ADVANCED INTEGRATIVE MEDICINE

REGISTRATION FORM

(Please Print)

Today's date:				PCP:		
PATIENT INFORMATION						
Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Social Security no.:	Home phone no.: ( )			
City/ State	Zip Code:	Cell phone: ( )	Preferred number for voice contact: Home Cell Work			
Occupation:	Employer:	Employer phone no.: ( )				
PHARMACY INFORMATION:	LOCAL PHARMACY NAME:	CITY:	PHONE:			
	MAIL ORDER PHARMACY:	PHONE:				
Other family members seen here:	Chose/referred to our clinic because:					
Email Address:						

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )		
Is this person a patient here? ❑ Yes ❑ No					
Occupation:	Employer:	Employer address:	Employer phone no.: ( )		
Is this patient covered by insurance? ❑ Yes ❑ No					
Please indicate primary insurance					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:		
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I understand that payment is my responsibility regardless of insurance coverage. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency and may be dismissed from AIM. I understand that any missed appointments without 24 hour notice will result in a $25 or $75 fee, depending on visit type. A $15 returned check fee will be charged for checks returned due to insufficient funds. I also authorize ADVANCED INTEGRATIVE MEDICINE or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

PLEASE BE AWARE YOUR INSURANCE MAY BE CHARGED BETWEEN $301-$379 FOR THIS INITIAL VISIT (OR YOU CAN PAY OUT OF POCKET)

10455 Park Meadows Drive Unit 102
Lone Tree, Colorado 80124

HIPAA Privacy Rights Form

PATIENT INFORMATION

Date

Name (Last, first, middle initial)

Social Security # or Patient ID

Street address, City, ST, ZIP Code

Primary phone number | Other phone number

Email address

Please list below how you would like to be contacted with results or medical issues:

☐ Home Phone_____ ☐ Cell phone_____ ☐ Text Message
☐ Work Phone_____ ☐ _____ ☐ _____

Please list below the person or persons that may receive your test results or whom we may discuss your medical issues with:

Please list the phone numbers you authorize Advanced Integrative Medicine to call and leave test results, confirmation calls, or detailed medical issues on:

Phone number — Date

Phone number — Date

I authorize Advanced Integrative Medicine to leave medical results on my personal voicemail YES NO

I have read the Notice of Privacy Practices YES NO

SIGNATURE: DATE:

Privacy Official signature — Date

Attach additional documentation, if applicable.

AUTHORIZATION TO RECEIVE MEDICAL INFORMATION ONLINE OR BY FIRST CLASS US MAIL

1. RISK OF USING THE INTERNET OR FIRST CLASS US MAIL TO RECEIVE MEDICAL RECORDS. Advanced Integrative Medicine, PC (the "Practice") offers patients the opportunity to receive medical records (including lab results) online or by first class US mail. Transmitting patient information online or by first class US mail, however, has a number of risks that patients should consider before using these methods (the "Risks"). These Risks include, but are not limited to, the following:

- Storing patient records online can be subject to theft by third party hackers (who may then try to sell or publicize such records);
- If you do not properly secure your login and password, others may be able to access your records;
- First class US mail can be lost, stolen or delivered to the wrong address, potentially resulting in third parties having access to your records.
- First class US mail may be opened by others living or visiting at your address.

2. CONDITIONS FOR THE USE OF THE INTERNET AND FIRST CLASS US MAIL. The Practice will use reasonable means to protect the security and confidentiality of records stored online or sent by first class US mail. However, because of the Risks outlined above, the Practice cannot guarantee the security and confidentiality of receiving records online or by first class US mail, and will not be liable for improper use and/or disclosure of your confidential medical information (including Protected Health Information that is the subject of the federal Health Insurance Portability and Accountability Act of 1996, as amended) that is not caused by the Practice's intentional misconduct. Thus, patients must consent to receiving medical records online or by first class US mail. The patient is responsible for informing the Practice of any types of information the patient does not want to be received online or by first class US mail. The patient is also responsible for protecting his/her password or other means of access to online records and taking precautions to preserve the confidentiality of online access, such as using screen savers and safeguarding his/her computer password. The Practice is not liable for breaches of confidentiality caused by the patient or any third party.

3. PATIENT ACKNOWLEDGMENT AND AGREEMENT I acknowledge that I have read and fully understand the information the Practice has provided me regarding the Risks of receiving medical records online or by first class US mail. I understand such Risks and consent to the conditions outlined in this document. In addition, I agree to the instructions outlined above, as well as any other instructions that the Practice may impose regarding these matters.

_____ _____

Signature of patient or personal representative Date

_____

Printed name of patient or personal representative and his or her relationship to patient

ADVANCED INTEGRATIVE MEDICINE

Patient Financial Obligation Consent

I _____ on this day_____of _____, 2018, fully understand that my Advanced Integrative Medicine account is my full responsibility to pay, at either time of service or when first billed.

I authorize my insurance benefits to be paid directly to the physician.

