ADULT PATIENT REGISTRATION

(Please Print)

Date: ____________________

PATIENT: ______________________________________
(Last Name, First Name, Middle Initial)

Date of Birth: ___________________ ____Male ____Female Email: ________________________________

SSN: ______________________________________ ___Single ___Married ___Separated ___ Divorced

Street Address/P.O. Box: ____

City: ____ State: _________ ZIP Code: ____________________

Home Phone: _________________________________ Cell Phone: ________________________________

Employer: ___________________________________ Business Phone: ______________________________

Street Address/P.O. Box: ____

City: ____ State: _________ ZIP Code: ____________________

Medical Insurance

Name of Insured/Responsible Party: ______________________________ Relationship to Patient: _____________

Date of Birth: ___________________________________ SSN: ____________________________________

Street Address/P.O. Box: ____

City: ______________________________________ State: _________ ZIP Code: ____________________

Home Phone: _________________________________ Cell Phone: ________________________________

Primary Insurance Company: ____

Policy Holder's Name: _________________ Subscriber #: __________________ Group #: _______________

Secondary Insurance Company: ____

Name: ________________________ Subscriber #: _____________________ Group #: __________________

Preferred Pharmacy:__________________________ **Phone #**__________________**Policy** #___________________

In case of emergency, who should be notified? _____________________________ Phone: ____________________

How did you learn about our practice? ____

ASSIGNMENT AND RELEASE / MEDICARE AUTHORIZATION

I request that payment of authorized medical benefits to include all Medicare benefits be made on my behalf to Matthews-Vu Medical Group for any services furnished me. I authorize any holder of medical information about me to release to the insurance payor and/or the Center of Medicare and Medicaid Services or its agents any information needed to determine benefits payable for billed services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. My signature authorizes the release of information to the insurer or agency shown in Medicare assigned cases, Matthews-Vu Medical Group agrees to accept the determination of the Medicare carrier. The patient is responsible for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based on the charge determination of the Medicare carrier.

____ ____
Signature of Insured/Guardian Date

ADULT HEALTH HISTORY

Patient Name	Date of Birth	Date Today
Medications taken regularly (include doses)		
Allergies to Medications		
Ongoing Medical Problems		
Previous Surgeries		
Occupation	**Marital Status**	

Immunizations and Personal Habits

	Yes	No	Date		Yes	No	Amount / Frequency
Flu				**Smoke**			
Pneumonia (Pneumococcal-23)				**Drink Alcohol**			
Pneumonia (Prevnar-13)				**Street Drugs**			
Tetanus (Td)				**Marijuana**			
Tetanus-Diptheria-Pertussis (TDaP)				**Exercise**			
Shingles (Zoster Vaccine)				**Drink Coffee/Cola**			
Allergic reactions to vaccine(s)?							
If yes, which vaccine(s)?							

Preventive Screening History

	Date		Yes	No	Date
Last Colonoscopy		**Last Pap Smear** Abnormal?			
Performed by:		**HPV testing** Abnormal?			
Last Bone Density testing		**Performed by:**			
Performed by:		**Hysterectomy** Cervix removed?			
Last Abdominal Aorta Aneurysm (AAA) Screening		**Performed by:**			
Performed by:		**Last Mammogram** Abnormal?			
		Performed by:			

Patient Signature

Personal Health Are you troubled by any of the following?

General	Yes	No
Extreme tiredness		
Unexplained weight loss		
Extreme thirst		
Lumps or swelling		
If yes, where?		
Other		
Skin and Hair	**Yes**	**No**
Repeated skin rash		
Repeated sores		
Moles that have changed		
Other		
Eyes, Ears, Nose, Throat	**Yes**	**No**
Hearing loss		
Ringing in ears		
Vision disturbance		
Repeated nose bleeding		
Nasal stuffiness/drainage		
Severe dental problems		
Hoarseness or voice changes		
Trouble swallowing		
Date of last eye exam		
Performed by:		
Other		
Heart, Lungs, Circulation	**Yes**	**No**
Chronic cough		
Coughing up blood		
Abnormal chest x-ray		
Wheezing		
Chest pain		
Shortness of breath		
Irregular heartbeat		
Heart murmur		
Leg cramps while walking		
Ankle swelling		
Other		

