# New Patient Intake Form

MarillacHealth
Committed to a healthier you.

| Today's Date: | Current Primary Care Provider: |
|---|---|

**PATIENT INFORMATION**

| Patient's Last Name: | First: | Middle: |
|---|---|---|
| | | |

| Mailing address: | City: | State: | Zip Code: |
|---|---|---|---|
| | | | |

| Date of Birth: | Social Security Number: | Marital Status: (Please Circle One) |
|---|---|---|
| | | Single Married Divorced Widow(ed) Common-law |

| Gender Identity: (Please Circle One) | Sexual Orientation: (Please Circle One) |
|---|---|
| Male Female Transgender Male Transgender Female Choose not to Disclose | Straight Gay/Lesbian Bi-sexual Other |

| Home Phone Number: | Cell Phone Number: | Employment Status: |
|---|---|---|
| | | |

| Employer: | Work Phone Number: |
|---|---|
| | |

| Race: (Please Circle One) | Ethnicity: | Preferred Language: |
|---|---|---|
| White Black Hispanic American Indian Native Hawaiian Pacific Islander Other: _____ | Hispanic Non-Hispanic | |

| Household Status: (Please Circle One) | Public Housing: (Please Circle One) | Location: |
|---|---|---|
| Not Homeless Homeless | Yes No | |
| **Emergency Contact Name:** | **Relationship to Patient:** | **Emergency Contact Phone:** |
| | | |

Preferred Pharmacy:

Other Notes:

**PARENT/GUARDIAN INFORMATION (IF APPLICABLE)**

| Last Name: | First: | Middle: |
|---|---|---|
| | | |

| Work Phone Number: | Home Phone Number: | Cell Phone Number: |
|---|---|---|
| | | |
| **Social Security Number:** | **Birth Date:** | **Relationship to Patient:** |
| | | |

| Additional Emergency Contact: | Phone Number: | Relationship to Patient: |
|---|---|---|
| | | |

Additional Notes:

-------- Continued on next page -------

# New Patient Intake Form

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Committed to a healthier you.

## INSURANCE INFORMATION

*(Please present your insurance card)*

| Person responsible for bill: | Birth Date: | Address (if different): | Home Phone Number: |
|---|---|---|---|
| | | | |
| **Employer:** | **Supervisor Name:** | **Employer Address:** | **Employer Phone Number:** |
| | | | |

| Primary Health Insurance: | Subscriber's name: | Birth date: |
|---|---|---|
| | | |

| Subscriber's SSN: | Group Number/ID: | Policy Number: | Co-payment: |
|---|---|---|---|
| | | | $ |

Patient's relationship to subscriber:

| Name of secondary insurance (if applicable): | Subscriber's name: | Group Number: | Policy Number: |
|---|---|---|---|
| | | | |

Patient's relationship to subscriber:

## ADDITIONAL INSURANCE INFORMATION

| **MEDICAID:** | MEDICAID ID: | Member ID: |
|---|---|---|
| | | |
| PCP/HMO Provider: | Provider Phone Number: | |
| | | |

| **CHP:** | Birth Date of Cardholder: | ID or PIN # on Card: | Group Number: |
|---|---|---|---|
| Name on Card: | | | |

| **Dental Insurance:** | Subscriber's SSN: | Cardholder Birth date: | Group Number/ID: | Policy Number: |
|---|---|---|---|---|
| Company: | | | | |

Patient or legal Guardian Signature: _____

Please print patient or legal Guardian Name: _____

Date:

# Health History Questionnaire Medical

MarillacHealth
Committed to a healthier you.

Your answers on this form will help your health care provider better understand your medical concerns and conditions. Add any notes you think are important. ALL QUESTIONS ARE KEPT PRIVATE AND PROTECTED BY HIPAA.

| Today's Date: | Patient Date of Birth: |
|---|---|

**PATIENT INFORMATION**

| Patient's Last Name: | First: | Middle: |
|---|---|---|

| How would you rate your general health? (Please Circle One) | Main reason for today's visit? | Other Concerns? |
|---|---|---|
| Excellent Good Fair Poor | | |

**PAST MEDICAL HISTORY**

| HEENT | Respiratory | Neurologic |
|---|---|---|
| □ Allergies | □ Asthma | □ Epilepsy |
| □ Blindness | □ Bronchitis | □ Head Injury/Concussion |
| □ Cataracts | □ COPD | □ Headaches |
| □ Chronic Sinus Problems | □ Emphysema | □ Migraines |
| □ Glaucoma | □ Pneumonia | □ Seizures |
| □ Hearing Loss | □ Tuberculosis | □ Stroke |
| □ Macular Degeneration | □ Other: _____ | □ Other: _____ |
| □ Other: _____ | | |

| Cardiovascular | Gastrointestinal | Hematology/Cancer |
|---|---|---|
| □ Atrial Fibrillation | □ Celiac Disease | □ Anemia |
| □ Circulatory Problems | □ Crohn's Disease | □ Blood Clots |
| □ Please Specify: _____ | □ Eating Disorder (Anorexia/Bulimia) | □ Breast Cancer |
| □ Congestive Heart Failure | □ Gastritis (Stomach Pain) | □ Colon Cancer |
| □ Heart Disease; Specify: _____ | □ Hemorrhoids | □ Prostate Cancer |
| □ Heart attack; when: | □ Hepatitis | □ Cancer; Other _____ |
| □ Heart Murmur | □ Hernias | **Skin Disorders** |
| □ High Blood Pressure/Hypertension | □ Irritable Bowel Syndrome | □ Eczema |
| □ High Cholesterol/Hyperlipidemia | □ Jaundice | □ Psoriasis |
| □ Valvular Heart Disease | □ Pancreatitis | □ Skin Cancer |
| □ Other: _____ | □ Ulcerative Colitis | □ Other: _____ |
| | □ Reflux (Frequent Indigestion) | |
| | □ Ulcers | |
| | □ Other: _____ | |

