ Last Name: _____ DOB: _____
Sex: Male ☐ Female ☐
Race: ☐Amer Indian/Alaska Native ☐Asian ☐Black/African Amer ☐Hispanic/Latino ☐Native Hawaiian ☐White ☐Other
Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Other
Address: _____ City: _____ State: _____ Zip: _____
Primary Phone: _____ Type: Home / Mom Cell / Dad Cell / Work / Other
Ok to leave message: Yes or No
Secondary Phone: _____ Type: Home / Mom Cell / Dad Cell / Work / Other
Ok to leave message: Yes or No
Email Address: _____
Patients Home Care Company (Oxygen): _____

Parent/Guardian Information

Mother's Name: _____ DOB: _____
Employer: _____ Work Phone: _____
Father's Name: _____ DOB _____
Employer: _____ Work Phone: _____

Emergency Contact

Contact Name: _____ Contact Phone: _____
Relationship to Patient: _____

Insurance Information

Primary Insurance: _____ ID #: _____ Group #: _____
Secondary Insurance: _____ ID #: _____ Group #: _____
***We will bill your insurance as a courtesy to you. It is your responsibility to know your benefits and you are ultimately responsible for payment if not covered. Please be prepared to make payment or copayment at the time of service.**

Physician Information

Were you referred to us by a Doctor, Clinic, ER or Hospital? ☐ Yes ☐ No
If no, are you requesting this consultation yourself? ☐ Yes ☐ No

Referring Physician:
Physician Name: _____
Name of Practice: _____
Address: _____
City/State/Zip: _____
Phone: _____
Fax: _____

Primary Physician: ☐ Same as Referring
Physician Name: _____
Name of Practice: _____
Address: _____
City/State/Zip: _____
Phone: _____
Fax: _____

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Office Policies

Appointments:

We make every effort to see our patients on time, but we need your help in doing so! **We ask that all patients (even established patients) arrive 15 minutes early.** This will allow the staff to update your address/ insurance information and check the patient's vital signs. Arriving early to your appointment will allow you to spend more time face to face with your provider. Please initial the following.

_____When one patient arrives late it can affect the schedule for the rest of the day. Therefore, patients arriving 15 minutes or more after their appointment time will need to reschedule. We apologize for any inconvenience this may cause.

All patient appointments are very valuable and very much in high demand. In an effort to serve you better, we ask for proper notice for any cancellation.

_____ Patients failing to provide at least 24-hour notice will be charged $50.00 for any missed appointments (no show) in the Denver (Rose) office. For missed appointments in Ft. Morgan, Avista(Coal Creek), Colorado Springs, Castle Rock and Lone Tree the charge will be $60.00.

_____ Patients who give same day cancellation notice will be charged $25.00 (less than the missed appointment fee).

Insurance:

We understand that health insurance benefits can be very frustrating and confusing and can lead to misunderstanding or conflict between our office and our patient. Please initial the following.

_____ Please keep us updated on any insurance changes that may happen. If your benefits include a co-pay we ask that the co-pay be paid at time of check in.

_____ We ask that you call and confirm that our providers are in-network with your health benefits plan. We accept all major insurance carriers but it is your responsibility to make sure we are in-network.

_____ Please be aware that only PPO's do not require a referral. All other plans will need a referral in order to be seen. Your primary doctor will need to be the one who submits for a referral. If you schedule an appointment with no referral you will be responsible for the balance.

Patient Balance:

_____ If a patient has a balance over $100.00, it must be paid by the time of next visit. We understand that some families may experience financial hardships. If payment cannot be made, the responsible party will need to speak with our billing department at 1-888-701-8826 ext 108 to set up a payment plan.

Patient Name: _____ Date of Birth: _____

Parent Signature: _____ Date: _____

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Preferred Pharmacy Information

Pharmacy Name: _____

Address: _____

Telephone: _____

Fax: _____

e-Prescribing allows your physician to send eligible new prescriptions and refills to your pharmacy electronically. It is a highly convenient process that maximizes prescription accuracy and eliminates the need for patients to keep up with paper prescriptions. It significantly lessens the wait time associated with dropping off prescriptions to your pharmacy after your visit or having a staff member call it in. prescriptions arrive to your pharmacy instantaneously.

You may also wish to allow your physician to have electronic access to your medication history using the Surescripts Network. With your consent, your doctor will be able to view critical information about your past and current prescriptions. This will improve your safety and quality of care (e.g. preventing potentially harmful drug interactions or intolerances)

Authorization for electronic access to medication history

_____ I consent to allowing my physician to electronically view my medication history through Surescripts

_____ I do not consent to sharing any medication History

_____ I would like a copy of this notice for my records

Patient Name: _____ Date of Birth:_____

Signature:_____ Date: _____

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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.

