Western CO Pediatrics Patient Request

PRIMARY CARE PARTNERS
3150 N. 12th Street • Grand Junction, Colorado 81506
P.O. Box 10700 • Grand Junction, Colorado 81502

☐ Grand Jct ☐ Fruita

Date | Office Requested | Preferred Physician (if applicable)

Referred by (if applicable)

Previous Provider/Physician

Are you a Hilltop or St. Mary's employee? Yes ☐ No ☐

Do you have Monument Health Insurance Yes ☐ No ☐

Are any of your family members current patients? Yes ☐ No ☐

Patient Information

Responsible Party Name | DOB | Phone | Email

[Please circle preferred contact method]

SS# | DL # | Language

Address | City | State | ZIP Code

Spouse Name | DOB | Phone | Email

May we share financial information regarding this account with your spouse? Y N

SS# | DL# | Language

Male Female

Child #1 Name (last, first) | DOB | Gender (circle one)

SS# | Relation to Responsible Party

Race (circle one): American Indian/Alaskan | Asian | Native Hawaiian/ Pacific Islander | Black/ African American | White | Decline to Answer

Ethnicity (circle one): Hispanic/ Latino | Non Hispanic/ Latino | Decline to Answer

Language

PCP Care Village
3150 N 12th Street
Grand Junction, CO 81506
Western Colorado Pediatrics 970-243-5437
Family Physicians of Western Colorado 970-245-1220
Tabeguache Family & Sports Medicine 970-256-5201
Diagnostics & Mammography 970-241-6014
Physical Therapy Specialty Center 970-241-5856
Nutrition Therapy & Wellness 970-255-1576

After-Hours Clinic
3150 N 12th Street
Grand Junction, CO 81506
DOCS on Call 970-255-1576

Wellington Location
1120 Wellington Ave
Grand Junction, CO 81501
Western Colorado Physicians Group 970-241-6011

Fruita Location
455-456 Kokopelli Blvd
Fruita, CO 81521
Western Colorado Pediatrics 970-243-5437
Red Canyon Family Medicine 970-256-5285

PRIMARY CARE PARTNERS

3150 N. 12th Street • Grand Junction, Colorado 81506
P.O. Box 10700 • Grand Junction, Colorado 81502

Male ○ Female ○

Child #2 Name (last, first) | DOB | Gender (circle one)

SS#

Relation to Responsible Party

Race (circle one): ○ American Indian/Alaskan ○ Asian ○ Native Hawaiian/ Pacific Islander ○ Black/ African American ○ White ○ Decline to Answer

Ethnicity (circle one): ○ Hispanic/ Latino ○ Non Hispanic/ Latino ○ Decline to Answer

Language

Notify in case of emergency (other than in household) | Phone | Relationship to Patient

Child's Insurance | Member ID | Group #

Medicaid/CHP+ Member ID #

Parent's Employer

Email ○ Decline ○ | Print ○ Decline ○

How did you hear about us?

Reminder Communication

Appointment Summary

PCP Care Village
3150 N 12th Street
Grand Junction, CO 81506

Western Colorado Pediatrics
970-243-5437

Family Physicians of Western Colorado
970-245-1220

Tabeguache Family & Sports Medicine
970-256-5201

Diagnostics & Mammography
970-241-6014

Physical Therapy Specialty Center
970-241-5856

Nutrition Therapy & Wellness
970-255-1576

After-Hours Clinic
3150 N 12th Street
Grand Junction, CO 81506

DOCS on Call
970-255-1576

Wellington Location
1120 Wellington Ave
Grand Junction, CO 81501

Western Colorado Physicians Group
970-241-6011

Fruita Location
455-456 Kokopelli Blvd
Fruita, CO 81521

Western Colorado Pediatrics
970-243-5437

Red Canyon Family Medicine
970-256-5285

PRIMARY CARE PARTNERS
3150 N. 12th Street • Grand Junction, Colorado 81506
P.O. Box 10700 • Grand Junction, Colorado 81502
Medical Records | P: (970) 256-5240 | F: (970) 778-3136