Kidney, Bladder, Reproductive	Yes	No
Difficult or painful urination		
Urination more than once at night		
Trouble holding urine		
Bladder or kidney infection		
Blood in urine		
History of kidney stones		
Problem with sex function		
Sores or discharge		
Problems having children		
Sexually active		
If yes, type of contraception		
Other		
Skeleton and Joints	**Yes**	**No**
Swollen or painful joints		
Gout		
Back trouble		
Difficulty walking		
Bursitis or tendonitis		
Other		
Nervous System	**Yes**	**No**
Frequent or severe headaches		
Loss of balance		
Unexplained dizziness		
Fainting (blackout)		
Head injury		
Twitching or tremors (shaking)		
Numbness/Tingling in hands/feet		
Stress or nervousness		
Feeling depressed		
Thoughts of suicide		
Forgetfulness		
Difficulty concertrating		
Have you had counseling?		
Do you desire counseling?		
Other		

Stomach and Bowels	Yes	No
Poor appetite		
Heartburn		
Repeated abdominal pain		
Tarry (black) stool		
Frequent nausea or vomiting		
Changes in bowel movements		
Constipation		
Frequent diarrhea		
Rectal bleeding		
Last Colonoscopy		
Performed by:		
Other		
Women Only	**Yes**	**No**
Irregular periods		
Severe cramps		
Hysterectomy		
If yes, partial or total?		
Date of hysterectomy		
	Date	
Last Pap Smear		
Abnormal Pap Smear		
HPV Testing?		
Performed by:		
Last Mammogram		
Abnormal Mammogram		
Performed by:		
Last Bone Density Testing		
Performed by:		
Men Only	**Yes**	**No**
Swelling or Tenderness of the scrotum or testicles		
Prostate trouble		
Vasectomy		
	Date	
Last Abdominal Aorta Aneurysm (AAA) Screening		
Performed by:		

Patient Signature

Physician Comments

Physician Signature

HIPAA ACKNOWLEDGEMENT NOTICE

PLEASE DO NOT SIGN THIS NOTICE UNTIL YOU HAVE COMPLETELY READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES

I understand that under the Health Information Portability & Accountability Act of 1996 (HIPAA), I have certain rights to my Protected Health Information and how it is used. I understand that this information can and will be used by Matthews-Vu Medical Group and staff to carry out treatment, payment or healthcare operations.

I understand that I may refer to the Notice of Privacy Practices for a more complete description of these uses and disclosures. I acknowledge that I have been informed and read the Notice of Privacy Practices in its entirety prior to signing this consent.

I understand that I may request in writing that you restrict how my private information is used and disclosed. I also understand that the office of Matthews-Vu Medical Group are not required to agree to my requested restrictions, but if they do agree then they are bound to abide by such restrictions. I understand that if this request is granted and information needed to carry out payment for treatment is restricted, this office exercises its right to collect payment for those services in full prior to services being rendered. I also understand that it will be my responsibility to seek reimbursement for those services from my insurance company.

I understand that Matthews-Vu Medical Group reserves the right to amend the Notice of Privacy Practices from time to time and that I may, at any point, request a copy of the current Notice.

I understand that I may revoke this consent in writing at any time, except to the extent that the covered entity has taken action in reliance of poor consent and authorization. I understand the consent musts be signed in person with the Privacy Officer or in written form and sent via certified return receipt mail to the attention of the Privacy Officer named.

____ ______________________________

Signature of Patient/Personal Representative Date

____

Printed Name

Notice of Privacy Practices – Consent to Share

We at Matthews-Vu Medical Group, are committed to safeguarding the privacy and confidentiality of your medical records including the personal information you share with us. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

To assist us in protecting your privacy, please complete the following: (***please print***)
Patient Name ____Date of Birth: _____________

Preferred Contact number(s): May we leave a detailed message? Y N (***circle one***)

Home: ______________________ Cell: ______________________ Work: ___________________
Yes No Yes No Yes No

Please list the people that we have your permission to discuss your medical records and are allowed to have a copy of your information:

Name of person (s)/Relationship	Date of Birth	Phone Number (if available)

This authorization applies to the following information: (***please initial***):
All Records _______ Labs ________ Imaging Records ________ Immunizations_______

Mental Health/Behavioral Health _______ Substance Abuse ______

I have been made aware and have had the opportunity to review the privacy policies of Matthews-Vu Medical Group.

Patient/Guardian Signature: _____________________________________ Date: _______________

Print Name: ____

Matthews-Vu
Healthcare for Children and Adults
4190 East Woodmen Road, Suite 100
Colorado Springs, CO 80920
Phone: 719-632-4455
Fax: 719-633-4613

Consent for Patient Reminders and Notifications

You are consenting to receive messages from Matthews-Vu Medical Group, your healthcare provider, which utilizes an automatic telephone dialing system to deliver a text, voice or pre-recorded message that may contain health related information or healthcare management advice at the telephone number(s) that you have provided. You understand that you are not required to provide consent in order to receive such information or advice from your healthcare provider.

