

New Patient Registration Form

Patient Information	Patient Last Name		First Name		Middle Name		Maiden Name		
	Address (Street or Box)			City		State		Zip	
	Home Phone #		Work Phone #			Cell Phone #			
	Sex (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth	Age	Social Security #			Driver's License #	
	Marital Status (check one) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				Spouse's Name (If Applicable)		Email		
	Employer Name				Employer Address				
	Primary Care Physician Name		Phone #		Referring Physician Name			Phone #	
	Race (optional) <input type="checkbox"/> White <input type="checkbox"/> American Indian <input type="checkbox"/> Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Hawaiian <input type="checkbox"/> Declined				Ethnicity (optional) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Declined		Primary Language		

Complete this section only if the patient is a minor

Responsible Party	Responsible Party Patient Last Name		First Name		Middle Name		Maiden Name		
	Address (Street or Box)			City		State		Zip	
	Home Phone #		Work Phone #			Cell Phone #			
	Sex (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth	Age	Social Security #			Driver's License #	

Insurance	PRIMARY Insurance Company		Effective Date		SECONDARY Insurance Company		Effective Date	
	Policy Holder (if other than patient)		DOB		Policy Holder (if other than patient)		DOB	
	Policy Holder Social Security #		Relationship to Patient		Policy Holder Social Security #		Relationship to Patient	

Financial Responsibility	<p>I hereby authorize payment of medical benefits directly to <i>Colorado Pulmonary Intensivists, PC</i> and/or the physician or nurse practioner for services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patients' medical insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to CPI. I further understand that should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses of CPI, if any.</p> <p>The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.</p>	
	<p>_____ Patient Name (please print)</p>	
	<p>_____ Signature of Patient, Parent, or Legal Guardian</p>	
	<p>_____ Date</p>	

Colorado Pulmonary Intensivists

Privacy Policy Acknowledgment & CORHIO Authorization



HIE Exchange Consent

Electronic Health Information Exchange

Colorado Pulmonary Intensivists endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your 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 test and procedures. However, you may choose to opt-out of participation in the <CORHIO> HIE or cancel an opt-out choice, at any time.

I would like to participate in the CORHIO HIE (described above). I understand that I can opt-out or cancel at any time.

Print Name

Patient (or Patient Representative) Signature

Date

Privacy Practices

Acknowledgment of Receipt of the CPI Notice of Privacy Practices:

I acknowledge that I have received the Notice of Privacy Practices ("The Notice") for the practice of Colorado Pulmonary Intensivists, P.C.

Print Name

Patient (or Patient Representative**) Signature

Date

**If Patient Representative, legal documentation must be included to show authority to sign or receive information.

For Practice Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐
☐
☐
☐

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify) _____

Approved HIPPA Contacts

Whom may we disclose healthcare info to on your behalf?

I **DO** consent CPI to leave detailed messages as follows:

☐ **Do not speak with anyone**

I, _____, give Colorado Pulmonary Intensivists, PC and the staff my permission to leave messages regarding my medical care with the following (This will remain in effect until you change it in writing):

Home Phone _____ Initials _____

Cell Phone _____ Initials _____

My spouse _____ Initials _____

Family or Other _____ Initials _____

Emergency

Emergency Contact Information:

Emergency Contact Name _____ Relationship to patient _____

Emergency Contact Phone Number _____

NAME: _____ DATE: ____/____/____ BIRTHDATE: ____/____/____

REASON FOR VISIT: _____

CHECK IF YOU HAD ANY OF THESE MEDICAL PROBLEMS IN THE PAST:

MAJOR ILLNESSES			
AIDS		Kidney Disease	
Alpha -1 Antitrypsin Deficiency		Liver Disease	
Anxiety/Depression		Mycobacterial Infection	
Atrial Fibrillation		Neuromuscular Disease	
Asthma		Obesity	
Cancer – specify where		Obstructive Sleep Apnea- Adult	
Cerebrovascular Accident (CVA)/Stroke		Pneumonia	
Chronic Obstructive Pulmonary Disease (COPD)		Pneumothorax	
Congestive Heart Failure		Pulmonary Embolism	
Cystic Fibrosis		Pulmonary Fibrosis	
Deep Vein Thrombosis (Blood Clot)		Pulmonary Hypertension	
Diabetes Mellitus, Type II		Pulmonary Nodule (Lung Nodule)	
Gastroesophageal Reflux (GERD)		Reactive Airway Disease	
Heart Attack		Rhinitis, Allergic	
History of Lung Cancer		Transient Ischemic Attack (TIA)	
History of Tuberculosis		Others:	
Hypercholesterolemia (high cholesterol)			
Interstitial Lung Disease			

CHECK IF YOU HAD ANY OF THESE SURGERIES IN THE PAST:

Surgery	Date	Physician	Surgery	Date	Physician
Aneurysm Repair			Hip/knee Replacement		
Appendectomy			Hysterectomy		
Cardiac Valve Repair/Replacement			Internal Defibrillator (AICD)		
Carotid Endarterectomy			Laparoscopic Nissen Procedure		
Cervical Disc Surgery			Lung Surgery		
Colon Surgery			Mastectomy		
Coronary Artery Bypass			Pacemaker		
Coronary Artery Stent			Removal/Repair of Spleen		
Gallbladder			Thyroid Surgery		
Hernia Repair			Tracheostomy		
Other:					

BIRTHDATE:____/____/____

PLEASE LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

DRUG NAME	DOSE	HOW MANY TIMES/DAY	DRUG NAME	DOSE	HOW MANY TIMES/DAY
INHALERS:					

Are you currently on oxygen? If yes, how much LPM of oxygen during:

Day:	Liters/min	At rest:	Liters/min
Night:	Liters/min	With exertion:	Liters/min

DRUG ALLERGIES:		

CIRCLE AND CHECK IF ANY OF YOUR BLOOD RELATIVES HAVE HAD:

MAJOR ILLNESSES	<input checked="" type="checkbox"/>	MATERNAL/PATERNAL RELATIVE:	Age of Diagnosis:
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Autoimmune Disease			
Cancer- specify type			
Clotting Problems			
Heart Disease (Angina, MI, Palpitations, Arrhythmias)			
Lung Disease			
Severe Arthritis			
Tuberculosis - TB			
OTHER:			

YOUR SOCIAL HISTORY

PLEASE LIST HABITS

Do you Drink Alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount used per day/week: _____
Are you a current smoker?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pack per day: _____ x _____ years
Are you an ex smoker?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Age started: _____ x _____ years
Never smoker?	<input type="checkbox"/> Yes	Date quit: _____
Smokeless tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount used per day/week: _____
Do you use illicit drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount used per day/week: _____

Marital Status: Married ☐ Divorced ☐ Single ☐ Widowed ☐

Occupation: _____

Education Level:

Pets in House: ☐ Yes ☐ No Birds in House: ☐ Yes ☐ No

Hot Tub: ☐ Yes ☐ No

Travel in last 12 months: ☐ Yes ☐ No If yes, where:

Place of birth: _____



Patient Name: _____

DOB: _____

Date of Service: _____

Modified Berlin Questionnaire

1. Have you ever been diagnosed with OSA (obstructive sleep apnea)? Yes No
- a. If yes, were you prescribed CPAP? Yes No
- b. If yes, are you using it every night? Yes No

Category I

2. Do you currently snore? Yes No Don't Know
- a. Snoring frequency: Almost every day 3-4x/wk 1-2x/wk 1-2x/month Never/Almost never
3. How often have your breathing pauses been noticed?
- a. Almost every day 3-4x/wk 1-2x/wk 1-2x/month Never/Almost never

Category II

4. Are you tired during awake time?
- a. Almost every day 3-4x/wk 1-2x/wk 1-2x/month Never/Almost never
5. Have you ever fallen asleep while driving? Yes No

Category III

6. Have you been diagnosed with high blood pressure? Yes No Don't Know
- a. If so, are you on blood pressure medication? Yes No

-OR-

Weight _____

Height _____

Office use only
BMI _____ (>30 kg/m²)

Interpretation:

You are defined as high risk for sleep apnea in each category if:

Category I: You snore at least 3-4 times/wk and have breathing pauses at least 3-4 times/wk

Category II: You are tired during wake time at least 3-4/wk and/or have ever fallen asleep driving

Category III: You have high blood pressure and/or A BMI >30 kg/m²

*If you are high risk in at least 2 categories, you may need a formal sleep study (positive predictive value of 0.89).