Records Release Authorization

* FAXED OR MAILED RECORDS RELEASE SHOULD BE ACCOMPANIED BY PICTURE ID (OR THAT OF A PARENT/GUARDIAN) & WITNESS SIGNATURE *

I give permission to Primary Care Partners to: (check one)

- ☐ Obtain (get) information
- ☐ Release (give) information
- ☐ Exchange (share) information

Name

Address

Phone | Fax

This authorizes the release of the requested information on the individual(s) below:
(One patient per line. If additional space is needed, please use back of form)

Patient Name DOB

Patient Name DOB

Information Format: ☐ Mail ☐ Pick up ☐ Fax ☐ Email _____ ☐ USB drive

Information Requested:

- ☐ Standard Records (last 3 yrs. office visits, physicals, growth chart, vaccines, problem list, laboratory results, radiology reports, hospital notes)
- ☐ Limited Records (event, dates: _____)
- ☐ Complete Records
- ☐ Immunization Records
- ☐ Psychotherapy Notes
- ☐ Radiology Images (date: _____) Primary Care Partners can only provide images for tests we have conducted. For radiology done by a third party, please request the images directly from them.

I request and authorize the above named provider/s to release this information. I understand the records may include information regarding the following conditions: drug or alcohol abuse, psychological or psychiatric conditions, developmental disabilities, HIV, AIDS, sexually transmitted diseases, pregnancy or other sensitive information. I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment, my eligibility for benefits, etc. will not depend in any way on whether I sign this authorization or not. I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. This authorization will expire 1 year from the date below.

First copies are at no charge. I understand that I may be charged a reasonable fee per rates set by the Colorado State Board Health after the first courtesy release for: paper copies or transfer, electronic records, or mailing (includes postage/materials).
☐ I hereby agree to pay the charges specified above. Please bill me. ☐ Please contact me with total incurred cost

Print Name Relationship to Patient

Signature Date

Witness Signature Date

PCP Care Village
3150 N 12th Street
Grand Junction, CO 81506
Western Colorado Pediatrics 970-243-5437
Family Physicians of Western Colorado 970-245-1220
Tabeguache Family & Sports Medicine 970-256-5201
Diagnostics & Mammography 970-241-6014
Physical Therapy Specialty Center 970-241-5856
Nutrition Therapy & Wellness 970-255-1576

After-Hours Clinic
3150 N 12th Street
Grand Junction, CO 81506
DOCS on Call 970-255-1576

Wellington Location
1120 Wellington Ave
Grand Junction, CO 81501
Western Colorado Physicians Group 970-241-6011

Fruita Location
455-456 Kokopelli Blvd
Fruita, CO 81521
Western Colorado Pediatrics 970-243-5437
Red Canyon Family Medicine 970-256-5285

Western Colorado Pediatrics
Social & Family History Intake

PRIMARY CARE PARTNERS
3150 N. 12th Street • Grand Junction, Colorado 81506
P.O. Box 10700 • Grand Junction, Colorado 81502

(We are collecting this information to help update your child's health history. Thank you for your patience in filling out this form.)

Patient Name: _____ Date of Birth: _____
Birth information: (*Check one)* Term ☐ –or-- Premature ☐ _____weeks Birth Weight: _____
Hospitalizations *(include age and reason):* _____
_____
Surgeries *(include age and reason):* _____
Previous wheezing or asthma? *(check)* Yes ☐ No ☐ Age at onset: _____
Previous kidney or bladder infection? *(check)* Yes ☐ No ☐ Age(s): _____
Allergies *(include type of reaction)*: Medications? _____ Foods/Other: _____
Other Medical Problems:_____

Living Situation
Who does the child live with? (Please include ONLY those living with this child).
Name of Mother: _____ Name of Father: _____
Name of Step-Mother: _____ Name of Step-Father: _____
Name of Grandparents living with the child: _____
Name/relationship to the child of Other Adults living in the home: _____
Siblings (name and ages): _____
Smokers: Yes ☐ No ☐ ANY smoking in the home or automobile? Yes ☐ No ☐

