Thank you for choosing Pinon Family Practice (PFP) as your Primary Care Provider team. We are committed to making sure you receive quality medical care by utilizing evidence-based guidelines. We look forward to partnering with you and helping you to achieve your best possible health! It is also our goal to be transparent regarding our policies and procedures and to keep our lines of communication open. We take this partnership very seriously and feel honored that you've chosen Pinon Family Practice!

Office Information and Policies

PFP is open to **see patients from 8 am – 7 pm, Monday through Thursday and 8 am – 5 pm on Friday.** We are closed from 12-1 pm every day for lunch and until 1:30 on meeting days. Phone hours are from 8-5 Monday-Friday and are transferred to our answering service for urgent concerns only, during lunch and after business hours. We are closed on all major holidays and list these closures on our website. **For any life/limb threatening Emergency please call 911.**

We have a **provider on-call at all times outside of our normal office hours** to provide advice for acute medical questions/concerns. The on-call provider will respond to acute/urgent concerns ONLY. Her/she may not choose treat over the phone and if appropriate, may refer you to Urgent Care or an Emergency Department or recommend waiting until the office reopens if appropriate. The on-call provider may not always have full access to your complete medical record and **will not refill prescriptions, prescribe controlled substances, answer patient portal requests/resets or provide test result questions.**

If you **need a routine prescription refill**, please first contact your pharmacy or request via the Patient Portal. **Allow at least 48 hours for all refills to be processed.** It is necessary that you plan ahead for medication refills and request them before you run out. To avoid confusion, please cancel any prescriptions with pharmacy's you no longer use as they will continue to send refill requests.

If you **need to cancel your appointment**, please do so at least 24 hours advance by calling during our normal phone hours, Monday - Friday 8:00 am - 5:00 pm. Our answering service cannot schedule or cancel appointments and patient portal messages will not be accepted . Please plan ahead. Late cancellations will incur a $79 fee.

We respectfully ask that you **arrive on time to each scheduled appointment.** If you do not arrive by your scheduled time, you will be marked as a "no-show" and a no-show fee will be assessed per the signed Financial Policy. To help avoid the fee, we will do our best to accommodate you if there is a later appointment or an opening with another provider available. If we cannot accommodate you or you choose not to be seen at that point, you will incur a $79 no-show fee. Our office will attempt to send a reminder text/email for appointments scheduled 5 days in advance, however, it is still your responsibility to plan for any visit you schedule. Three no-show's will result in dismissal from the practice.

We will ask you to **update paperwork and signatures annually or as often as your personal information changes** including any changes to insurance. We require completion for each individual patient so we can submit labs, imaging facilities, specialty referrals, etc… Additionally, consents and acknowledgement of Privacy Practices are mandated by the Federal Government and are required.

New patients must first establish care with a PFP provider before an annual physical can be scheduled or performed and before any medications an be prescribed. A **parent or guardian must be present for the initial visit** with any patient under the age of 18. Consent can be signed for teens between 16 through 17. PFP will not establish care with patients who have not received or intend to receive all childhood vaccinations.

Please understand that **we cannot effectively treat medical conditions over the phone or via patient portal messages.** This is medically inappropriate and can result in misdiagnosis and/or inadequate care. Therefore, we prefer that you schedule an appointment with a medical provider for proper evaluation and treatment. PFP providers will not authorize specialty referrals or imaging requests without seeing you in-office first.

An **Annual Physical exam is required annually** for each patient of PFP. The Annual Physical and Wellness Exam policy will be strictly enforced. Annual Physicals are meant for wellness and disease prevention, not for acute medical concerns or establishing a new plan of care and treatment of chronic issues. Prescriptions, medications, paperwork etc…may be delayed or denied as a result of not having an annual physical. For many reasons we do not find it appropriate to complete a Physical Exam during a New Patient visit – this will need to be scheduled separately. Please read our Annual Physical Policy for more details.