| Genitourinary | Endocrine | Rheumatologic |
|---|---|---|
| □ BPH | □ Diabetes Mellitus Type I; age onset: _____ | □ Fibromyalgia |
| □ Kidney Disease | □ Diabetes Mellitus Type II; age onset: _____ | □ Gout |
| □ Kidney Stones | □ Gestational Diabetes | □ Lupus |
| □ Frequent Urinary Tract Infections | □ Hyperthyroidism | □ Osteoarthritis |
| □ Urinary Incontinence | □ Hypothyroidism | □ Rheumatoid Arthritis |
| □ Other: _____ | □ Other: _____ | □ Other: _____ |

| Psychiatric | Musculoskeletal | STD's |
|---|---|---|
| □ Alcohol Problems | □ Arthritis | □ Chlamydia |
| □ Anxiety | □ Osteoporosis/Osteopenia | □ Genital Herpes |
| □ Depression | □ Scoliosis | □ Genital Warts |
| □ Drug Problems/Addiction | □ Other: _____ | □ Gonorrhea |
| □ Other: _____ | | □ HIV/Aids |
| | | □ Other: _____ |

**PAST SURGICAL HISTORY**

| SURGERY | REASON | YEAR | HOSPITAL |
|---|---|---|---|
| 1 _____ | _____ | _____ | _____ |
| 2 _____ | _____ | _____ | _____ |
| 3 _____ | _____ | _____ | _____ |

# Health History Questionnaire Medical

MarillacHealth
Committed to a healthier you.

## REVIEW OF THE SYSTEMS

Please check all that apply

### Allergic/Immunologic

- ☐ Frequent Sneezing
- ☐ Hives
- ☐ Itching
- ☐ Runny Nose
- ☐ Sinus Pressure

### Cardiovascular

- ☐ Arm Pain on Exertion
- ☐ Chest Pain on Exertion
- ☐ Chest Heaviness/Pressure on Exertion
- ☐ Irregular Heartbeats (Palpitations)
- ☐ Known Heart Murmur
- ☐ Light Headed on Standing
- ☐ Shortness of Breath When Lying Down
- ☐ Swelling (Edema)

### Constitutional

- ☐ Exercise Intolerance
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain ( _____ lbs)
- ☐ Weight Loss ( _____ lbs)

### Eyes

- ☐ Dry Eyes
- ☐ Irritation
- ☐ Vision Change
- ☐ Date of last exam: _____

### Ear/Nose/Mouth/Throat

- ☐ Bleeding Gums
- ☐ Difficulty Hearing
- ☐ Dizziness
- ☐ Dry Mouth
- ☐ Ear Pain
- ☐ Frequent Infections
- ☐ Frequent Nose Bleeds
- ☐ Hoarseness
- ☐ Mouth Breathing
- ☐ Mouth Ulcers
- ☐ Nose/Sinus Problems

### Endocrine

- ☐ Fatigue
- ☐ Increased Thirst/Hunger/Urination

### Gastrointestinal

- ☐ Abdominal Pain
- ☐ Black or Tarry Stool
- ☐ Blood in Stool
- ☐ Change in Appetite
- ☐ Frequent Indigestion
- ☐ Hemorrhoids
- ☐ Trouble Swallowing
- ☐ Vomiting
- ☐ Vomiting Blood

### Genitourinary

- ☐ Blood in Urine
- ☐ Difficulty in Urinating
- ☐ Incomplete Emptying
- ☐ Increased Urinary Frequency
- ☐ Urinary Loss of Control

### Hematologic/Lymphatic

- ☐ Easy Bruising/Bleeding
- ☐ Swollen Glands

### Integumentary (Skin)

- ☐ Changes in Moles
- ☐ Dry Skin
- ☐ Eczema
- ☐ Growth/Lesions
- ☐ Itching
- ☐ Jaundice (Yellow Skin/Eyes)
- ☐ Rash

### Musculoskeletal

- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Aches
- ☐ Muscle Weakness

### Neurological

- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Memory Loss
- ☐ Migraines
- ☐ Numbness
- ☐ Restless Legs
- ☐ Seizures
- ☐ Weakness

### Psychiatric

- ☐ Alcohol Overuse
- ☐ Anxiety/Stress
- ☐ Depression
- ☐ Do not feel safe in relationship
- ☐ Mania
- ☐ Sleep Problems

### Respiratory

- ☐ Cough
- ☐ Coughing up Blood
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Wheezing

## MEN ONLY

- ☐ PSA Date: _____ Abnormal
- ☐ Pain or lump(s) in testicles
- ☐ Penile (penis) itching, burning, or discharge
- ☐ Problems starting or stopping your urine stream
- ☐ Wake in the night to go to the bathroom
- ☐ Sexual Problems or concerns
- ☐ History of sexually transmitted disease
- ☐ Sexually active? Yes No
  - Current sexual partner is: Male Female
  - Do you use condoms? Yes No
  - Interested in being screened for STD's? Yes No
- ☐ Vasectomy? Yes No

## WOMEN ONLY

- ☐ Last PAP Smear Date: _____ Abnormal?
- ☐ Last Mammogram Date: _____ Abnormal?
- ☐ Age of first menstrual period: _____
- ☐ Date of last menstrual period or age of menopause: _____
  - Number of pregnancies: _____ Births: _____ Miscarriages: _____
  - Abortions: _____
- ☐ Cesarean Sections? Yes No If yes, then number: _____
- ☐ Bleeding between periods
- ☐ Heavy Periods
- ☐ Extreme Menstrual Pain
- ☐ Vaginal itching, burning, or discharge
- ☐ Wake in the night to go to the bathroom
- ☐ Hot flashes
- ☐ Breast Lump or nipple discharge
- ☐ Painful intercourse
- ☐ Sexually active? Yes No
  - Current sexual partner is: Male Female
  - Do you use condoms? Yes No
  - Interested in being screened for STD's? Yes No

# Health History Questionnaire Medical

MarillacHealth
Committed to a healthier you.