Family Health History *(Relatives of your child are listed in the table)*

Please check the appropriate boxes and write in any needed additional information.	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other *(Write the relationship to the child in the boxes below)*
Healthy	☐	☐	☐	☐	☐	☐	☐	☐	
Alcoholism	☐	☐	☐	☐	☐	☐	☐	☐	
Allergies	☐	☐	☐	☐	☐	☐	☐	☐	
Anemia	☐	☐	☐	☐	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	
Bleeding Problem	☐	☐	☐	☐	☐	☐	☐	☐	
Clotting Problem	☐	☐	☐	☐	☐	☐	☐	☐	
Epilepsy	☐	☐	☐	☐	☐	☐	☐	☐	
Depression	☐	☐	☐	☐	☐	☐	☐	☐	
Drug Dependency	☐	☐	☐	☐	☐	☐	☐	☐	
Genetic Disorder	☐	☐	☐	☐	☐	☐	☐	☐	
Deafness	☐	☐	☐	☐	☐	☐	☐	☐	
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐	
Overweight	☐	☐	☐	☐	☐	☐	☐	☐	
Seizure	☐	☐	☐	☐	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	
Sudden Infant Death	☐	☐	☐	☐	☐	☐	☐	☐	
Tuberculosis (TB)	☐	☐	☐	☐	☐	☐	☐	☐	
Diabetes-Type 1 (Child)	☐	☐	☐	☐	☐	☐	☐	☐	
Diabetes-Type 2 (Adult)	☐	☐	☐	☐	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	☐	☐	☐	☐	

PRIMARY CARE PARTNERS

3150 N. 12th Street • Grand Junction, Colorado 81506
P.O. Box 10700 • Grand Junction, Colorado 81502

New Insurance Information

Primary Insurance _____ Secondary Insurance _____ Other Insurance(s) _____

GUARANTOR/INSURED PERSON'S INFORMATION REQUIRED BELOW:

Name _____ DOB _____ SSN _____

Is this the plan provided by the Guarantor's employer? Yes ☐ No ☐

Guarantor's Employer _____

PLEASE LIST ALL MEMBERS COVERED BY THE NEW INSURANCE

List primary insurance members:

Name	DOB	Insurance ID # (Insurance ID# only required if different than the Guarantor/Insured)

List secondary insurance members:

Name	DOB	Insurance ID #

* OFFICE USE ONLY: COPY FRONT AND BACK OF CARD BELOW *

PCP Care Village
3150 N 12th Street
Grand Junction, CO 81506

Western Colorado Pediatrics
970-243-5437

Family Physicians of Western Colorado
970-245-1220

Tabeguache Family & Sports Medicine
970-256-5201

Diagnostics & Mammography
970-241-6014

Physical Therapy Specialty Center
970-241-5856

Nutrition Therapy & Wellness
970-255-1576

After-Hours Clinic
3150 N 12th Street
Grand Junction, CO 81506

DOCS on Call
970-255-1576

Wellington Location
1120 Wellington Ave
Grand Junction, CO 81501

Western Colorado Physicians Group
970-241-6011

Fruita Location
455-456 Kokopelli Blvd.
Fruita, CO 81521

Western Colorado Pediatrics
970-243-5437

Red Canyon Family Medicine
970-256-5285

PRIMARY CARE PARTNERS

Your Healthcare Destination

NOTICE OF PRIVACY PRACTICES

PRIMARY CARE PARTNERS, PC

Primary Care Partners HIPAA Compliance Team – 970-256-5211

Effective Date: 01/22/2022

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others.We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information.If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores in an electronic health record and in some cases in paper form. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection, compliance programs and business planning and management. We may also share your medical information with our "business associates," that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your medical information. We may also share medical information about you with the other health care providers that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations such as area hospitals. We also share information with Quality Health Network, a Grand Junction based health information exchange (HIE) that helps medical and behavioral health providers in western Colorado securely share patient data that enhances care coordination, reduces duplication of services, and identifies individuals at risk so that efforts can be focused where they are needed most

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet.We may use and disclose medical information about you by having you sign in when you arrive at our offices. We may also call out your name when we are ready to see you.

6. Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative, or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care.If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, recommend that you participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health

information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law.As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health.We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order.We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety.We may, and are sometimes required by law, to disclose your health information to appropriate persons to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student if you have agreed to the disclosure on behalf of yourself or your dependent.

18. Specialized Government Functions.We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. Worker's Compensation.We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition.We are

also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

22. Psychotherapy Notes.We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: 1) your treatment, 2) for training our staff, students and other trainees, 3) to defend ourselves if you sue us or bring some other legal proceeding, 4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, 5) in response to health oversight activities concerning your psychotherapist, 6) to avert a serious threat to health or safety, or 7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.

23. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections.You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed.If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, we ask for a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an

alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, we will provide your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal Colorado law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional. You also have a right to ask that we exchange or provide your electronic health information for your use, access or exchange.

4. Right to Amend. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial.We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures.You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

   If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice.After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received.We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.]

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the way this practice handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201
OCRMail@hhs.gov

The complaint form may be found at:
www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf.

You will not be penalized in any way for filing a complaint.

Acknowledgement of Receipt of Notice

PRIMARY CARE PARTNERS
3150 N. 12th Street • Grand Junction, Colorado 81506
P.O. Box 10700 • Grand Junction, Colorado 81502

Notice of Privacy Practices

Compliance Officer 970-254-2609

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Print Name _____ **Date** _____

Signature _____ **Phone Number** _____

If not signed by the patient, please indicate relationship:

- ☐ **Parent or guardian of minor patient**
- ☐ **Spouse**
- ☐ **Guardian or conservator of an incompetent patient**
- ☐ **Beneficiary or personal representative of deceased patient**

Names of adults on this account: _____

Names of children under the age of 18 on this account: _____

_____

For Office Use Only:

Account #: _____ **Signed form received by:** _____

Acknowledgment refused

Efforts to obtain: _____ **Reasons for refusal:** _____

_____ _____

_____ _____

PCP Care Village
3150 N 12th Street
Grand Junction, CO 81506

Western Colorado Pediatrics
970-243-5437

Family Physicians of Western Colorado
970-245-1220

Tabeguache Family & Sports Medicine
970-256-5201

Diagnostics & Mammography
970-241-6014

Physical Therapy Specialty Center
970-241-5856

Nutrition Therapy & Wellness
970-255-1576

After-Hours Clinic
3150 N 12th Street
Grand Junction, CO 81506

DOCS on Call
970-255-1576

Wellington Location
1120 Wellington Ave
Grand Junction, CO 81501

Western Colorado Physicians Group
970-241-6011

Fruita Location
455-456 Kokopelli Blvd
Fruita, CO 81521

Western Colorado Pediatrics
970-243-5437

Red Canyon Family Medicine
970-256-5285

HIPPA Disclosure Authorization

PRIMARY CARE PARTNERS
3150 N. 12th Street • Grand Junction, Colorado 81506
P.O. Box 10700 • Grand Junction, Colorado 81502

As required by the Health Insurance Portability and Accountability Act of 1996

Primary Care Partners, PC may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. **Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to this office.**

AUTHORIZATION

I, _____ _____
Print Name Phone Number

hereby authorize the [use]◯ [disclosure]◯ [use & disclosure]◯ of the following health information that pertains to me

☐ All medical records: Medical testing, treatments, medicines, any notes doctors make about you and your health
☐ Psychiatric Records
☐ Limited Records (specify): _____
_____

Name	Relationship	Phone Number

Name	Relationship	Phone number

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that this authorization will automatically expire one year from the signing date.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

I understand that I am under no obligation to sign this authorization. I further understand that [my ability to obtain treatment, my eligibility for benefits, etc.] will not depend in any way on whether I sign this authorization or not.

