Thank you for your interest in Southwest Internal Medicine

Please complete and return New Patient Paperwork 24 hours prior to appointment

Cancellation policy

Please notify us at 970-564-8730 prior to 24hrs if you are unable to keep your scheduled appointment. Without this notice, we do have a $100.00 cancellation charge.

What you need for your first office visit:

- Completed New Patient Paperwork
- Insurance card
- Your co-pay. We accept Credit Cards or Debit Cards, Check or cash (small bills appreciated)

At each visit thereafter, checking in you will be asked for:

- Your insurance cards
- Your co-pay

You will be asked to:

- Review your medications
- Complete a patient questionnaire for your office visit

Prescriptions

Start the refill process for your medications at least 72hrs before needed!

First step: Call the pharmacy

- If your prescriptions are filled at a local pharmacy, please call the pharmacy to renew your prescriptions even if there are no refills. They start the process for refills.

Call our office if:

- Your prescriptions are filled at a mail order pharmacy
- Your prescription was not prescribed by a doctor at our office
- You have a change in your prescription
- You need a controlled medication refilled

Once you have established as a patient at our office, contact us before going to the emergency room. We provide same day appointments for urgent needs.

Contact Info:

Office: (970) 564 8730

Fax: (888) 832 1367

After Hours: (970) 565 6666, have the Southwest Internal Medicine On Call Doctor paged

New Patient Questionnaire

Personal Information:

Name
(as it appears on insurance card, or legal name): _____Birth date: _____

Social Security#: _____What name do you prefer to be called? _____

Mailing Address: _____ Home Phone: _____

_____ Cell Phone: _____

_____ Email Address: _____

Employer _____ Work Phone: _____

Spouse or Parent Name: _____ Relationship: _____ Phone Number: _____

Emergency Contact Name: _____ Relationship: _____ Phone Number: _____

Preferred Pharmacy: _____

Insurance: _____

Please describe the main reason for your visit today:

Have you been a patient at Southwest Internal Medicine before? _____

If yes, when: _____ Do you have a provider preference _____

Who referred you to our office? _____

Advanced Directive:

Do you have a medical power of attorney? Yes ____ No____

If yes, Name and Phone Number of this person: _____

Do you have a living will? Yes ____ No____

Would you like information on Advance Directives planning? Yes ____ No____

Allergies:

Allergies to medications? Yes____ No____ If so please list below:

Medication: Reaction:

_____ _____

_____ _____

_____ _____

_____ _____

Medications:

Please list any prescription medications/over-the-counter medications/herbs/vitamins/supplements you are currently taking, the doses, and your reason for taking them:

Medication:	Dosage:	How many times per day:	Reason:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medical History:

Please list your current medical conditions:

Please list prior medical conditions:

Please list all hospitalizations:

Please list all surgical procedures you have had:

Please list all healthcare providers you are currently seeing or whom you have seen in the past 5 years and why you are or have been seeing those providers:

Have you ever received a blood transfusion? _____ Year Received _____
Would you accept blood products if needed? Yes____ No ____
Have you ever been exposed to Tuberculosis? Yes____ No ____
Have you ever received PPD Testing for Tuberculosis? Yes____ No ____ Result_____
Are there any reasons that you would be at risk for HIV? _____

Women:

Have you been pregnant?	Yes ___	No ___	If yes, how many times?	___
Ectopic pregnancy?	Yes ___	No ___	If yes, how many?	___

Women (continued):

Miscarried pregnancy? Yes ___ No ___ If yes, how many? ___

Aborted pregnancy? Yes ___ No ___ If yes, how many? ___

When was your most recent menstrual period? _____

Menstruation occurs every: 21-24 days___ 25-28 days___ Other _____

Are you using birth control? Yes ____ No ___

Age of Menopause: _____

Immunizations:

Please check the vaccines you have received and provide the approximate date you received it:

Vaccine:	Date of most recent one:
___ Tetanus (Tdap)	_____
___ Prevnar/PCV-13 (a pneumonia vaccine)	_____
___ Pneumococcal/PSV-23 (a pneumonia vaccine)	_____
___ Zostavax (to prevent shingles)	_____
___ Hepatitis B	_____
___ Influenza	_____
___ HPV	_____
___ Chicken Pox	_____
___ Shingrix	_____
Other vaccines (please list):	
_____	_____
_____	_____
_____	_____