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Office Use: Check if defined as High Risk

(Netzer NC, RA Stoow, CM Netzer, K Clark, KP Strohl. Using The Berlin Questionnaire To Identify Patients At Risk For The Sleep Apnea Syndrome. Ann Intern Med 1999;631:485-491)

Notice of Privacy Practices for Protected Health Information (PHI)

Colorado Pulmonary Intensivists P.C.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY!

Effective date: August 1, 2013

The Practice of Colorado Pulmonary Intensivists P.C. is required by applicable federal and state laws to maintain the privacy of your health information. Protected health information (PHI) is the information we create and maintain in the course of providing our services to you. Such information may include documentation of your symptoms, examination and test results, diagnoses and treatment protocols. It also may include billing documents for those services. We are permitted by federal privacy law (the Health Insurance Portability & Accountability Act of 1996 (HIPAA)), to use and disclose your PHI, without your written authorization, for purposes of treatment, payment, and health care operations.

Examples of Using Your Health Information for Treatment Purposes:

- Our nurse obtains treatment information about you and records it in your medical record.
- During the course of your treatment, the physician determines he will need to consult with a specialist. He will share the information with the specialist and obtain his/her input.
- We may contact you by phone, at your home, if we need to speak to you about a medical condition or to remind you of medical appointments.

Example of Using Your Health Information for Payment Purposes:

- We submit requests for payment to your health insurance company. We will respond to health insurance company requests for information from about the medical care we provided to you.

Example of a Using Your Information for Health Care Operations:

- We may use or disclose your PHI in order to conduct certain business and operational activities, such as quality assessments, employee reviews, or student training. We may share information about you with our Business Associates, third parties who perform these functions on our behalf, as necessary to obtain their services.

Your Health Information Rights

The health and billing records we maintain are the physical property of the Practice. The information in them, however, belongs to you. You have a right to:

- Obtain a paper copy of our current Notice of Privacy Practices for PHI ("the Notice");
- Receive Notification of a breach of your unsecured PHI;
- Request restrictions on certain uses and disclosures of your health information. We are not required to grant most requests, but we will comply with any request with which we agree. We will, however, agree to your request to refrain from sending your PHI to your health plan for payment or operations purposes if at the time an item or service is provided to you, you pay in full and out-of-pocket;
- Request that you be allowed to inspect and copy the information about you that we maintain in the Practice's designated record set. You may exercise this right by delivering your request, in writing, to our Practice;
- Appeal a denial of access to your PHI, except in certain circumstances

- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our Practice. We may deny your request if you ask us to amend information that (a) was not created by us (unless the person or entity that created the information is no longer available to make the amendment), (b) is not part of the health information kept by the Practice, (c) is not part of the information that you would be permitted to inspect and copy, or (d) is accurate and complete. If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be placed in your record;
- Request that communication of your health information be made by alternative means or at alternative locations by delivering a written request to our Practice;
- If we engage in fundraising activities and contact you to raise funds for our Practice, you will have the right to opt-out of any future fundraising communications;
- Obtain a list of instances in which we have shared your health information with outside parties, as required by the HIPAA Rules.
- Revoke any of your prior authorizations to use or disclose information by delivering a written revocation to our Practice (except to the extent action has already been taken based on a prior authorization).

Our Responsibilities

The Practice is required to:

- Maintain the privacy of your health information as required by law;
- Notify you following a breach of your unsecured PHI;
- Provide you with a notice ('Notice') describing our duties and privacy practices with respect to the information we collect and maintain about you and abide by the terms of the Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods for communicating with you about your health information and comply with your written request to refrain from disclosing your PHI to your health plan if you pay for an item or service we provide you in full and out-of-pocket at the time of service.

