New Patient Checklist

PLEASE READ

Below are items that you either need to bring to the appointment or need to be noted.

□ Completed Paperwork

- Patient Registration Form
- Patient Medical History
- HIPAA Acknowledgement Form
- Financial Policy and Consent to Treat

□ Insurance Card

□ Photo ID

□ Medications To Hold For Skin Testing – **see Information Page**

□ If there are custodial issues, adoption situations, medical power of attorney, etc. – we MUST have a copy of the legal documents showing the custodial parents.

□ Parents must accompany the child to the first visit to sign consent forms, etc. **(NO EXCEPTIONS)**

Rocky Mountain Pediatric Respiratory and Allergy Care

2055 High Street, Suite 360 Denver, CO 20205
Phone: 303-322-2203 Fax: 303-861-6281

Office hours: Phones will be rolled to answering service during lunch hour from 12-12:30pm.

Monday	Tuesday	Wednesday	Thursday	Friday
8am-4:30pm	8am-4:30pm	8am-4:30pm	8am-4:30pm	8am-4:30pm

Emergencies: For life threatening situations, call 911. If you have an urgent problem, please call our office for instructions. After hours, our answering service will inform you of how to reach a physician on call.
Test results: For test results call **303-322-2203**
Prescriptions: All prescriptions and refill requests should be submitted during normal office hours. Please have your pharmacy call the office at **303-322-2203** for renewal of medication.

For appointments, please call 303-322-2203

- For your first appointment, please arrive 30 minutes early with new patient paperwork completed. **For all appointments, your check in time with the nurse is <u>15 minutes prior</u> to your appointment time with the physician.**
- Please call in advance for routine office visits. Make follow-up appointments as you leave. We make every effort to stay on schedule, although emergencies arise. If we are seriously delayed, we attempt to notify patients beforehand.
- As a courtesy to other patients and staff, please call the office as soon as possible if you are unable to keep your appointment or are going to be late.

Medications to hold for skin testing:

It is possible that your child may need skin testing during their appointment in our office. Many common medications may interfere with skin testing results or produce inaccurate results. For this reason, **do not administer** any of the following medications or any other over-the-counter or prescription medication that contains an antihistamine, **for at least 4 days.** If your child has a reaction, please treat them according to instructions you have been given previously and notify us of the occurrence:

Allegra (Fexofenadine)
Alavert (Loratadine)
Actifed
Atarax (Hydroxyzine)
Benadryl (Diphenhydramine)
Chlor-Trimeton (Chlorpheniramine)
Clarinex (Desloratadine)
Claritin (Loratadine)
Dallergy
Dimetane
Dimetapp
Doxepin (Silenor)
Duravent-DA
Periactin (Cyproheptadine)
Any "PM," "Cold," or "Allergy" Medication
Phenergan (Promethazine)
Rondec
Sudafed Cold
Tavist (Clemastine)
Tylenol PM
Xyzal (Levoceterizine)
Zyrtec (Cetirizine)
Zzzquil (Diphenhydramine)

On day of testing hold the following:

Axid (Nizatidine) Pepcid (Famotidine) Tagamet (Cimetidine) Zantac (Ranitidine)

If your child has a reaction, please treat them as directed then notify our office.
In an emergency, dial 911.

Please phone our office with any questions or concerns about the medication list above.

Rocky Mountain Pediatric Respiratory and Allergy Care at The Rocky Mountain Hospital for Children
Main Office Directions
2055 High Street #360 Denver, CO 80205
(Building highlighted in Yellow)