_____ _____ _____
Signature **Date** **Account #**

REVOCATION

I hereby revoke this authorization:

_____ _____
Signature **Date**

PCP Care Village
3150 N 12th Street
Grand Junction, CO 81506
Western Colorado Pediatrics
970-243-5437
Family Physicians of Western Colorado
970-245-1220
Tabeguache Family & Sports Medicine
970-256-5201
Diagnostics & Mammography
970-241-6014
Physical Therapy Specialty Center
970-241-5856
Nutrition Therapy & Wellness
970-255-1576

After-Hours Clinic
3150 N 12th Street
Grand Junction, CO 81506
DOCS on Call
970-255-1576

Wellington Location
1120 Wellington Ave
Grand Junction, CO 81501
Western Colorado Physicians Group
970-241-6011

Fruita Location
455-456 Kokopelli Blvd
Fruita, CO 81521
Western Colorado Pediatrics
970-243-5437
Red Canyon Family Medicine
970-256-5285

PRIMARY CARE PARTNERS

3150 N. 12th Street • Grand Junction, Colorado 81506
P.O. Box 10700 • Grand Junction, Colorado 81502

Payment Policy

Date

Account Number

It is the policy of Primary Care Partners, P.C., that payment for medical services is due at the time service is provided. Where participating insurance coverage is involved, we will request co-payments from you at the time of service. If we are not contracted with your insurance company, we will provide you with a copy of the billing form to submit the claim yourself. If we contract with your insurance carrier, we will submit a bill on your behalf.

Insurance settlements are strictly between you and your carrier. Payment is expected at the time of service for any appropriate co-payments.. If you are unable to make payment, arrangements must be made with our Credit Manager.

Accounts over 28 days old, from the date of the first patient statement, will be charged an annual interest rate of 18% on the outstanding balance. Delinquent accounts will be turned over to our collection agency unless other arrangements are made with our collections department prior to that time. Our collection agency charges up to 45% of the unpaid principal balance at the time it is turned to them. That fee will become your responsibility in addition to all monies owed to us. You will be responsible for any charges denied by your insurance carrier.

I have read the above policy regarding payment for services by Primary Care Partners, P. C., and agree to the terms and conditions outlined therein. I further agree, in the event of nonpayment, to bear the cost of collection and/or court costs and reasonable legal fees should this be required.

Patient/Legal Representative Signature

Printed Name Date

PRIMARY CARE PARTNERS
3150 N. 12th Street • Grand Junction, Colorado 81506
P.O. Box 10700 • Grand Junction, Colorado 81502

WCPA PATIENT OVERVIEW

Insurance:
Please have your health insurance I.D. card available at the time of *each* visit. It is important that we have the correct billing information. Financial responsibility for your child(ren)'s treatment is ultimately that of the parent/guardian. Parents/Guardians are responsible for all co-pays and deductibles for all services being rendered. If you have an insurance that we do not participate with or do not have insurance, it is your responsibility to *pay* at the time of service unless payment arrangements have been made with our Credit Managers, 970-245-9370.

Payment and Patient Balances:
WCPA expects Payment for services and/or co-payments at the time of your appointment. If you cannot pay your balance within 30 days, we encourage you to contact Credit Managers office to discuss your account. Credit Managers 970-245-9370

Appointments:
Appointments are confirmed via text. Please arrive 15 minutes early for your appointment. If you arrive after your scheduled appointment, we might need reschedule your appointment or move your appointment to a different provider.

Mobile Pre-Visits:
We now offer mobile check-in, giving you a faster registration experience. You can check in before your appointment from your computer, tablet or phone, whenever is most convenient for you. Just make sure we have your updated e-mail or cell phone number on file and we will send you a registration link a few days before your appointment!

Missed Appointment (Non-Cancelled)/Cancellations:
We understand hectic schedules! Please give our staff a 2 hours' notice if you cannot make an appointment. If you do not call, we cannot give that appointment to another child who may need it.

PRIMARY CARE PARTNERS
3150 N. 12th Street • Grand Junction, Colorado 81506
P.O. Box 10700 • Grand Junction, Colorado 81502

SEPARATED AND DIVORCED FAMILIES GUIDE

At Western Colorado Pediatric Associates, our highest priority is the care of our patients. It is our intent to work cooperatively with parents in accordance with any legal orders that are in place.

Custody: Custody decisions are made between parents with the help of the courts or the Department of Children and Families. In order to avoid any confusion for our staff, and to make sure we are managing your child's care appropriately, we require legal documentation of any provisions the court has set forth in regards to custody and communication with our office. In the absence of legal orders, we expect that both parents will cooperate with each other in the best interest of the child. We are unable to restrict communication with any parent without court documentation or documentation from the Department of Children and Families.