## IMMUNIZATION HISTORY

Immunizations and most recent date:

- □ Chickenpox Date: _____
- □ Flu Shot Date: _____
- □ Gardasil/HPV Date: _____
- □ Hepatitis A Date: _____
- □ Hepatitis B Date: _____
- □ Chickenpox Date: _____
- □ Meningococcus Date: _____
- □ MMR (Measles, Mumps, Rubella) Date: _____
- □ Pneumonia Date: _____
- □ Tdap (Tetanus and pertussis) Date: _____
- □ Tetanus Date: _____
- □ Zostavax (Shingles) Date: _____

## ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc) and how each affects you:

| ALLERGY | REACTION |
|---|---|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |

## MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

| DRUG NAME | STRENGTH | FREQUENCY TAKEN |
|---|---|---|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |
| 5. _____ | _____ | _____ |
| 6. _____ | _____ | _____ |
| 7. _____ | _____ | _____ |
| 8. _____ | _____ | _____ |
| 9. _____ | _____ | _____ |
| 10. _____ | _____ | _____ |
| 11. _____ | _____ | _____ |
| 12. _____ | _____ | _____ |

## HEALTH MAINTENANCE SCREENING TESTS

| TEST | DATE | ABNORMAL |
|---|---|---|
| □ Calcium Screen CT | _____ | Y / N |
| □ Colonoscopy | _____ | Y / N |
| □ Bone Density (Osteoporosis) | _____ | Y / N |
| □ Exercise Stress Test | _____ | Y / N |
| □ Lipid (Cholesterol) | _____ | Y / N |
| □ Pulmonary Function Test | _____ | Y / N |

## FAMILY HEALTH HISTORY

| RELATION | ALIVE? | AGE | SIGNIFICANT HEALTH PROBLEMS |
|---|---|---|---|
| Grandmother (maternal) | Y / N | _____ | |
| Grandfather (maternal) | Y / N | _____ | |
| Grandmother (paternal) | Y / N | _____ | |
| Grandfather (paternal) | Y / N | _____ | |
| Father | Y / N | _____ | |
| Mother | Y / N | _____ | |
| Brother/Sister | Y / N | _____ | |
| Brother/Sister | Y / N | _____ | |
| Other: _____ | Y / N | _____ | |

# Health History Questionnaire Medical

MarillacHealth
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**SOCIAL HISTORY**

Occupation: _____

Education: < High School Diploma  High School Diploma/GED  Some College  Technical School  Associates Degree  Bachelor's Degree  Graduate Degree

Marital Status: Single  Married  Divorced  Widow(ed)  Common-law

| | |
|---|---|
| Exercise Level: | □ None (No Exercise)<br>□ Occasional Exercise (i.e: climb stairs, walk 3 blocks, golf)<br>□ Moderate Exercise (i.e. work or recreation, less than 4x/week for 30 minutes<br>□ High Level Exercise (i.e. work or recreation 4x/week for 30 minutes |
| Diet: | Are you dieting? Yes No<br>If yes, are you on a physician prescribed medical diet? Yes No<br># of meals you eat in an average day? _____ |
| Caffeine | Number of cups/cans per day? _____ |
| Alcohol | Do you drink alcohol? Yes No |
| | How many drinks per week? _____<br>Did you ever drink excessively? Yes No<br>Do you drive after drinking? Yes No |
| Tobacco | Do you use tobacco?<br>If not currently using, did you ever use tobacco?<br>Cigarettes - _____pk a day _____ Chew - _____ per day _____ Pipe - _____ per day Cigars - _____ per day<br>Number of years _____ Or year quit _____ _____ E-Cig/Vaping - _____ per day |
| Drugs | Do you currently use recreational or street drugs?<br>If yes, list: _____ |
| Personal Safety | Live alone or with others? Alone Others _____ |
| | Guns present in home? Yes No<br>Does anyone smoke in your home? Yes No<br>Smoke alarm in home? Yes No<br>Carbon Monoxide alarm in home? Yes No<br>Seatbelts used routinely? Yes No<br>Sunscreen used routinely? Yes No<br>Advanced directive or living will? Yes No<br>Colorado CPR directive? Yes No<br>Durable medical power of attorney? Yes No |

Please add any other information about your health that you would like your provider to know here:

_____
_____
_____
_____
_____

_____ _____
Signature of Patient
(If over 18 or seeking Minor Consent services)
Today's Date

_____ _____
If minor, name of patient and date of birth
Date of Birth

_____ _____
Signature of Patient or Legal Guardian
Today's Date

_____ _____
PRINTED Name of Patient or Legal Guardian
Relationship to Patient

# Mental Health Disclosure

MarillacHealth
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As a patient of MarillacHealth you may be offered behavioral health services and we would like you to be informed as to our providers and their credentialing. Each of the below providers may be reached at the following business address and phone number: 2333 N. 6th Street, Grand Junction, CO 81501, (970) 200-1600.