Terms & Conditions
Your request to receive automated voice and text message from Matthews-Vu Medical Group, your healthcare provider, constitutes your agreement to these terms and conditions. You agree that we may send you automated voice and text messages through your wireless provider to the valid mobile or landline number that you have provided us. You agree to indemnify, defend and hold us, our technology service vendor – healow LLC, our electronic medical record vendor – eClinicalWorks LLC and it affiliated companies harmless from any third-party claims, liability, damages or costs arising from your request to receive automated voice or text messages or from providing Matthews-Vu Medical Group with a phone number that is not your own. You agree that we and our technology solutions vendors will not be liable for failed, delayed or misdirected delivery of any information sent to you or from you, including opt-out requests. You must be 18 years or older in order to participate. This is a standard-rate messaging program where message and date rates may apply. Frequency of messages may vary depending on the number of messages that you are due to be sent by your healthcare provider.

Supported carriers include AT&T, Verizon Wireless, T-Mobile®, Metro PCS®, Sprint, Boost, Virgin Mobile, U.S. Cellular® and others. Additional carriers may be added at any time. Carriers are not liable for delayed or undelivered messages.

Frequently asked questions:

What sort of messages can we send you?
As your healthcare provider, our goal is to stay in touch with your even when you're not in their office. To keep the lines of communication open and based on need, we can send you messages via voice SMS/text, email and secure messages on the Patient Portal and using healow. Example of communication from our practice can include: appointment reminders, prescription refill messages and health/wellness notifications for test or other procedures. We respect your need for privacy and will <u>not</u> send you telemarketing related messages or share your contact details with anyone.

What does it mean when you opt-in or activate?
By choosing to opt-in for voice and or text messages from Matthews-Vu Medical Group, you are consenting to receive phone, text and/or other electronic messages to the number we have on file for you. We have chosen to use this automated service reminders offered by healow and eClinicalWorks. Please direct all your communication directly with us and not our technology vendor companies.

Please note: *Phone, emails and text messages are considered unsecure methods of contact and may result in disclosure of sensitive information to unauthorized individuals. You are assuming the risk involved by activating these services and will not hold the practice responsible.*

Can you turn off these services later?

Yes, simply contact Matthews-Vu Medical Group and ask to adjust your communication preferences. You can also text **STOP** on reply to a text message that you receive from us. **On texting STOP**, your phone number will be unsubscribed from this service and you will not receive any further health and wellness messaging notifications via text.

What if you need further help?

Please note that these services are either simply to remind you of important or necessary steps that you need to take for living a better, healthier lifestyle or for offering you convenient ways to connect with Matthews-Vu Medical Group outside the walls of our clinic. If there is ever an emergency, or if you need help, please call 911.

Did you know simple steps you take can protect your health information online?

Password protect any device from which you review or download your health information, both on your mobile phone and home computer. Make sure your password meets the criteria for a strong, secure password which means it consists of at least six characters and uses a combination of letters, numbers and symbols. Also, if you are using a public computer to access your health information, be sure to log out.

❑ OPT IN I wish to receive notification/reminder messages from Matthews-Vu Medical Group

❑ OPT OUT I do ***not*** wish to receiving notification/reminder messages from Matthews-Vu Medical Group

____ ___________________________________

Patient/Guardian Signature Date

____

Print Name

Patient Name**: ________________** **Date of Birth: ____________**

Financial Payment Policy

Thank you for choosing Matthews-Vu Medical Group as your primary care provider. As part of our commitment to offer quality medical and affordable health care, we are also committed to building a successful provider-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is part of that relationship. If you have any questions about our fees, or your responsibilities, please ask. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc.)

1. **Insurance** – Our office participates in many insurance plans. If you are not insured by a plan we have a contract with, payment in full is expected at each visit. If you are insured by a plan we are contracted with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Your insurance benefits is a contract between you and your insurance company; we are not party to that contract. Failure to provide complete insurance information results in patient responsibility for the entire bill. Please contact your insurance company with any questions you may have regarding your coverage. As a courtesy, we will file all applicable office charges with your insurance company. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If the provider deems **medical necessity** for certain services/test and these services/tests are not covered or not considered reasonable or necessary by insurers, the patient is financially responsible.

2. **Co-payments and deductibles** – **All co-payments, deductibles and/or co-insurance must be paid at the time of service**. We accept Cash, Checks, Master Card, Visa, American Express or Discover. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us uphold the law by paying your co-payments at each visit. Patients with **high deductible health insurance plans** will be required to pay a deposit of $70 for each visit (unless you have a letter from your insurance company stating you have reached your deductible). Patients are responsible for working with their insurance company to know if they have reached their deductible. If a patient pays $70 and the insurance company determines the patient has already met this year's deductible, the business office will issue a refund. If you are not able to pay at the time of service you must call the business office and set up a payment plan prior to your appointment.

