LITTLETON PEDIATRIC MEDICAL CENTER

Patient Information Sheet

THANK YOU VERY MUCH FOR COMPLETING THIS FORM.
IT IS AN IMPORTANT PART OF YOUR RECORDS.
PLEASE PRINT - USE FULL NAME - NO NICK NAMES.

Is The Patient: **Alaskan Native** Y / N **American Indian** Y / N

TODAY'S DATE

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE	PHONE (AREA CODE) ( )
STREET ADDRESS			APT.
CITY	STATE	ZIP CODE	SOCIAL SECURITY NUMBER
BIRTH DATE	SEX(CIRCLE ONE) M F		
FATHER'S NAME	HOME PHONE	WORK PHONE	EMAIL:
MOTHER'S NAME	HOME PHONE	WORK PHONE	EMAIL:
FATHER'S BIRTH DATE	FATHER'S SOCIAL SECURITY	MOTHER'S BIRTH DATE	MOTHER'S SOCIAL SECURITY
IF THIS IS A NEW PATIENT, HAVE ANY OF YOUR OTHER CHILDREN BEEN SEEN PREVIOUSLY BY OUR PHYSICIANS? YES NO		CHILD'S FIRST AND LAST NAME	

PERSON TO CONTACT IN CASE OF EMERGENCY (NOT LIVING WITH YOU)

NAME	HOME PHONE	WORK PHONE

PERSON RESPONSIBLE FOR BILLING

LAST NAME	FIRST NAME	BIRTH DATE	SOCIAL SECURITY NUMBER	HOME PHONE
STREET ADDRESS		CITY	STATE	ZIP CODE
RELATIONSHIP TO PATIENT	EMPLOYER			WORK PHONE

HEALTH INSURANCE

HEALTH INSURANCE (MARK ONE) ☐ PATIENT ONLY ☐ ENTIRE FAMILY AMOUNT OF COPAYMENT Reg. Hours: $_____
After Hours: $_____

NAME OF INSURANCE CO. _____

GROUP # _____ SUBSCRIBER # _____

SUBCRIBER NAME _____ EFFECTIVE DATE _____

PRIMARY PHYSICIAN'S NAME _____

IF THIS IS NEW INSURANCE INFORMATION, WHEN DID YOUR PREVIOUS COVERAGE TERMINATE ? DATE _____

OTHER CHILDREN COVERED BY PLAN	DATE OF BIRTH	OTHER CHILDREN COVERED BY PLAN	DATE OF BIRTH

In that my son/daughter is a minor (less than eighteen (18) years of age and primarily supported by parent or guardian), I agree and understand that he/she may be treated by any other physician associated here. This may include physical and laboratory tests, x-rays, minor surgery, immunizations, and prescription medications in my absence. Littleton Pediatric Medical Center has my consent to leave messages pertaining to my child's clinical care or account information on designated answering machine, voice mail, or fax numbers. This agreement will be in effect until revoked by me in writing. If for some reason the coverage with my insurance company is not effective for the above person(s), I agree to pay for any charges incurred in this office. When applicable, I authorize LPMC to file insurance claims.
I have had the opportunity to read LPMC's Privacy Practice Policy on the back of this form.

SIGNATURE OF PATIENT OR GUARDIAN	DATE
RELATIONSHIP TO PATIENT	

LP-123

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required to keep your health information secure and confidential, by law. Also by law, we need to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your treatment of progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your treatment information into our computer system.

We may share your medical information with our business associates. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send information to you. We may also call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person that answers the phone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We will need to release some or all of your health information, when required by law.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose some or all of your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

You have the right to receive communication about your health information in the manner you prefer. We will also use whatever communication method, number or system you prefer to contact you.

You have the right to transfer a copy of your health information to another practice. Notify us in writing of where you would like to send a copy of your health information for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a report of who we disclose your information to.

If our privacy and security measures or systems are breached in any way, we will notify you.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services in writing (200 Independence Avenue SW, Room 509F, Washington DC 20201), online (http://www.hhs.gov) or by email (OCRComplaint@hhs.gov). You will not be retaliated against for filing a complaint.

Please contact our Privacy Officers, Geneva E. Elder or Nita D. O'Brien, R.N. at 303-791-9999 for more information, to make a request, to file a complaint with us or for assistance regarding your health information policy.

BILLING FOR SERVICES PROVIDED

Insurance plans' requirements and coverage are ever changing. Your insurance plan **may or may not** cover all routine preventative services. We are legally obligated to assign procedure and diagnosis codes based on the services provided to you. Please keep in mind, while the appointment may be just for a physical or just for illness, if both kinds of services are provided during a visit, then **both services may be billed.**

Patient/Guardian Signature	Date of Birth	Today's Date