Preventive Health Care:

Please check the tests you have had and provide the approximate dates you most recently had the test done:

Test:	Date:	Performed at:
___ Colonoscopy	_____	_____
___ Stool cards for colon cancer screening	_____	_____
___ Bone density testing	_____	_____
___ Pap smear (women)	_____	_____
___ Mammogram (women)	_____	_____
___ Bone Density (DXA) (women)	_____	_____
___ PSA to test for prostate cancer (men)	_____	_____

Social History:

Race: _____

Ethnicity: _____

Social History (continued):

Sexual Orientation: Please indicate below (Leave blank if you would rather discuss directly with physician)

__ Heterosexual __ Homosexual __ Bisexual __Asexual
__ Other (please describe):

Gender Identification: Please indicate your gender identity. (Leave blank if you would rather discuss directly with physician)
__ Male __ Female __Other (please describe):

What level of education have you completed?

__ Elementary __ Junior High __ High School __ College __ Post-Graduate

Relationship status: Please indicate below.
__ Single __Long-term partner __ Married __ Civil Union __Divorced
__Separated __ Widowed __ Other (please describe):

Do you have a religious preference you would like to let us know about? If so, please indicate:

_____

Current/former occupation: _____

Exercise:
How many days per week to you exercise? _____
What type of exercise? _____

Tobacco Use:
Do you use or have you used tobacco? __ Yes __ No
If yes, what form? _____How much? _____ For how long? _____
If you are a former user of tobacco products, when did you quit? _____

Alcohol Use:
Do you currently drink alcohol? __ Yes __ No
If yes, how many drinks do you have per week? _____
If yes, do you ever have more than 3 drinks at one time? __ Yes __ No
If you do not currently drink alcohol, have you done so in the past? __ Yes __ No
If yes, how much did you used to drink? _____
When did you quit? _____

Caffeine intake:
Do you drink caffeinated beverages? __ Yes __ No
If yes, what type? _____ How often? _____

Social History (continued):

Marijuana use:
Do you use recreational or medicinal marijuana? __ Yes __ No
If yes, what for? _____ How much? _____ How often?:_____

Illegal drugs: (Leave blank if you would rather discuss directly with physician)
Have you ever used or do you currently use any illegal recreational drugs or illegally obtained prescription drugs?
__ Yes __ No

If yes, please list what type and for how long:

Family History: Please indicate age, living or deceased, medical conditions

Relative	**Living?**	**Current age or age at death**	**Medical Conditions**
Mother:	____	_____	_____
			_____
			_____
Father:	____	_____	_____
			_____
			_____
Sisters:	____	_____	_____
	____	_____	_____
	____	_____	_____
	____	_____	_____
Brothers:	____	_____	_____
	____	_____	_____
	____	_____	_____
	____	_____	_____
Daughters:	____	_____	_____
	____	_____	_____
	____	_____	_____
	____	_____	_____
Sons:	____	_____	_____
	____	_____	_____
	____	_____	_____
	____	_____	_____

Southwest Internal Medicine

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

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.

Southwest Internal Medicine is required to maintain the privacy of your health information and to provide you with a notice of its legal duties and privacy practices. We will not use or disclose your health information except as described in this Notice. This Notice applies to all of the medical records generated by Southwest Internal Medicine, as well as records we receive from other providers.

USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION IN TREATMENT, PAYMENT & HEALTH CARE OPERATIONS

Treatment: Southwest Internal Medicine may use and disclose your protected health information in the course of providing or managing your health care as well as any related services. For the purpose of treatment, we may coordinate your health care with a third party. For example, we may disclose your protected health information to a pharmacy to fulfill a prescription for medication, to a radiology facility to order an X-ray, or to another physician who is assisting in your health care. In addition, we may disclose protected health information to other health care providers related to the treatment provided by those other providers.

Payment: When needed, Southwest Internal Medicine will use or disclose your protected health information to obtain payment for its services. Such uses or disclosures may include disclosures to your health insurer to get approval for a recommended procedure or to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. When obtaining payment for your health care, we may also disclose your protected health information to your insurance company to demonstrate the medical necessity of the care or for utilization review when required to do so by your insurance company. Finally, we may also disclose your protected health information to another provider where that provider is involved in your care and requires the information to obtain payment.