| CREDENTIALS |
| --- |
| Rachel Lloyd is a licensed clinical social worker in the state of Colorado. She received her Master's Degree in Social Work from University of Denver in May of 2017. |
| Steven Martinez is a licensed addiction counselor and an unlicensed psychotherapist in the state of Colorado. He received his Master's Degree in Social Work from University of Denver in 2019. |
| S. Rod Pyland, is a licensed social worker in the state of Colorado. He received his Master's Degree in Social Work from University of Denver in 1978. Acupuncture Detoxification Specialist (Registered Trainer) 2014. |
| Connie Mercer-Cogburn is a Licensed Professional Counselor in the state of Colorado. She received her Master's Degree in Clinical Mental Health from Adam's State University in May of 2017. |

| CREDENTIALING |
| --- |
| The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The Board of Registered Psychotherapist Examiners can be reached at 1560 Broadway, Suite 1350, Denver, CO. 80202, (303) 894-7800. As to the regulatory requirements applicable to mental health professionals: |
| 1. A Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a master's degree in their profession and have two years of post-masters supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. A Licensed Social Worker must hold a master's degree in social work. A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure.<br>2. A Certified Addiction Counselor I (CAC I) must be a high school graduate, complete required training hours and 1,000 hours of supervised experience. A Certified Addiction Counselor II (CAC II) must complete additional required training hours and 2,000 hours of supervised experience. A Certified Addiction Counselor III (CAC III) must have a bachelor's degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements.<br>3. A Registered psychotherapist is a psychotherapist listed in the State's database and is authorized by law to practice psychotherapy in Colorado, but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state. |
| CLIENT'S RIGHTS. You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy (if known) and the fee structure. You can seek a second opinion from another therapist or terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported the Department of Regulatory Agencies, Division of Registrations, Mental Health Section.<br>Your therapist will attend to any concern or complaint that you may have about psychotherapy. Another option is to contact the Mental Health Grievance Board at the contact information listed above. |

# Mental Health Disclosure

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| CREDENTIALING |
|---|
| CONFIDENTIALITY. The information provided by you during therapy sessions is legally confidential. There are exceptions to this confidentiality, some of which are listed in section 12-43-218 of the Colorado Revised Statutes, and the HIPAA Notice of Privacy Rights you were provided as well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report suspected child abuse to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly. The Mental Health Practice Act (CRS 12-43-101, et seq.) is available at: http://www.dora.state.co.us/mental-health/Statute.pdf. |
| 1. The counselor has an obligation to report "in good faith" any suspected child abuse or neglect to the appropriate department of human services and/or law enforcement agency.<br>2. The counselor has a duty to notify the proper authorities when a client/patient communicates a serious and imminent threat to harm him/herself or another person and also refuses to seek treatment on a voluntary basis.<br>3. The counselor may disclose client information if the client makes or creates an articulable and significant threat against a school or occupants of a school.<br>4. The counselor may disclose client information in response to a Grievance Board Inquiry.<br>5. The counselor may disclose client information to respond to a lawsuit or complaint made against the counselor regarding the care or treatment of the client.<br>6. A court in the state of Colorado with competent jurisdiction may order the release of confidential client/patient information.<br>7. As you are participating in counseling services in a medical setting, we claim the right for the counselor to discuss your case with other clinic staff as needed for continuity of care. By signing this form you agree to have your therapy records kept in the agency's outpatient medical record. Client records may not be maintained after seven years pursuant to section 12-245-226(1)(a)(II)(A) of the Colorado Revised Statutes. |
| I have read the preceding information, it has also been provided verbally, and I understand my rights as a client or as the client's responsible party. |

| | |
|---|---|
| Client or Responsible Party Signature: _____<br>Please Print Client's Name: _____ | Date: _____ |
| If signed by responsible party, please state relationship to client and authority to consent: | |
| | |

MarillacHealth
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PERMISSION FOR TREATMENT

I understand that all patients of MarillacHealth may be seen by staff or volunteer physicians, physician's assistants, or nurse practioners who are licensed in the State of Colorado and are supervised by the Clinic's Medical Director and/or Dental Director. I hereby give permission for evaluation and treatment, for myself or for the minor child named, by these providers. I understand that the Clinic functions as a teaching facility for medical/dental students of all disciplines, and those patients may be seen by these students. I understand that all students are under the direct supervision of the medical/dental staff of the Clinic. I understand that I have the right to request that I not be treated by a student. I understand that this care may include routine clinic procedures, diagnostic testing, intravenous therapy, injections, minor surgery, and no guarantees have been made to me about the services, treatment or the outcome of this care. I understand that my prescription history may be obtained from any pharmacy I may have used.

USE AND DISCLOSURE OF INFORMATION FOR TREATMENT AND HEALTHCARE OPERATIONS:

I understand that federal regulations permit the Clinic to obtain, use, and disclose my protected health information for treatment, payment and health care operations and as otherwise allowed by law, as explained in the Clinic's Notice of Privacy Practices. I also understand that some or all of my medical records (or copies of my medical records) may be disclosed or provided to other health care providers (such as physicians, nurses, psychologists, or their staff) involved in my current or future treatment. This type of disclosure may be by written correspondence, in person, by fax, by phone, or other means. I understand that my permission is not needed for those uses or disclosures. The Clinic may also release my information in order to process payment claims. While this office will make reasonable efforts, I understand that the confidentiality of my medical records cannot be insured once they leave this office. I understand that my picture may be taken and or my photo ID may be scanned and used for identity verification. I understand my records may contain identifying information including photographs, examination, treatment, diagnosis and prognosis and amounts charged and paid, as well as sensitive information concerning substance abuse, psychiatric history and treatment, HIV status, any diagnosis / treatment for AIDS or AIDS-related disease, sexual orientation, and/or sexual activities or disease. I understand that this information may be released or disclosed as necessary in accordance with the Clinic's Notice of Privacy Practices unless otherwise protected or provided for by state or federal law. I understand that I may request restrictions on how any of my health information and/or my medical records is to be used, disclosed or shared. I understand that the Clinic and St. Mary's Hospital participate in a Continuum of Care Agreement whereby billing and clinic information is shared without specific consent from me. I understand that the Clinic utilizes a collaborative care model for treatment and that mental health records are part of the medical record.