For your convenience, our staff will attempt to **send a reminder for Annual Physicals**. Please make sure you have an active email and mobile phone on file for these reminders. Ultimately, it is your responsibility to document your appointments as you make them. If made in the office, you will be offered an appointment reminder card. You may also access any scheduled appointments on your patient portal.

If you'd like **someone other than yourself to have access to your medical** or billing information or call on your behalf, we must have a signed consent on file. This Federal Law will be strictly enforced for all patients years of age and older, regardless of who holds insurance or pays medical bills. All State laws for minors and privacy will apply as well.

PFP requests **all patients 18 years of age and older to be active users of the Patient Portal.** Parents can access a child's portal account through the age of 12. This is our preferred method of contact regarding normal test results, normal imaging results, services due, patient statements and rx refills. If you have a portal set up, **result messages will go to your patient portal.** The portal allows you access to visit/clinical summaries, medications and refill requests, lab results, referral information, past and future appointments, pertinent education materials, statements and online payments. If you choose not to use the patient portal, we can inactivate it however, it is all or nothing and you will be required to check it regularly or as you receive email updates.

******Please note******

*While you are able to send non-emergent/non-urgent questions or concerns through the portal, messages can take up to 3 business days for response. **PFP will not respond to messages sent outside of normal business hours, including weekends and holidays.** Call the office if you need a more timely response or, the provider on call after hours for urgent concerns.

**Questions/concerns sent are monitored by PFP staff. As directed by a PFP provider, you may be asked to schedule a visit.

***The patient portal will be our primary means of sending patient statements and making credit card payments. You will only receive a mailed statement if you are not on the patient portal or if your account is past due.

****Telemedicine is not accessible via the Patient Portal.

Important Numbers: Main Line - 303-948-2676

- **Schedule or cancel an appointment - option #3**
- **Refill a prescription - contact your Pharmacy or request via Patient Portal**
- **Non Urgent medical question/concern - option #7**
- **Telemedicine Visits already scheduled -** https://www.pinonfamilypractice.com/telehealth-1
- **Referral Information - dial ext. 110**
- **After hours provider on call (urgent medical concerns ONLY) - 303-948-2676**
- **Billing Questions - option #5**
- **Billing Statements/Payments - Patient Portal or option #5**

https://www.pinonfamilypractice.com/our-patient-portal

Pinon Family Practice

Annual Physical Policy

As part of the annual physical expectation mentioned in the Office Information and Policies, the Annual Physical Policy will be provided to you at your visit and require acknowledgement and signature. We ask that you plan accordingly to make the best use of your visit(s).

Many of our patients have health insurance plans that cover the cost (including co-pay) of a yearly preventive health care visit – otherwise known as your annual physical. Not all insurance coverage is the same; you can find out more about your coverage and policy specifics by contacting your insurance company.

The American Medical Association (AMA), Centers for Medicare and Medicaid Services (CMS) and commercial insurance company guidelines identify a predetermined list of components that are considered part of an annual physical. For example, during your annual physical, you may expect that your provider will do the following:

- Gather or update your comprehensive medical history
- Outline plans for the reduction of risk factors
- Provide interventions or counseling to improve overall health
- Order appropriate laboratory/diagnostic procedures based on your personal medical conditions
- Order and/or administer appropriate immunizations
- Manage minor health concerns that have already been diagnosed
- Routine prescription refills for chronic medications (blood pressure, cholesterol, allergy, birth control, etc.)
- Special attention to a skin lesion or mole and plan for evaluation and/or removal (not same day)

More specific and problem focused or acute health concerns <u>are not covered</u> as part of an annual physical. These are concerns that would normally prompt you to schedule an appointment if you were not scheduled for your physical or already had one. If time permits, your provider may elect to address this at the time of your physical; it is therefore appropriate according to coding, billing and insurance guidelines for your provider to generate an additional charge for an office visit, which would be subject to your out-of-pocket expense according to your agreement/policy with your insurance carrier. If time does not allow, your provider will help to prioritize these concerns at the time and then ask that you schedule a separate appointment and/or reschedule the annual physical.