Information of File: The address listed first for your child (ren) should be the address at which the child resides. If parents share custody and the child resides at two different addresses, please list the address of the parent providing insurance coverage first, followed by the address of the other parent. Please don't eliminate the "other" parent by listing a step-parent instead, as this prevents us from keeping appropriate information on file when both parents are entitled to information about their child(ren).

Communication: We ask that both parents reach an agreement regarding major health decisions before visiting the office as we will not mediate disagreements. We expect parents to communicate with each other regarding appointment scheduling, insurance, and any changes in medical care or treatment plans.

Billing: Copays will be collected at the time of service by the parent accompanying the child. If the court agreement states the other parent is responsible for copayments, it is the accompanying parent's responsibility to pay at the time of the visit and collect reimbursement from the responsible parent. We will be happy to provide a copy of the receipt.

Disputes: The providers and staff will not get involved in disputes between parents. If disputes regarding your child's medical care interfere with our ability to care for your child, we reserve the right to ask you to transfer care to another practice. In closing, we ask that you please remember separation is hard on children and your cooperation with each other is very important to your child's mental and physical health.

Thank you for your cooperation in this matter.

PRIMARY CARE PARTNERS
Your Healthcare Destination

Create an Account from an **Email Invitation**

Proxy Registration Instructions for Children

With the all-in-one personal health record and patient portal, accessing your child's medical information from any computer, tablet or smartphone is easier than ever!

Just follow these simple steps to get connected today!

1

Check your email. You will receive an email from noreply@followmyhealth.com. **Set up needs to be done on a computer/tablet.** Click the registration link and follow the on screen prompts. If you don't receive an email, please check your junk/spam folder.

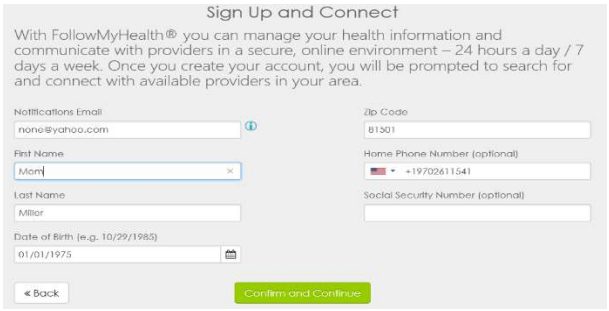
2

Don't have a Portal Account? Click Sign Up and Connect

-OR-

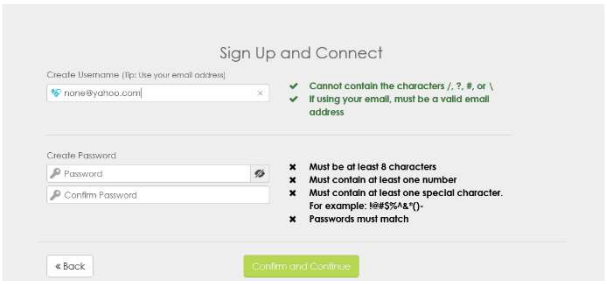
If you have an existing portal account for yourself **Click on "Sign in and add this connection." Log In to <u>Your</u> Portal Account**. Skip to **Register as a Proxy** step #5.

3



Enter <u>YOUR</u> name, email address and DOB (not your child's) and click "Confirm and Continue". Then accept the Health Records Terms of Use.

4



Create a username for **Your** portal account. By default, your email address that your invitation was sent to will appear in the username box. It is recommended to use this email address as your username.

Next, **create a password** following the criteria noted on the right of the screen.