This notice is effective as of 04/14/2003

USES AND DISCLOSURE OF HEALTH INFORMATION TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Rocky Mountain Pediatric Pulmonology, PC uses and discloses your child's protected health information or your information if you are at least 18 years old for treatment, payment and health operations. Some examples of when our office may use or disclose your child's health care information for these purposes include.

- Sharing test results with other health care providers for confirmation of a diagnosis.
- Providing your diagnosis or other information about your health to your insurance provider or our billing service to obtain payment for the health care services that were provided.
- Reviewing information as part of our quality improvement program.

OTHER USES AND DISCLOSURES

Rocky Mountain Pediatric Pulmonology, PC may also use or disclose your protected health information, in compliance with guidelines outlined by law, for the following purposes:

- Providing you with information related to you or your child's health.
- Contacting you regarding appointments, information about treatment alternatives, or other health related services.
- Incidental uses or disclosures (e.g., listing your or your child's name on a sign-in sheet, ect.)
- Compliance with all laws (including reports of suspected abuse, neglect, or violence)
- Providing certain specific information to law enforcement or correctional institutions.
- Providing information to a coroner, medical examiner, funeral director, or organ procurement organization.
- Public health activities when requested by a public authority or the FDA
- Responding to health oversight agencies.
- Responding to court or administrative tribunal orders, subpoenas, discovery requests or other lawful process.
- Research activities.
- When necessary to avert a serious threat to health or safety.
- Military affairs, veteran affairs, national security intelligence, Department of State or Presidential protective service activities.
- Providing information regarding your or your child's location, general condition or death to public or private disaster relief agencies.
- Informing a family member, or other relative to the individual's involvement with your care.
- Notification of your location, general condition or death.
- To assist in your or your child's health care (e.g.,, pick-up prescriptions or other documents, note follow-up care instructions, etc.)

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AUTHORIZATION FOR OTHER USES

Rocky Mountain Pediatric Pulmonology will make other uses and disclosures of your protected health information only after obtaining your written authorization. If you authorize a use not contained in this notice, you may revoke that authorization at any time by notifying us in writing that you wish to revoke that authorization.

YOUR RIGHTS REGARDING THE PRIVACY OF YOUR HEALTH INFORMATION

Subject to limitations outlined by law, you have certain rights regarding that use and disclosure of your or your child's protected health information, including the right to:

- Request restrictions on certain uses and disclosures. However, Rocky Mountain Pediatric Pulmonology is not obligated to agree to requested restrictions.
- Receive confidential communications of protected health information.
- Inspect and copy your protected health information with some limited exceptions.
- Amend your health information.
- Receive an accounting of disclosures of your health information.
- Obtain a copy of this notice

ROCKY MOUNTAIN PEDIATRIC PULMONOLOGY DUTIES REGARDING THE PRIVACY OF YOUR HEALTH INFORMATION

Subject to limitations outlined by law, Rocky Mountain Pediatric Pulmonology has certain duties related to your protected health information, including:

- Rocky Mountain Pediatric Pulmonology is required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.
- Rocky Mountain Pediatric Pulmonology is required to abide by the terms of the private notice that is currently in effect.
- Rocky Mountain Pediatric Pulmonology reserves the right to change a privacy practice described in this notice and to make such changes effective for all protected health information. Revised notice will be posted in our office and available upon request.

CONCERNS

If you believe your privacy rights have been violated, you may make a complaint by contacting the Secretary for the Department of Health and Human Services. No individual will be retaliated against for filling a complaint.

ACKNOWLEDGEMENT

I acknowledge that I have read this notice regarding the use and disclosure of my or my child's health information.

Patient Name: _____ Date of Birth: _____

Responsible Party Signature: _____ Date: _____

Responsible Party Name: _____ Relationship: _____

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Patient Consent Form

- I understand, hereby consent to the following Treatment:
  - Administration and performance of all treatments.
  - Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient.
  - Use of prescribed medication.
  - Performance of diagnostic procedures/tests and cultures.
  - Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgement of the attending physician or their assigned designees
- I fully understand that this is given in advanced of any diagnosis or treatment.
- I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommened. The consent will remain in full force until revoked in writing.
- I understand that Rocky Mountain Pediatric Pulmonology may include consent at satellite offices under common ownership.
- I understand acknowledse that Rocky Mountain Pediatric Pulmonology will use and disclose my information for the purposes of treatment, payment and healthcare operations as describe in the Notice of Privacy Practices.
- A photocopy of this consent shall be considered as valid as the original.

I acknowledge that I have been given Rocky Mountain Pediatric Pulmonology Notice of Privacy Practices. **Responsible Party Initials**: _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Name: _____ Date of Birth: _____

Responsible Party Signature: _____ Date: _____

Responsible Party Name: _____ Relationship: _____