Following are examples of specific health concerns that may NOT be covered as part of your physical:

- Sinus infection
- Sore throat (testing for strep, COVID or flu)
- New cough
- New or changed headache pattern
- Abdominal pain
- Pelvic pain
- Depression or anxiety
- Joint pain, both specific and general
- General fatigue
- Sleeping problems
- Irregular periods
- Significant changes in status of a chronic health or mental health problem
- Urinary tract or bladder infection
- New diagnosis or significant change as determined by bloodwork or other test results

If you have concerns about whether a charge for an additional office visit will be generated, ask your health care provider for more information. Our goal is to be transparent, to help you to prioritize your needs and utilize your time in our office as efficiently as possible.

<u>Please note:</u> In January 2018, Pinon Family Practice began work with the State Innovation Model (SIM) to address mental health and provide whole-person healthcare. It is our expectation and our goal to ensure that all patients, families, caregivers, insurance companies, government agencies etc., equally consider and cover mental health prevention and disease as that of physical health. Accordingly, it is our policy that every patient of Pinon Family Practice be screened annually (and quarterly if a mental health concern is present) with a PHQ9 and/or GAD7 questionnaire . Most insurance carriers cover this screening as part of preventative health benefits, however we have found that some plans don't cover/pay. The insurance carrier "allowed amount" ranges from $5 -$8 per screening and will be billed to you if not covered by insurance.

I acknowledge that I have read and understand the above Annual Physical Policy. I understand that my insurance policy and benefits are an agreement/contract between my insurance carrier and myself/policy holder. I understand that PFP will code and bill for services scheduled and provided and will not change or alter for the purpose of coverage or out-of-pocket expense. As such, I agree to pay Pinon Family Practice accordingly for services rendered and in accordance with the Financial Policy.

Signature will be collected at the time your scheduled annual physical visit

New Patient _____

Patient Information- 2024

Patient Update _____

(please print) ***PLEASE FILL OUT ALL SECTIONS BELOW ***

Patient Information

Last Name:	First Name:	Previous name / Nickname
Mailing Address:		Date of Birth:
City/State/Zip:		
Primary Phone #:	Secondary Phone #:	Can we leave a detailed message regarding medical care and/or test results? ____Yes ____No
Social Security #	Do you use our patient portal? ____ Yes ____No *Marking "NO" will disable use of the patient portal*	How did you hear of our office? If another pt, name please.
Email address:		Primary Care Provider (PCP) at Pinon Family Practice:
Legal/Sex at Birth: ___ Female ___ Male ___ Other		Marital Status: ___ Single ___ Married ___Divorced ___Widowed
Gender Identity: (if applicable)	Sexual Orientation: Straight / Lesbian, Gay or Homosexual / Bisexual / Choose not do disclose / Other	

Race (please select one or select "Decline")			**Ethnicity (please select one)**
___ White	___ American Indian/Alaska Native	___ Other	___ Hispanic or Latino
___ Hispanic	___ Black or African American	___ Decline	___ Not Hispanic or Latino
___ Asian	___ Native Hawaiian or Pacific Islander		___ Decline

Preferred Language (please select one)	**Emergency Contact: (this does not enable access to your Protected Health Info)**
English ___ Spanish___ ASL___ Other_____	Name: Phone:
Employer Name:	Employer Phone:
Preferred Pharmacy Name(s): Local	Mail Order
Cross Streets Phone:	City/State: Phone:

Responsible Party

FOR MINOR CHILDREN or ADULT POWER OF ATTY

Last Name:	First Name:	
Mailing Address: same as patient? ____		
City/State/Zip:		
Date of Birth:	Phone(s):	Social Security #:
Other Parent(s) Name:	Phone(s):	

Insurance Information

Primary Medical Insurance (please complete ALL fields)	**Secondary Medical Insurance** *(if applicable)*
Ins. Co. Name:	Ins. Co. Name:
Policy Holder Name:	Policy Holder Name:
Policy Holder / DOB:	Policy Holder / DOB:
Policy Holder Employer:	Policy Holder Employer:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:
Member ID #:	Member ID #:
Group ID #:	Group ID #:
Copay Amount: $	Copay Amount: $

Financial Policy - 2024

Please read and initial each section of the policy's below

Insurance

Complete and accurate and/or updated insurance information must be provided at every visit. Please have your current card available. Pinon Family Practice (PFP) reserves the right to deny service, reschedule or make your account self-pay at any time if this information is not present at the time of service or is inaccurate. It is your responsibility to confirm with your insurance carrier and specific plan within that PFP is in-network and that services rendered to you will be covered. PFP will do its best to notify you of any known out-of-network plans however, any out-of-network expense(s) incurred will be your responsibility.