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PATIENT FINANCIAL RESPONSIBILITY:

I agree to provide all financial information requested by the Clinic in order to qualify for services. I attest that all of this information is accurate to the best of my knowledge. I understand that if I provide false financial information, or fail to update changes in income or insurance status, that I may no longer be eligible for Clinic services. I understand that the Clinic expects payment of incurred expenses at the time of the visit. If I am not able to pay the reduced fee at this time, I will meet with the Clinic's appropriate personnel to make payment arrangements. I understand that there may be additional fees for Immunizations, lab work, procedures, medications or other items. I understand that I may be referred to a specialist physician for consultation or treatment. I understand that I, as the patient, am financially responsible for payment of all charges for services provided by these specialists. I understand that the Clinic is not financially responsible and will not pay for any services outside the Clinic. I understand that the Clinic provides only routine, outpatient care during regular posted office hours, and that should emergency or life threatening events occur I will access care at an emergency facility at my own expense. I understand that if I am in a life-threatening condition while at the Clinic, emergency transportation will be called to transport me to an emergency room. I understand that I am financially responsible for the cost of such emergency care and transportation. I realize that failure to keep my appointments, to cancel my appointments or arrive late for an appointment may jeopardize my eligibility for continued care at the Clinic.

Initials:_____

ASSIGNMENT OF BENEFITS / MEDICARE AND MEDICAID:

I certify that the information given by me in applying under Title XVIII of the Social Security Act is correct. I authorize the Clinic to release to the Social Security Administration or its intermediaries or carriers or insurance companies any information needed for this or a related Medicare/Medicaid claim or a private insurance claim. I assign the benefits payable for the physician services to the physician or organization furnishing the services so that the Clinic can directly be paid or authorize such physician or organization to submit a claim to Medicare/Medicaid for payment to me.

I understand this entire consent, financial responsibility and assignment of benefits form will be valid now and in the future until revoked in writing by me and the revocation given to the clinic.

| | |
|---|---|
| _____ | _____ |
| If minor, name of patient and date of birth | Date of Birth |
| _____ | _____ |
| Signature of Patient or Legal Guardian | Today's Date |
| _____ | _____ |
| PRINTED Name of Patient or Legal Guardian | Relationship to Patient |

# Verbal Communication Consent

MarillacHealth
Committed to a healthier you.

| Today's Date: | Primary Care Provider: |
|---|---|

**SECTION 1 - PATIENT INFORMATION**

| Patient's last name: | First: | Middle: | | |
|---|---|---|---|---|
| Address: | City: | | Birth date: | Age: |
| State: | Zip Code: | | | |

| Social Security Number: | Home Phone Number: | Cell phone Number: |
|---|---|---|
| | | |

**SECTION 2 - VERBAL DISCLOSURE**

*I authorize MarillacHealth to speak with the following individual(s) regarding my current care and treatment :*

| Organization Name: | Organization Name: | Organization Name: |
|---|---|---|
| | | |
| Phone Number: | Phone Number: | Phone Number: |
| | | |
| Relationship to Patient: | Relationship to Patient: | Relationship to Patient: |
| | | |

**SECTION 3 - INFORMATION TO BE RELEASED**

*The following information MAY be communicated verbally to the individuals named in Section 2*

| | | | | |
|---|---|---|---|---|
| Progress Notes | Dental | Labs | Billing | Case Management |
| Medications | Imaging | Other | Other | Other |

**SECTION 4 INFORMATION TO BE RESTRICTED**

*The following information **MAY NOT** be communicated verbally to the individuals named in Section 2*

| | | | |
|---|---|---|---|
| HIV Results | Alcohol/Drug Notes | Psychiatry Notes | Mental Health |
| Sexually Transmitted Disease | Genetic Testing | Other: | Other: |

**SECTION 5 - VOICE MESSAGES**

*I authorize MarillacHealth to leave messages regarding medical information pertaining to my care by the following methods and will assume responsibility to notify MarillacHealth when the information changes.*

| Home Phone: | Work Phone: | Cell Phone: | Voicemail/Answering Machine: |
|---|---|---|---|
| | | | |

**SECTION 6 - I UNDERSTAND THAT…**

1. The information to be released verbally may not include a diagnosis or reference to the following condition(s): behavioral health services/psychiatric care; sickle cell anemia; genetic testing; acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV); or drug and/or alcohol abuse.
2. Without my express revocation, this authorization will automatically expire 1 year from the date signed below, unless I request an expiration date less than 1 year.
3. I may revoke this authorization in writing at any time, except to the extent that action has already been taken to comply with it.
4. Information disclosed pursuant to the authorization may be subject to redisclosure by the recipient and is no longer protected by the HIPAA Privacy Rule.

My signature is required to validate this authorization. If I do not sign this authorization, MarillacHealth will still provide treatment and seek payment for services provided. According to State Statutes, this care site may charge for copies of medical records.

Patient or Legal Guardian Signature: _____ Date:

Please Print Patient or Legal Guardian Name: _____

# Zero Tolerance Policy

MarillacHealth has a zero tolerance policy. Patients may ultimately be dismissed from the practice and removed from a provider's panel for failing to abide by this policy. If dismissed, patients will be informed in writing and will not be allowed back into any of the Marillac facilities or departments.