5 Register as an authorized individual

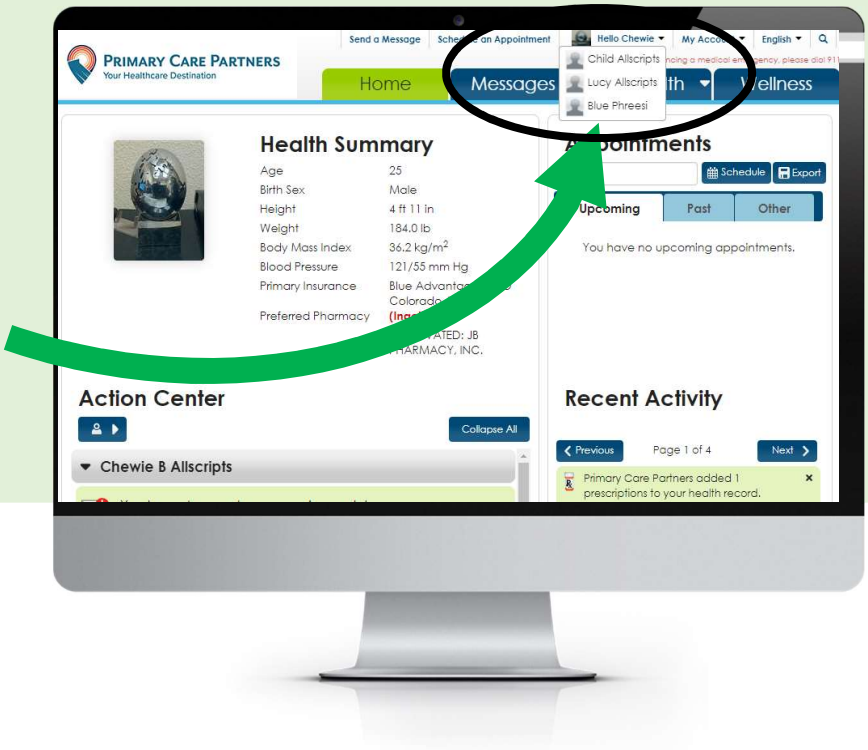
Get Connected. Follow the on-screen prompts on the next four screens to complete your connection. These screens include accepting our **Terms of Service,** entering your **Invite Code (the last 4 digits of the parent's SS#)** and accepting the **Release of Information,** (If you have multiple children this will need to be for all of them).

Your child's health record will then begin to upload. Once populated, you'll be logged in to your account. To view your loved one's information, simply click on **Hello (Your Name)** in the top right corner of your portal, and drop down to your loved one's record will appear.

Have Questions for Your Loved One's Physician?

Avoid phone tag—communicate with your child or dependent adult's doctor by using the secure messaging feature within the portal. It's quick and easy—n just like email!

Remember, that your main FollowMyHealth account is under <u>your</u> name and you need to be sure to click the drop down arrow next to the "HELLO" to send messages under the correct child.



FollowMyHealth® Universal Health Record

PRIMARY CARE PARTNERS

3150 N. 12th Street • Grand Junction, Colorado 81506
P.O. Box 10700 • Grand Junction, Colorado 81502

Minor Proxy Form

Primary Care Partners provides patients with online access to their records through FollowMyHealth. Once enrolled for access, you will receive an email invitation from noreply@FollowMyHealth.com to activate your account. If you do not see the invitation within a few days, please check your Junk or Spam folder.

☐ WCPA ☐ FPWC ☐ WCPG ☐ TFSM ☐ PTSC ☐ RCFP ☐ NTW			Patient #/MRN#:
Parent/ Guardian	Full Name:		Phone#:
	Address:		
	City:	State:	Zip:
	Date of Birth:	Last 4 digits Social Security #:	
	Email Address:		
Please complete the below section for each child under the age of 18			
Child 1	Child's Name:		Date of Birth:
	Child's Address: Same as above ☐		Proxy's Relationship to Child:
Child 2	Child's Name:		Date of Birth:
	Child's Address: Same as above ☐		Proxy's Relationship to Child:
Child 3	Child's Name:		Date of Birth:
	Child's Address: Same as above ☐		Proxy's Relationship to Child:

By signing below, I authorize Primary Care Partners to enroll me and/or provide proxy access to my information to the above listed individual(s) in Primary Care Partner's patient portal. Authorized representative maybe required to submit copies of legal documents supporting his/her authority to act on a patient's behalf.

Patient/Legal Representative Signature Relationship to Patient Date