By signing below, you authorize PFP to file with your insurance carrier and assign payment of medical benefits to PFP. You further acknowledge PFP to release any and all medical records and information necessary to process any claim generated by a service you or your dependent(s) receive. When applicable, it is your responsibility to ensure that a PFP provider is designated as your PCP on file with your carrier as required. It is your responsibility to be familiar with your insurance policy so you are aware of what services are covered and/or non covered. You will be responsible for payment of any medical services if your insurance denies payment. PFP does not know and cannot guarantee your insurance coverage, plan or benefits, this is your agreement with the carrier.

All copays are due at the time of service for every visit with a provider, including any telehealth encounters and follow-up requests. You will be asked to reschedule if you do not have the means to pay. This is your agreement with your carrier. Any outstanding balance will be collected at check-in or you will be asked to reschedule until payment is made. PFP cannot waive or write off copay's, deductibles or non-covered services that are due as per your insurance policy. PFP is contractually obligated to collect these fees.

PFP is contractually obligated to bill for any service(s) rendered and will abide by all industry standards of insurance and coding and billing guidelines. PFP will not re-code a visit different from what was scheduled and/or documented by the PFP provider at the time of service for the purpose of additional coverage/benefit.

If PFP does not accept your insurance or plan, you can choose to pay as self-pay however you must understand that medications, referrals, tests, imaging etc…may not be covered if ordered by our providers. PFP does NOT participate with Health First/Medicaid of CO and cannot enter into a self-pay agreement for any reason.

Initial _____ **I have read, understand and agree to the policies stated above.**

Self Pay

No Insurance/Out-of-network. Payment in full is due at the time of your appointment, including telehealth encounters. PFP will provide a 15% discount for all professional services (excluding vaccines and medications). A deposit of $106 is due at check-in (cash or credit/debit card) prior to any services rendered. Providers will code your visit using industry standards and coding and billing guidelines as indicated by the AMA and CMS standards. If at check-out, your service total is less than the deposit amount, we will immediately refund the difference. If your visit is more (i.e.: vaccine, medications, labs, etc...) you are expected to pay the difference at that time. If you leave without settling your balance, you will forfeit any self-pay discount and incur a $10 billing fee.

Initial _____ **I have read, understand and agree to the policies stated above.**

Account Balance

Any out of pocket amount assigned is due immediately upon the processing of your claim(s) by insurance. We will hold a current credit/debit/HSA card on file and process no sooner that 14 days from the date we are notified by your insurance carrier of your responsibility (see the PFP Credit Card Policy). This allows time for you to review and contact us if necessary. You should be notified simultaneously (or able to access your insurance Explanation of Benefits) as your insurance carrier process your claim(s). Generally, it takes the insurance 2-4 weeks to process claims. Additionally, you can also access your PFP statement anytime on our Patient Portal. We accept Visa, MasterCard and American Express, Discover and HSA payments.

As we identify any deductible/coinsurance amount due (per electronic download of your insurance benefits) PFP will require the minimum contractual allowed amount be paid at the time of service should you do not choose to keep a credit card on file.

There will be a $10.00 billing charge assessed for every 30 days your account is past due. If you choose not to leave a credit card on file or, the card fails and you fail to pay or make arrangements within 14 days as indicated above, you will incur the $10 billing charge as a result. The card on file and "annual consent" is required to be updated annually. Please note: should your account become “delinquent” at any time, Pinon does reserve the right to and may deny services, prescriptions, paperwork etc….