Below are some examples of behavior that will not be tolerated:

- Use of force or attempt to assault patients, visitors or health center staff
- Use of force or destruction of physical property in the premises of the health center, including parking and common areas
- Use of inappropriate touching, spitting, raising fists or feet or verbally threatening language
- Sexually inappropriate gestures or language against patients, visitors or staff
- Racial remarks or shouting at any person
- Intimidating behavior such as banging on counters, doors, etc.
- Persistent non-compliance with care (medication management) or care planning
- Persistent abuse or overutilization of services
- Persistent no-shows
- Severe breakdown in the provider-patient relationship
- Smoking in bathrooms/facilities/premises

Aggressive/abusive behavior is not tolerated and each event is discussed and recorded.

Aggressive/abusive patients may be escorted or removed from the facility by security or the police. If removed by the police, patients may be charged with trespassing or charged with criminal charges.

| | |
|---|---|
| _____ | _____ |
| If minor, name of patient and date of birth | Date of Birth |
| _____ | _____ |
| Signature of Patient or Legal Guardian | Today's Date |
| _____ | _____ |
| PRINTED Name of Patient or Legal Guardian | Relationship to Patient |

# Notice of Privacy Practices

MarillacHealth
Committed to a healthier you.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

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.

If you have any questions, contact Privacy Officer at 970-200-1600; or by mail at 2333 N. 6th Street, Grand Junction, CO 81501. To learn more about MarillacHealth, please visit our website at www.marillachealth.org

Medical information about you and your health is private. We strive to protect your health records when you are being seen in the clinics. We will use your records to care for you, bill for care, and to comply with the law.

This Privacy Notice applies to all MarillacHealth clinic services sites. This Notice tells you about the ways MarillacHealth may use or give out information from your private health records. It also explains your rights and responsibilities.

*Note: The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires all physicians and health care facilities to provide patients with a notice describing how an individual's medical information may be used and disclosed, and how a patient may obtain access to their personal health information.*

**Who Follows The Terms of This Notice:**

- Any health care provider who treats you at any of our locations
- All employees, volunteers, and staff at the hospital and clinics
- Healthcare students in training programs
- Any business associate who performs work for us that requires them to see your medical information to do their jobs

**Acknowledgement of Receipt:**

I understand that, as allowed and required by law, MarillacHealth staff will use and give out my health records, without my consent or authorization, for:

- **Treatment**: Care providers will use my health history, symptoms, exams, test results, diagnosis, treatment and plan of care to take care of me.
- **Payment:** MarillacHealth will use my health records to bill me, my insurance or other aid programs for my care if this applies to the clinic where I receive my care.
- **Healthcare Operations:** MarillacHealth will use my health records to run the clinics and to make sure patients receive quality care.

Please not that there is an attached copy of HIPAA to this consent form, for the patient or parent/guardian of a minor receiving medical or mental health counseling services at MarillacHealth. You must sign below, indicating that you have received a copy of our HIPAA policies, prior to the patient receiving services.

I certify that a copy of the Health Insurance Portability and Accountability Act of 1996 was provided with MarillacHealth's consent form, to the patient or parent/guardian _____ on (Date) _____

| | |
|---|---|
| _____ | _____ |
| If minor, name of patient and date of birth | Date of Birth |
| _____ | _____ |
| Signature of Patient or Legal Guardian | Today's Date |
| _____ | _____ |
| PRINTED Name of Patient or Legal Guardian | Relationship to Patient |

MarillacHealth
Committed to a healthier you.

**HIPAA NOTICE OF PRIVACY PRACTICES**

**Effective Date: March 9, 2021**

**THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

We provide health care to our patients and residents together with physicians and other health care professionals. This Notice of Privacy Practices ("Notice") describes how we will use and disclose protected health information.

## I. Our Commitment to Safeguard Your Protected Health Information.

Each time you visit our facility, a record of your visit is made. Information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is called protected health information ("PHI"). Your medical record is a means of communication among the many health professionals who care for you. PHI may include documentation of your symptoms, examination, test results, diagnoses and treatment. It also includes documents related to billing and payment for care provided.

We are committed to protecting the privacy of your protected health information. We are required by law to:

- Maintain the privacy of your protected health information;
- Provide you with this Notice about our privacy practices that explains how, when, and why we use and disclose your protected health information;
- Abide by the terms of the current Notice;
- Make a good faith effort to obtain your written acknowledgment that you have received this Notice; and
- Notify you following a breach of your unsecured protected health information.

## II. How We May Use and Disclose Your Protected Health Information

This Notice informs you about the ways in which we may use and disclose your protected health information. The following categories describe different ways that we use and disclose protected health information. For each category of uses or disclosures, we explain what we mean and give some examples to help you better understand the meaning. If a use or disclosure is not included in one of these categories, we will seek your permission first.

### Uses and Disclosures Without Your Permission

The following categories describe different ways that we are permitted to use and disclose your protected health information without your permission (which is called an "authorization" under HIPAA).

***For Treatment***

We may use and disclose your protected health information to provide you with medical treatment and services. We may disclose protected health information about you to doctors, nurses, technicians, medical students, and other healthcare personnel who provide you with healthcare services or are involved in taking care of you. This may include health care professionals at other facilities, such as your doctor's office, other hospitals, nursing homes or home health agencies. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process.

***For Payment***
We may use and disclose your protected health information to obtain payment for your health care services provided by us. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

***For Health Care Operations.***
We may use and disclose your protected health information for operations necessary for our facility to function and make sure our patients receive quality care. For example, we may use your protected health information in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. This information may also be used in an effort to continually improve the quality and effectiveness of the health care and services we provide. We may disclose your protected health information to another health care provider or a health plan that you have a relationship with, for their operations' activities.

