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

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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

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PRIMARY CARE PARTNERS
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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

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Western Colorado Pediatrics
Social & Family History Intake

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(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:	☐	☐	☐	☐	☐	☐	☐	☐	

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Minor Proxy Release 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

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.

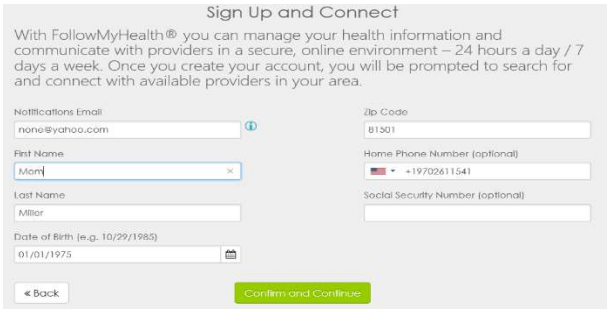
2

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

-OR-

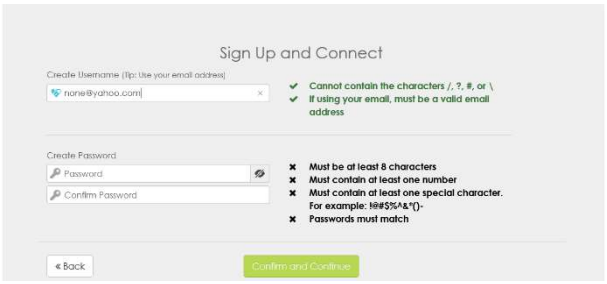
If you have an existing portal account for yourself **Click on "Sign in and add this connection." Log In to <u>Your</u> Portal Account**. Skip to **Register as a Proxy** step #5.

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

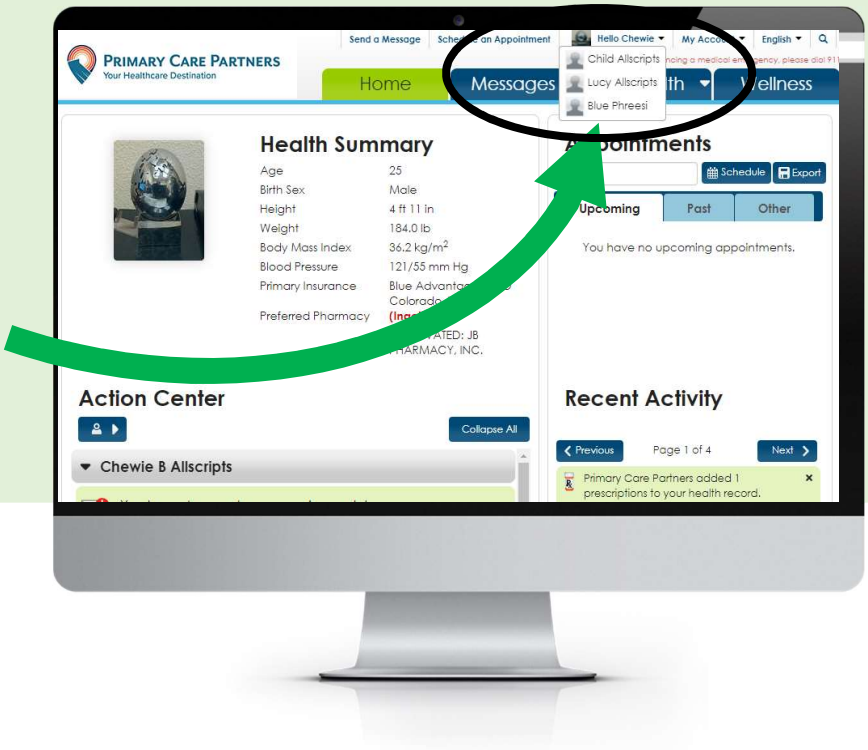
Get Connected. Follow the on-screen prompts on the next four screens to complete your connection. These screens include accepting our **Terms of Service,** entering your **Invite Code (the last 4 digits of the parent's SS#)** and accepting the **Release of Information,** (If you have multiple children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

WESTERN COLORADO PEDIATRICS

a division of Primary Care Partners

WCP 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 at the time of service. 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:

WCP 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 PRIOR to** your appointment. If you arrive after your scheduled appointment, we will reschedule your appointment or move your appointment to a different provider. (*Please note that the missed appointment due to being late will count as a No Show)*

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 **3** days before your appointment!

Missed Appointment (Non-Cancelled)/Cancellations:

We understand hectic schedules! Please give our staff a **3** hour notice if you cannot make an appointment. If you do not call, we cannot give that appointment to another child who may need it.

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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.