We reserve the right to amend, change, or eliminate provisions of our privacy practices and to enact new provisions regarding the PHI we maintain about you. If our information practices change, we will amend our Notice. You are entitled to receive a copy of the revised Notice upon request by phone or by visiting our website or Practice.

Other Uses and Disclosures of your PHI

Communication with Family

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment for care, if you do not object or in an emergency. We may also do this after your death, unless you tell us before you die that you do not wish us to communicate with certain individuals.

Notification

- Unless you object, we may use or disclose your PHI to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care about your location, your general condition, or your death.

Research

- We may disclose information to researchers if an institutional review board has reviewed the research proposal and established protocols to ensure the privacy of your PHI. We may also disclose your information if the researchers require only a limited portion of your information.

Disaster Relief

- We may use and disclose your PHI to assist in disaster relief efforts.

Organ Procurement Organizations

- Consistent with applicable law, we may disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation/transplant.

Food and Drug Administration (FDA)

- We may disclose to the FDA your PHI relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers' Compensation

- If you are seeking compensation from Workers Compensation, we may disclose your PHI to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

- We may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; or to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

As Required by Law

- We may disclose your PHI as required by law, or to appropriate public authorities as allowed by law to report abuse or neglect.

Employers

- We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of the release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of information to your employer.

Law Enforcement

- We may disclose your PHI to law enforcement officials (a) in response to a court order, court subpoena, warrant or similar judicial process; (b) to identify or locate a suspect, fugitive, material witness, or missing person; (c) if you are a victim of a crime and we are unable to obtain your agreement; (d) about criminal conduct on our premises; and (e) in other limited emergency circumstances where we need to report a crime.

Health Oversight

- Federal law allows us to release your PHI to appropriate health oversight agencies or for health oversight activities such as state and federal auditors.

Judicial/Administrative Proceedings

- We may disclose your PHI in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

For Specialized Governmental Functions or Serious Threat

- We may disclose your PHI for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, to public assistance program personnel, or to avert a serious threat to health or safety. We may disclose your PHI consistent with applicable law to prevent or diminish a serious, imminent threat to the health or safety of a person or the public.

Correctional Institutions

- If you are an inmate of a correctional institution, we may disclose to the institution or its agents the PHI necessary for your health and the health and safety of other individuals.

Coroners, Medical Examiners, and Funeral Directors

- We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about our Patients to funeral directors as necessary for them to carry out their duties.

Website

- You may access a copy of this Notice electronically on our website.

Other uses and disclosures of your PHI not described in this Notice will only be made with your authorization, unless otherwise permitted or required by law. Most uses and disclosure of psychotherapy notes, uses and disclosures of your PHI for marketing purposes, and disclosures of your PHI that constitute a sale of PHI will require your authorization. You may revoke any authorization at any time by submitting a written revocation request to the Practice (as previously provided in this Notice under "Your Health Information Rights.")

To Request Information, Exercise a Patient Right, or File a Complaint

If you have questions, would like additional information, want to exercise a Patient Right described above, or believe your (or someone else's) privacy rights have been violated, you may contact the Practice's Privacy Officer at (303) 952-1100, or in writing to us at:

**Dawn Holdren
Colorado Pulmonary Intensivists P.C.
15 West Dry Creek Circle
Littleton, CO 80120**

Please note that all complaints must be submitted in writing to the Privacy Officer at the above address.

You may also file a complaint with the Secretary of Health and Human Services (HHS), Office for Civil Rights (OCR). Your complaint must be filed in writing, either on paper or electronically, by mail, fax, or e-mail. The address for the Colorado regional office is: Office for Civil Rights, U.S. Department of Health and Human Services, 999 18th Street, Suite 417, Denver, CO 80202; or call (800) 368-1019. More information regarding the steps to file a complaint can be found at:

www.hhs.gov/ocr/privacy/hipaa/complaints.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of HHS as a condition of receiving treatment from the Practice.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of HHS.