***Business Associates.***
We may disclose your protected health information to other companies that help us. These business associates may include billing companies, claims processing companies, collection agencies, accountants, attorneys, consultants, and others that assist us with payment activities or health care operations. We contractually require our business associates to safeguard the privacy and security of your PHI.

***Individuals Involved in Your Care or Payment for Your Care.***
We may disclose protected health information about you to a family member, personal representative, or other person involved in your care or responsible for payment of your health care services. We may also discuss your condition with your family or friends and tell them that you are in the hospital. If you do not want us to share information with your family or others involved in your care, please contact the person listed in Section V of this Notice.

***Public Health Authorities***
We may disclose your health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made to a public health authority for the purpose of preventing or controlling disease. We may also disclose your protected health information to a person or company subject to the jurisdiction of the FDA to report adverse events, product defects or problems or biologic product deviations; to track FDA-regulated products; to enable product recalls; to make repairs or replacements; or for other purposes related to the quality, safety or effectiveness of a product or activity regulated by the FDA.

***Public Safety.***
We may disclose protected health information for public safety purposes in limited circumstances. We may disclose protected health information to law enforcement officials in response to a search warrant or a grand jury subpoena. We also may disclose protected health information to assist law enforcement officials in identifying or locating a person, to prosecute a crime of violence, to report deaths that may have resulted from criminal conduct, and to report criminal conduct at the facility. We also may disclose your protected health information to law enforcement officials and others to prevent a serious and imminent threat to health or safety.

***Judicial and Administrative Proceedings.***
We may disclose protected health information if we are ordered to do so by a court, for an administrative hearing, or if we receive a subpoena or a search warrant. You will receive advance notice about this disclosure in most situations so that you will have a chance to object to sharing your protected health information.

***Fundraising Activities.***
We may use your protected health information in an effort to raise funds for our facility, including through our affiliated Foundation. The money raised through these activities is used to expand and support the health care services and educational programs we provide to the community. If you do not wish to receive our fundraising communications, you may notify the Foundation and we will honor your wish. Future treatment or payment will not be conditioned upon your decision regarding receipt of fundraising communications.

***Facility Directory.***
We may include certain limited information about you in our facility directory while you are a patient at our facility. This information may include your name, location in the facility, general condition (such as whether you are in fair, good, or serious condition), and your religious affiliation. The directory information, except for your religious affiliation, may be disclosed to people who ask for you by name. Your religious affiliation may be given to a member of the clergy or designated church representatives even if they don't ask for you by name. You have the right to withhold information in the facility directory from being disclosed to others. If you do so, it means that we will not be able to tell your friends, family or others (such as florists) where you are. If you want to withhold information in the facility directory, please contact the person listed in Section V of this Notice.

***Disaster Relief Efforts.***
As part of a disaster relief effort, we may disclose your protected health information to an agency assisting in the relief effort so that your family can be notified about your condition, status and location. You may have the opportunity to object, unless it would impede our ability to respond to emergency circumstances.

***Coroners, Medical Examiners, and Funeral Directors.***
We may disclose health information consistent with applicable law to coroners, medical examiners, and funeral directors to assist them in carrying out their duties.

***Research.***
Under certain limited circumstances, we may use and disclose your protected health information for research purposes. For example, a research project may involve comparing the health and recovery of all patients who receive one medication to those who receive another for the same condition. All research projects are subject to a special approval process. Before we use or disclose protected health information for research, the project will have been approved through this research approval process.

***Reports Required by Law.***
We will disclose your protected health information when required to do so by federal, state, or local law. For example, we make disclosures when a law requires that we report information to government agencies and/or law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot and other wounds; to report reactions to medications or problems with products; or to notify people of product recalls.

***Public Health Activities.***
We may disclose your protected health information for public health activities. For example, we report information about births, deaths, and various diseases to government officials in charge of collecting that information.

***Health Oversight Activities.***
We may disclose protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the healthcare system, government programs, and compliance with civil rights laws.

***Organ and Tissue Donation.***
If you are an organ donor, we may notify organ procurement organizations to assist them in organ, eye, or tissue donation and transplants.

***Workers' Compensation.***
We may disclose your protected health information to the extent necessary to comply with laws relating to workers' compensation or similar programs providing benefits for work-related injuries or illness.

***Military, Veterans, National Security, and Other Government Purposes.***
If you are a member of the armed forces, we may release your health information to military command authorities or to the Department of Veterans Affairs if they require us to do so. We may also disclose protected health information for certain national security purposes and to the Secret Service to protect the president.

***Correctional Institutions.***
If you are or become an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official. This disclosure may be necessary for the institution (i) to provide you with health care; (ii) to protect your health and safety or the health and safety of others; or (iii) for the safety and security of the correctional institution.

***Participation in Health Information Networks.***
We participate in the Colorado Regional Health Information Organization (CORHIO) and/or Quality Health Network (QHN); both are secure computer networks which provide safe and efficient ways to share protected health information with other health care providers. For example, if you require emergency medical care while you are traveling, providers at other health care facilities in Colorado could have access to your protected health information to assist them in caring for you. By participating in this network and other electronic information exchanges, we intend to provide timely information to health care providers involved in your care. If you do not want your information to be shared through CORHIO and/or QHN, you may "opt out" by contacting the person listed in Section V below. This is an "all-or-nothing" choice, because CORHIO and QHN cannot block access to some types of protected health information while at the same time permit access to other protected health information. Opting-out of CORHIO and/or QHN may limit your health care providers' ability to provide the most effective care for you.