3. **Self-pay Accounts** – Patients without insurance coverage, or patients without an insurance card on file with our practice. It is the patients' responsibility to know if Matthews-Vu Medical Group participates with their health insurance plan. Self-pay patients will be required to make a deposit of $70 prior to appointment. After the visit, the patient will be required to pay the estimated remaining balance. After the claim has been reviewed by the business office coding team, a final bill will be determined and reconciled against the payment paid at time of service. If a balance is due from patient, the business office will submit a statement to the self-pay patient. If a credit balance is owed to the patient, the business office will issue a refund.

4. **Missed Appointments** – Matthews-Vu Medical Group requires 24-hour notice of appointment cancellation. Appointments missed that are not previously canceled may be charged a fee of $50.00. Please help us to serve you better by keeping your regularly scheduled appointment. If we determine a patient is an habitual offender of missed appointments, then we will request a $50.00 deposit prior to scheduling the next appointment.

5. **Return Checks** – The charge for a returned check is $30 payable in cash or credit card. This will be applied to your account in addition to any bank-insufficient-funds charge incurred by the practice. You may be placed on a cash or credit card only basis following any returned check.

6. **Outstanding Balance Policy** – Patients will receive a monthly statement with any outstanding balance of $5.00 or more. Please be aware that the balance after insurance pays is the patient's responsibility. If your insurance company does not pay your claim in 60 days, the balance may be billed to you. Patients can make payments by paying with check or by going online and using the patient portal to process a credit card payment. Patients can also call the billing office at (719)884-2799 to process a credit card payment over the phone. We accept Checks, Master Card, Visa, American Express or Discover. If your account becomes past due over 60 days, you will receive a phone call. On a case by case basis, a payment plan can be established with a credit card on file.

7. **Nonpayment** - If there was no attempt on the patient's behalf to contact and set up a payment plan, and your account is over 90 days past due, you will receive a letter stating you have 20 days to pay your account in full. Please be aware that if the balance remains unpaid, we may refer your account to a collection agency (patient responsible for collection fees) and you and your immediate family members may be discharged from this practice. If this occurs, you will be notified by regular mail that you have 30 days to find alternative medical care. During that 30-day period, our providers will only be able to treat you on an emergency basis.

This financial policy helps the office provide quality care to our valued patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

______________________________ ____________________

Patient/Guardian Signature Date

Matthews-Vu
Healthcare for Children and Adults

(Incoming Records)

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient: ______________________

Date of Birth: ______________ **SSN:** ______________

Requesting Records from:	**Where to send the records to:**
Name/Facility : ______________________	Matthews-Vu Medical Group
Attention: ______________________	Attention: Medical Records
Address: ______________________	4190 E Woodmen Rd, Ste 100
City:__________State:______ Zip:______	Colorado Springs, CO 80920
Phone: ( )________ Fax: ( )________	Phone: (719)632-4455 Fax: (719)633-4613

Please send records from the following date range: from: ____________ to: ____________

☐ All ☐ History and Physical ☐ Consultation Notes
☐ Progress Notes ☐ Labs ☐ Other:______________

Purpose of requested use or disclosure: ☐ Continuing Care ☐ Patient Request*
☐ Insurance* ☐ Legal* ☐ Other

***Copy Fee:** We reserve the right to charge a reasonable fee for the cost of producing and mailing the copies. Base fee of $20.00 per chart for personal records. Please make checks payable to Bactes.

I specifically authorize release of the following information (check and initial as appropriate):

☐ Mental health treatment information — Initial if requesting: ____________
☐ HIV test results — Initial if requesting: ____________
☐ Alcohol/drug treatment information — Initial if requesting: ____________

*If not checked and initialed, the records containing such information can NOT be released.

Duration: This Authorization expires [insert date]: ______________________
*If no Date is given; this authorization will expire 6 months from the signature date.

Revocation: I may revoke this authorization at any time, but I must do so in writing and submit it to Matthews-Vu. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

Re-disclosure: Information disclosed pursuant to this authorization could be re-disclosed by the recipient and no longer protected by federal privacy regulations.

Conditioning: I may refuse to sign this Authorization. If I refuse to sign this Authorization, I should know that by law, my health information cannot be released. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

This authorization is being requested of you to comply with the terms of the Confidentiality of the Medical Information Act of 1981, Civil Code Section 56 et seq. and the Health Insurance Portability and Accountability Act (HIPAA) of 2003.

Patient Signature: ______________________ **Date:** ____________

Legal Representative Signature: ______________________ **Relationship to Patient:** ____________

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