From the North

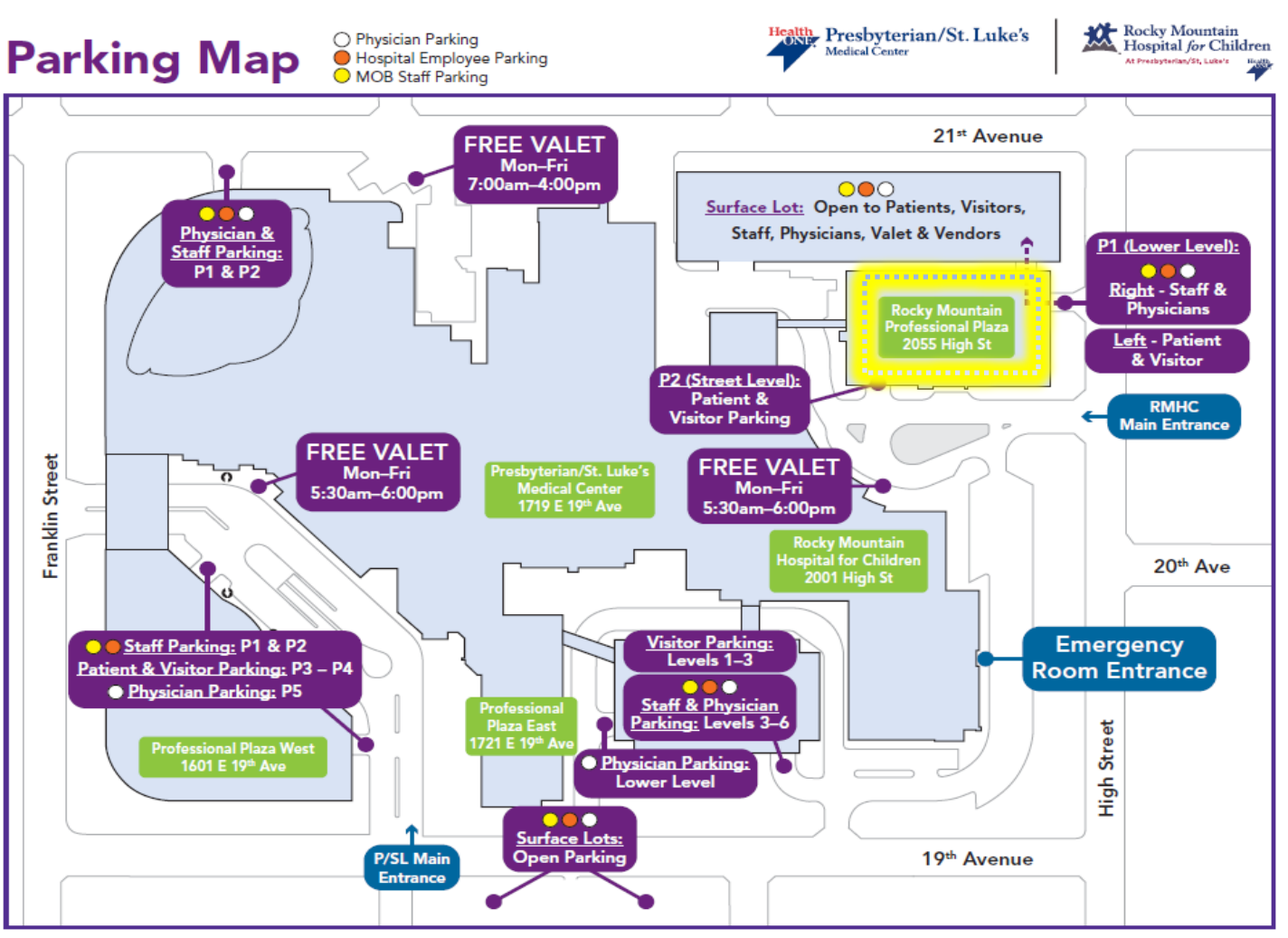
-Take I-25 South to Exit 38th Avenue/Park Avenue (#213)
-Continue North on Park Avenue
-Take left on 17th Avenue (one way going east)
-Take a left on High Street
-Continue on High Street and past 19th Avenue
-RMHC will be on the Left
-Take a left into drive way in front of the Medical Office Building and Emergency Room Entrance.

From the South

-Take I-25 North to Exit University Boulevard
-University will turn into Josephine Street
-Take a left on 18th Avenue (one way going West)
-Take a right on High Street
-Continue on High Street and past 19th Avenue
-RMHC will be on the Left
-Take a left into drive way in front of the Medical Office Building and Emergency Room Entrance.