**<u>Uses and Disclosures Requiring Your Permission</u>**
Other uses and disclosures of protected health information not covered by this Notice will be made only with your written permission. If you provide us permission to use or disclose protected health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose protected health information about you for the reasons covered by your written authorization, but we cannot take back any disclosures we have already made based on the permission you gave us before. If you want to revoke your permission, please contact the person listed in Section V of this Notice.

***Marketing Activities.***
We will not use or disclose your PHI to sell you products or services of a third party unless you provide permission. We may suggest products or services to you during our face-to-face communications.

***Sale of PHI.***
We will not sell your PHI (Personal Health Information) to third parties without your permission.

**Protected Health Information That Has Special Protection**

***Psychotherapy Notes.***
Psychotherapy notes are the personal notes of psychotherapists. We must obtain your permission to use or disclose psychotherapy notes, except under limited circumstances.

***Alcohol and Drug Abuse Patient Records.***
Use and disclosure of any protected health information about you relative to alcohol or drug abuse treatment programs, is protected by federal law. Generally, we will not disclose any information identifying you as a recipient of alcohol or drug abuse treatment unless: (i) you have consented in writing; (ii) we receive a court order requiring the disclosure; (iii) the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation; or (iv) disclosure is required to report child abuse or neglect.

***HIV/AIDS Information.***
Use and disclosure of any protected health information about you relative to HIV testing, HIV status, or AIDS, is protected by federal and state law. Generally, we will need your permission to disclose this information; however, state law may allow for disclosure of information for public health purposes.

***Minors.***
As a general rule, we disclose PHI about minors to their parents or legal guardians. However, in instances where state law allows minors to consent to their own treatment without parental consent (such as HIV testing), we will not disclose that information to a minor's parents without the minor's permission unless otherwise specifically allowed under state law.

## III. Your Rights Regarding Your Protected Health Information

The following section describes your rights with respect to your protected health information and a brief description of how you may exercise these rights.

***The Right to Inspect and Obtain a Copy of Your Protected Health Information.***
You have the right to see and receive a paper or electronic copy of protected health information maintained by us that may be used to make decisions about your care. (The law requires us to keep the original record.) Usually, this includes your medical and billing records. To inspect and/or receive a copy of your protected health information, you must submit your request in writing to our Health Information Management/Medical Records Department, 2333 North 6th Street, Grand Junction, CO 81501. If you request a copy of the information, we may charge you a reasonable fee based on our costs.

***The Right to Amend.***
If you believe that protected health information we have about you is incorrect or incomplete, you have the right to request that we correct the existing information or add missing information. To request an amendment, you must make the request in writing along with your reason for the request to the person listed in Section V below.

***The Right to a List of Disclosures.***
You have the right to request a list of certain disclosures of your protected health information. To request this list or accounting of disclosures, you must submit a request in writing indicating a time period, which can be no longer than six years, to the person listed in Section V below. The first list you request within a 12-month period will be free. For additional lists during the same year, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

***The Right to Request Restrictions on How We Use and Disclose Your Protected health information.***
You may ask us not to use or disclose your protected health information for a particular reason related to treatment, payment or health care operations. We will consider your request, but we are not legally obligated to agree to a requested restriction except in the following situation: if you have paid for services out-of-pocket in full, you may request that we not disclose information related solely to those services to your health plan. We are required to abide by such a request, except where we are required by law to make the disclosure. To request restrictions on the use or disclosure of your PHI, you may do so at the time you register for services or by contacting the person listed in Section V below.

**The Right to Request Confidential Communications.**
You have the right to ask that protected health information about you be communicated to you in an alternate confidential manner, such as asking that appointment reminders not be left on an answering machine, that mail be sent to an alternate address, or that notices or reminders be sent by e-mail instead of regular mail. We will agree to all reasonable requests so long as we can easily provide it in the format you request. To request protected health information be sent to an alternative address or by other means, please contact the person listed in Section V below in writing, or in a clinic setting, please contact the practice manager.

***The Right to a Paper Copy of This Notice.***
You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Paper copies are available at our registration locations and our HIM Department. You may also obtain a copy of this Notice on our website at www.marillacclinic.org.

## IV. Complaints
If you believe that we may have violated your rights with respect to your protected health information, you may file a written complaint with the person listed in Section V below. You also may initiate a complaint to the Office for Civil Rights, U.S. Department of Health and Human Services. More information about this complaint process is available at https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html. You will not be penalized for filing a complaint about our privacy practices. You will not be required to waive this right as a condition of treatment.

## V. Person to Contact for Information About This Notice or to Complaint About Our Privacy Practices
If you have any questions about this Notice or wish to make a complaint about our privacy practices, please contact our Privacy Officer at 970-200-1639. Formal complaints must be in writing. Complaint forms are available at all registration areas or from the HIM Department. Complaints should be sent to the Privacy Officer at 2333 North 6th Street, Grand Junction, CO 81501 or by fax to 970-298-1711.

## VI. Changes
We reserve the right to change the terms of this Notice and our privacy policies at any time. We reserve the right to make the revised Notice effective for protected health information we already have about you as well as any information we receive in the future. Before we make an important change to our policies, we will promptly change this Notice and post a new Notice in our registration areas. The Notice will contain the effective date. You can also request a copy of this Notice from the contact person listed in Section V above at any time or can view a current copy of the Notice on our website at www.marillachealth.org.

## VII. Acknowledgment
You will be asked to sign an acknowledgement of your receipt of this Notice of Privacy Practices. We are required by law to make a good faith effort to provide you with our Notice of Privacy Practices and obtain an acknowledgement from you that you received it. Your care and treatment at our facility does not depend on signing the acknowledgment.