Operations: Southwest Internal Medicine may use or disclose your protected health information when needed for the practice's health care operations for the purposes of management or administration of the practice and for offering quality health care services. Health care operations may include: (1) quality evaluations and improvement activities; (2) employee review activities and training programs; (3) accreditation, certification, licensing, or credentialing activities; (4) reviews and audits such as compliance reviews, medical reviews, legal services, and maintaining compliance programs; and (5) business management and general administrative activities. For instance, we may use, as needed, protected health information of patients to review their treatment course when making quality assessments regarding ophthalmologic care or treatment. In addition, we may disclose your protected health information to another provider or health plan for their health care operations.

Other Uses and Disclosures: As part of treatment, payment, and health care operations, Southwest Internal Medicine may also use or disclose your protected health information to: (1) remind you of an appointment; (2) inform you of potential treatment alternatives or options; or (3) inform you of health-related benefits or services that may be of interest to you.

USES & DISCLOSURES TO WHICH YOU MAY OBJECT

Family/Friends: Southwest Internal Medicine may disclose your protected health information to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose protected health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. If you have any objection to the use and disclosure of your protected health information in this manner, please tell us.

USES & DISCLOSURES THAT ARE REQUIRED OR PERMITTED WITHOUT YOUR AUTHORIZATION

Research: Under certain circumstances, Southwest Internal Medicine may use and disclose your protected health information to approved clinical research studies. While most clinical research studies require specific patient consent, there are some instances where a retrospective record review with no patient contact may be conducted by such researchers. For example, the research project may involve comparing the health and recovery of patients who received one medication for their medical condition to those who received a different medication for that same condition.

Regulatory Agencies: Southwest Internal Medicine may disclose your protected health information to government and certain private health oversight agencies, e.g., the Department of Public Health and Environment or the Board of Medical Examiners, for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary to monitor compliance with the requirements of government programs.

Law Enforcement/Litigation: Southwest Internal Medicine may disclose your protected health information for law enforcement purposes as required by law or in response to a court order or other process in litigation.

Public Health: As required by law, Southwest Internal Medicine may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury or disability. For example, we are required to report the existence of a communicable disease, such as acquired immune deficiency syndrome ("AIDS"), to the Department of Public Health and Environment to protect the health and well-being of the general public.

Workers' Compensation: Southwest Internal Medicine may release protected health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Military/Veterans: Southwest Internal Medicine may disclose your protected health information as required by military command authorities, if you are a member of the armed forces.

Organ Procurement Organizations: To the extent allowed by law, Southwest Internal Medicine may disclose your protected health information to organ procurement organizations and other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

As Otherwise Required or Permitted By Law: Southwest Internal Medicine will disclose your protected health information in any situation in which such disclosure is required by law (e.g., child abuse, domestic abuse) or any other use permitted under HIPAA, its amendments or regulations.

USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION:

Other than the circumstances described above, Southwest Internal Medicine will not disclose your protected health information unless you provide written authorization. An authorization is specifically required in most situations involving uses or disclosures of protected health information for marketing purpose, for the sale of protected health information, or for psychotherapy purposes. You may revoke your authorization in writing at any time except to the extent that we have already taken action in reliance upon the authorization.

YOUR RIGHTS RELATED TO YOUR HEALTH INFORMATION:

Although all records concerning your treatment obtained at Southwest Internal Medicine are the property of Southwest Internal Medicine, you have the following rights concerning your protected health information:

- ***Right to Confidential Communications:*** You have the right to receive confidential communications of your protected health information by alternative means or at alternative locations. For example, you may request that we contact you at work or by mail.
- ***Right to Inspect and Copy:*** You generally have the right to inspect and copy your protected health information, except as restricted by your physician or by law. Further, if we maintain your health records on an electronic health records system, you have the right to request an electronic copy of your health records.
- ***Right to Amend:*** You have the right to request an amendment or correction to your protected health information. If we agree that an amendment or correction is appropriate, we will ensure that the amendment or correction is attached to your medical record.
- ***Right to an Accounting:*** You have the right to obtain a statement of the disclosures that have been made of your protected health information other than by your authorization, other than to you and other than for the purpose of treatment, payment or routine operational purposes.

