

Aspen Medical Group Patient Information Forms

Today's Date: _____ Age at **TODAY'S** Visit: _____ Years Old
Patient's Name (First): _____ (Last): _____ (Middle): _____
Address: _____ Apt. #: _____
City: _____ State: _____ Zip Code: _____
Home Phone:(_____) _____ **Cell Phone:**(_____) _____
SSN #: ____-____-____ **Date of Birth:** ____/____/____ Sex (circle): F M
Marital Status (circle): Married Single Divorced Widowed Other
Employment Status (circle): Employed Self-Employed Unemployed Retired Student (Full Time/Part Time)
Employer Name: _____ **Work Phone:**(_____) _____
Employer Address: _____ City: _____
State: _____ Zip Code: _____ Occupation: _____
Who referred you to our Practice? _____

Spouse/Partner Information

Name (First): _____ (Last) _____ (Middle) _____
Work Phone:(_____) _____ Cell Phone:(_____) _____
Date of Birth: ____/____/____ Sex (circle): F M Occupation: _____
Emergency Contact (not at same address): _____ **Relationship:** _____
Home Phone:(_____) _____ **Work:**(_____) _____ **Cell:**(_____) _____

Responsible Party and Primary Insurance Information

Responsible Party Name (First): _____ (Last) _____ (MI) _____
Address: _____ Apt.#: _____
City: _____ State: _____ Zip Code: _____
Home Phone:(_____) _____ Cell Phone:(_____) _____
SSN #: ____-____-____ **Date of Birth:** ____/____/____ Sex (circle): F M
Employer Name: _____ Work Phone:(_____) _____
Employer Address: _____ City: _____
State: _____ Zip Code: _____
Insurance Name: _____ Customer Service Phone:(_____) _____
Subscriber ID: _____ Group ID: _____ Copay \$ _____
Effective Date _____ Termination Date: _____
Billing Address: _____
City: _____ State: _____ Zip Code: _____

Secondary Insurance Information

Insurance Name: _____ Customer Service Phone:(_____) _____
Subscriber ID: _____ Group ID: _____ Copay \$ _____
Effective Date _____ Termination Date: _____
Billing Address: _____
City: _____ State: _____ Zip Code: _____

Do you have a living will or a durable power of attorney? (circle one) YES NO

****If yes please provide the office a copy****

Signature: _____ **Date:** _____

Aspen Medical Group
HealthOne Clinic Services
Patient Consent Form

Financial Policy:

In order to reduce confusion and misunderstanding between our patients and the practice we have adopted the following financial policy. If you have any questions please discuss them with our billing staff. We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

Unless other arrangements have been made in advance by yourself or your health coverage carrier, full payment for office services are due at the time of service. For your convenience we will accept VISA, MasterCard, Discover, and American Express, as well as cash, check or money order.

About Health Insurance:

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer we will refund any overpayment to you.

About Participating Health Plans:

We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-payment **at the time of service.**

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be “not covered”, you will be responsible for the complete charge. Payment is due upon receipt of statement from our office.

It is your responsibility to verify that this office participates with your insurance. If we do not participate with your insurance, you will likely be responsible for all charges out of pocket.

By signing below, I acknowledge that I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

Signature

Date

Printed name if signed on behalf of patient

Relationship to Patient

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

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees.

I fully understand that this is given in advance of any specific diagnosis or treatment.

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

I understand **Aspen Medical Group** may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that **Aspen Medical Group** will use and disclose my information for the purpose of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

Medicare Patients: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services at **Aspen Medical Group**.

I acknowledge that I have been given the **Aspen Medical Group** Notice of Privacy Practices. I understand that if I have any questions or complaints that I should contact the Privacy Official.

Patient Initial _____

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

*** Please note that all in-office procedures (biopsy, vaccinations etc..) will be discussed with and may be refused by patients prior to being completed***

Patient (or Responsible Party) Signature Date

Patients Printed Name

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Telephone Messaging And Laboratory / Test Result Release Consent Form

Frequently someone at Aspen Medical Group will need to contact you by telephone regarding your health and/or your protected health information. In order to best protect your privacy, as well as provide excellent patient care, we ask that you complete the following consent. This provides us with specific direction as to where we may contact you, and with whom we may speak to on your behalf regarding health information. It also provides us with direction regarding test results or specific information that you may want us to send to you.

I permit Aspen Medical Group to leave phone messages at the following telephone numbers and/or with the following individuals. I acknowledge that only the individuals listed on this form will be able to discuss any issues related to my healthcare with physicians or staff of Aspen Medical Group. I agree that this consent will remain valid until revoked in writing by me or by an authorized designee (i.e., durable power of attorney)

Patient Name _____ Date of Birth _____

Contact Numbers	May we leave a detailed message?	Preference (1,2,or3)
Home: _____	Y/N	_____
Work: _____	Y/N	_____
Cell: _____	Y/N	_____

To whom may we speak with on your behalf:

1. Name: _____ Relationship: _____
Ph# _____

2. Name: _____ Relationship: _____
Ph# _____

If you request copies of your test results or office notes would you prefer we:

Mail _____ **Fax** _____

Patient Signature _____
Date