From the West

-Take 6th Avenue heading East into Denver
-Take a left on Lincoln
-Take a right on 17th Avenue
-Take a left on High Street
-Continue on High Street and past 19th Avenue
-RMHC will be on the Left
-Take a left into drive way in front of the Medical Office Building and Emergency Room Entrance



Consent for Treatment without Parent/Guardian Present

Patient Name: _____ DOB: _____

Parent/Legal Guardian Name: _____ Phone: _____

I, _____, hereby voluntarily consent to the rendering of healthcare, including diagnostic testing, examination and/or medical treatment, by the physicians and other designated medical professionals of the Rocky Mountain Pediatric and Respiratory and Allergy Care without me present.

I hereby give consent to the following individuals:

_____ and/or _____
to arrange for any medical care, and to make decisions in my place based on testing deemed to be necessary by the physician and medical team. This may include physical examination, lab work, medication injections/infusions, and/or any other treatment deemed necessary by my child's treating provider. I acknowledge that I am responsible for all reasonable charges in connection with care and treatment rendered during this period.

His/her address: _____
And his/her telephone number: _____

This consent is in effect for the following (please choose one)

- ☐ Date: _____
- ☐ Date range from: _____ to _____
- ☐ Until I revoke this document (Remainder of the current calendar year)

***Please note Parent or Legal Guardian MUST be present at initial visit.**

_____ _____
Printed Name of Parent or Legal Guardian Relationship to Minor

_____ _____
Parent or Legal Guardian Signature Today's Date

FINANCIAL POLICY

We want you to be informed of our office financial policy and require a signature to document that you have read and understand our policy. You will be given a copy for your records.

SERVICE:
Your child is here to receive a service. There are charges associated with the services we provide. Services include, and are not limited to: consultation, evaluation, and procedures. Services provided outside of our office will be charged by the entity providing the service (i.e: labs, radiology, respiratory therapy, speech therapy).

PAYMENT:
For patients with a co-pay plan, payment is expected at the time of service. When you check in for the appointment, we will collect the amount indicated on your card unless instructed otherwise. We accept credit cards, checks and cash. All insurance carriers have a fee schedule from which they will reimburse. Any services not covered**, deductibles and coinsurance** are your responsibility and will be billed to you by our office. Payment is due with-in 30 days. This may include copays for in-office procedures.

If you do not have insurance, payment is required at the time of service. If special circumstances make immediate payment impossible, payment arrangements must be approved in advance by speaking with one of our staff.

INSURANCE:
All services performed by our providers will be submitted as a courtesy to your insurance. Insurance plans vary considerably. It is your responsibility as the parent/guardian to provide accurate and timely insurance information.

INSURANCE REFERRALS:
It is your responsibility to understand the requirements of your insurance policy. If a referral is needed prior to seeing a specialist, you will need to obtain one through your primary care doctor office. If you choose to be seen without a valid referral in place, you will be responsible for any charges not covered by your insurance company.

CONSENT TO TREAT

I, the undersigned, hereby consent to the following treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- 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 medially 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 advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that HealthONE Clinic Services may include consent at satellite offices under common ownership

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

I acknowledge that I will be responsible for payment of all deductibles, co-insurance and non-covered services. The ultimate responsibility for payment rests with me.

Patient Name:_____ **Date of Birth:** _____

Guardian/Responsible Party Print:_____

Guardian/Responsible Party Signature: _____ **Date:** _____

ROCKY MOUNTAIN PEDIATRIC RESPIRATORY AND ALLERGY CARE
PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Patient Name**:** _____

Date of Birth: _____

_____ (Patient initials) **Notice of Privacy Practices.** I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ (Patient initials) **Release of Information.** I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?"

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient may revoke or modify this specific authorization and that revocation or modification must be in writing.

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

_____ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is_____.

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Revocation

I hereby revoke my request for future communications via email and/or text.

__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.

__ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.

NOTE: This revocation only applies to communications from this Practice.

Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____ Time: _____

Consent for Photographing or Other Recording for Security and/or Health Care Operations

____ (Patient Initials) I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

____ (Patient Initials) I do not consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities).

[OPTIONAL ON FORM- REMOVE THIS Section ONLY if NA to your practice]

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

____ (Patient initials) I wish to designate the following family member / friend to pick up an order on my behalf:

Name: _____ Date: _____

Name: _____ Date: _____

____ (Patient initials) I do not want to designate anyone to pick-up my prescription order.

Patient Signature _____ Date: _____

Patient Name (Printed): _____ DOB: _____