- ***Right to Request Restrictions:*** You have the right to request restrictions on certain uses and disclosures of your protected health information. If we agree, we will abide by the restrictions. Additionally, if you (or anyone on your behalf besides a health plan) pay for the care or services at issue in full out of your own pocket, we are required to comply with your request not to disclose your protected health information to a health plan, unless required by law to do so.
- ***Right to Receive a Copy of this Notice:*** You have the right to receive a paper copy of this Notice, upon request, if this Notice has been provided to you electronically.
- ***Right to Revoke Authorization:*** You have the right to revoke your authorization to use or disclose your protected health information, except to the extent that action has already been taken in reliance on your authorization.
- ***Right to Notice of Breach of Security:*** You have the right to be notified in the event of a breach of unsecured protected health information occurs.
- ***Right to Opt Out:*** You may be contacted for certain fund-raising purposes and you have the right to opt out of receiving such communications.

FOR MORE INFORMATION REGARDING HOW TO EXERCISE THESE RIGHTS: If you have questions or would like more information regarding any of the rights listed above, please contact the Compliance Officer at (970) 564-8730.

IF YOU BELIEVE THAT YOUR RIGHTS HAVE BEEN VIOLATED: You may file a complaint with Southwest Internal Medicine or with the U.S. Secretary of Health and Human Services. To file a complaint with Southwest Internal Medicine, please contact the Compliance Officer at (970) 564-8730. All complaints must be submitted in writing. There will be no retaliation for filing a complaint.

NOTICE EFFECTIVE DATE: This Notice is effective for all protected health information created on or after January 29, 2018.

CORHIO HIE Patient Notification

Southwest Internal Medicine endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the CORHIO HIE, or cancel an opt-out choice, at any time.

Authorization: I consent to treatment as necessary or desirable to the care of the patient named above, including but not limited to medications, operations, labs, x-ray or other studies that may be used by the attending physician, nurse or qualified designate. These services may not be considered covered by your individual insurance and your insurance will not pay for or be liable for such services. Charges shown by the statements are agreed to be correct and reasonable unless protested in writing within 30 days of the billing date. I also agree to be financially responsible for any balance due on my account. In the event legal action should become necessary to collect an unpaid debt for medical services rendered to me, I agree to pay reasonable attorney fees or other such costs, as the court deems proper. I hereby authorize payment of medical insurance benefits to Karla J. Demby M.D., Andrew M. McAlpin M.D., Erin M. Henderson M.D., and Robin E. Richard, M.D., and authorize release of medical information acquired in the course of my examination or treatment. This shall remain valid until such time as revoked by me in writing.

I acknowledge that I have received a copy of Southwest Internal Medicine's privacy practices. This notice describes how Southwest Internal Medicine may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____

Signature of patient or patient representative Date

Relationship to patient_____

SOUTHWEST INTERNAL MEDICINE

Authorization to Use or Disclose My Health Information

Patient name: _____ Date of Birth:_____

Previous name: _____

My Authorization

You may use or disclose the following health care information, to the following individuals, as indicated.:

NAME	PHONE	Any/all my health information.	Only information relating to a specific treatment or condition.	Only information for the noted date(s).	Only appointment information.

(If room for additional names is needed, please attach an additional sheet and include the patient's name and DOB at the top.)

This authorization ends*: ☐ On (date): _____

☐ When the following event occurs: _____

If no end date is provided, this authorization will expire one year from the date of signing

I may revoke this authorization at any time, in writing. If I revoke this authorization, it would not affect any actions already taken by the above-named practice based upon this authorization. Two ways to revoke this authorization are:

Once the office discloses health information, the person or organization that receives it may be able to redisclose it. Privacy laws may no longer protect it.

_____ _____ _____

Patient or legally authorized individual signature | Date | Time

_____ _____

Printed Name if signed on behalf of the patient | Relationship (parent, legal guardian, personal representative, etc.)

New Patient: Insurance Information

Name of Insurance Co: _____

Patient ID: _____

Group #: _____

Co-Pay: _____

Claims Mailing Address: _____

_____

_____