Please be aware that all copays are due at time of service. Also, if you have a deductible insurance plan, we will be collecting $70 towards the visit at your appointment time. This amount will be applied to your deductible for that date of service. This is until your deductible has been met for this year.

When I am billed, I understand this is what my insurance company will not cover under my plan, and that it is my responsibility to pay the remainder of said balance. Bills mailed to me are due upon receipt.

Failure to pay on my account within 90 days of notification, will result in a hold on all medication refills and appointments, until paid in full, for the remainder of the year.

Failure to pay the amount due, in full, may result in submission to a collection agency, and dismissal from AIM.

Missed appointments without 24 hour notice may result in a $25/$75 fee depending on the type of visit that was missed. A Check fee will be charged for returned checks or insufficient funds of $15.00.

I authorize AIM or my insurance company to release any information required to process my claims.

Printed Name: _____DOB:_____

Signature: _____ DATE:_____

PATIENT INFORMATION SHEET

ADVANCED INTEGRATIVE MEDICINE

NAME:_____ DOB:_____ DATE:_____

ALLERGIES:_____

SOCIAL HISTORY:

Recreational Drug Use: Current / Past / Never

Smoking: Currently Past Never Packs/day:_____ Exercise: times per week_____

Alcohol: Currently Past Never Drinks/day:_____ Occupation_____

Caffeine: Currently Past Never Drinks/day:_____

List ALL MEDICATIONS you take, including over the counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know please call your pharmacist to confirm

Medications/dose/frequency	OTC and Vitamins/dose/frequency

PREVENTATIVE HISTORY: (PLEASE FILL OUT WITH APPROXIMATE DATE)

Flu Vaccine	Date:	Measles Vaccine	Date:
Pneumovax(pneumonia)	Date:	Shingles Vaccine	Date:
Tdap Vaccine(tetnus,pertussis)	Date:	Tuberculin PPD skin test	Date:
Colonoscopy	Date: Normal/ Abnormal	Dxa (Bone Density)	Date: Normal/Abnormal
Female Patients:			
Last Menstrual Period	Date: Normal/ Abnormal	Mammogram	Date: Normal/Abnormal
Total number of pregnancies:		Pap smears:	Date: Normal/Abnormal
Total number of miscarriages or abortions:		Uses birth control:	

SURGERY AND PROCEDURE HISTORY: (circle)

NO prior surgical history	Colon surgery	Hernia	Tonsillectomy
Appendectomy	Gall Bladder surgery	Hysterectomy	Tubal ligation
Breast Lumpectomy	Heart surgery	Mastectomy	Vasectomy
Cataract surgery	Hemorrhoids	Back/ spine surgery	

OTHER HOSPITALIZATIONS/SURGERIES:_____

_____

PERSONAL MEDICAL HISTORY: (please circle/fill in all that apply)

ADHD	Dementia	Hernia	Parkinson's Disease
Alcoholism	Depression/Anxiety	Hepatitis	Peripheral Vascular
Allergies, Seasonal	Diabetes: 1 or 2	High Cholesterol	Peptic Ulcer
Anemia	Diverticulitis	High Blood Pressure	Psoriasis
Arthritis	DVT (blood clot)	HIV/Aids	Pulmonary Embolism
Asthma	Eczema	Irritable Bowel Synd.	Rheumatoid Arthritis
Bipolar	Emphysema/COPD	Kidney Disease	Sciatica
Bladder problems/ Incontinence	Gallstones	Kidney Stones	Seizure Disorder
Bleeding problems	GERD (acid reflux)	Lupus	Sleep Apnea
Carpal Tunnel	Glaucoma	Liver Disease	Stroke
Cancer:	Headaches/Migraine	Macular Degener.	Thyroid Disorder
Crohn's / Colitis	Heart Attack (MI)	Neuropathy	
Osteopenia/osteoporosis	Heart Disease	Nose Bleeds	

Other medical problems not listed above: _____

_____

FAMILY HISTORY:

FATHER: Living: Age_____ Deceased: Age_____

Alcoholism	Blood Clot/DVT	Depression	Kidney Disease
Anemia	Bipolar	Diabetes 1 or 2	Osteoporosis
Asthma	COPD/emphysema	High Cholesterol	Stroke
Arthritis	Dementia	High Blood Pressure	Thyroid Disorder
Cancer:			
Other:			

MOTHER: Living: Age_____ Deceased: Age_____

Alcoholism	Blood Clot/DVT	Depression	Kidney Disease
Anemia	Bipolar	Diabetes 1 or 2	Osteoporosis
Asthma	COPD/emphysema	High Cholesterol	Stroke
Arthritis	Dementia	High Blood Pressure	Thyroid Disorder
Cancer:			
Other:			

SIBLINGS: _____

_____

List other medical providers that you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, etc.)

_____

_____

PATIENT SIGNATURE:_____ DATE:_____

PROVIDER REVIEWED:_____ DATE:_____