Should your account become delinquent and assigned to a collection agency, you agree by signing below to pay an additional collection charge of 33% of the outstanding balance or a minimum of $40.00 whichever is greater to offset in part the collection agencies fee charged to this practice. Should legal action be initiated by the collection agency, you agree to pay a collection charge of 50% of the outstanding balance as well as all costs and reasonable attorney fees incurred in such collection efforts by this office or our assignee. Furthermore, you and your family members may be discharged from PFP due to nonpayment.

There will be a $25.00 fee for any returned checks and PFP will require cash or credit card for future payments.

There will be a $79 fee for no-showing scheduled appointments. Showing 5 or more minutes late will be considered a no-show. Three (3) no-show visits will result in dismissal from PFP. There will be a $79 fee for cancelled appointments without providing 24-hour notice. The card on file as agreed above, will be immediately run for no-show/late cancel visits.

Initial _____ **I have read, understand and agree to the policies stated above.**

Paperwork

Paperwork/forms requested without an appointment will incur a fee. FMLA and Disability paperwork - $75 due at time of pick-up; Sports Physical forms, return to work and biometric screening forms - $35 due at the time of pick-up.

Pursuant to Colorado Statute (C.R.S 25-1-801) Medical records printing fees are as follows: pages 1-10 $18.53 and pages 11-40 $.85 per page and 41+ pages $.57 per page, plus postage. You can access, download, save and print your records at any time through your patient portal, free of charge. As a courtesy, to forward records to another medical facility for continuity of care is free of charge. PFP uses a copy service and therefore, PFP staff cannot copy/release records at the office. Pursuant to Colorado Medical Board policy 40-07, release of records can take up to 30 days from the date of the initial request.

Initial _____ **I have read, understand and agree to the policies stated above.**

My signature below indicates that I have read and agree to the above Financial Policies and terms within. I agree that I am taking financial responsibility for any services rendered. I agree that a photocopy/digital image of this agreement shall be valid as the original.

If patient is under 18 years of age, a parent or legal guardian must sign below POA or Agent, please provide court approved documentation.

Patient Name: (please print)	**DOB:**
Signature of Patient, Guarantor or Agent:	**Date:**

Consent and Release of Information

If patient is under 18 years of age, a parent or legal guardian must sign below*

- I understand and agree to the policies outlined in Pinon Family Practice Office Information and Policies.
- I voluntarily agree to treatment including but not limited to physical exams, diagnostic tests, procedures, treatments or other modalities by which the attending PFP provider has deemed necessary and of which are administered to or to be performed under the direction of the attending provider and his/her designee. Unless otherwise noted by legal documentation and court approval, PFP will presume a custodial parent, their designee or POA has medical decision making authority and will provide medical care to the patient listed below. PFP will exercise professional judgement and act in the best interest of the patient in the absence of a court order. It is the responsibility of the parent or guardian to provide documentation.
- I understand that all visits and medically pertinent information will be documented by PFP providers and staff, including nicotine use, mental illness, illicit drug use, alcohol use, mental/physical abuse etc... I understand that PFP cannot change or delete this information for any reason.
- I allow Pinon Family Practice to access medication and medical history via electronic download from all local pharmacies and CORHIO – CO Regional Health Information Exchange. I understand that I am able to opt-out of CORHIO by request.
- I understand that if a controlled substance is being provided, limited information will be submitted into Colorado Prescription Drug Monitoring Program for limited purposes allowed under Colorado Law.
- I understand that any vaccinations received or refused will be entered into the Colorado Immunization Information System (CIIS). I understand that I am able to opt-out by request.
- I understand that it may be necessary for other healthcare professionals to review the contents of my (or minor dependents) medical record in order to render/continue medical care. I authorize Pinon Family Practice to discuss with and/or to copy all or part of my (or minor dependents) medical record for the purpose of continuity of care.

[ ] **I understand and agree to the above Consent and Release of Information. I understand and agree to the definitions outline in Office Information and Policies. I have had opportunity to ask questions and receive answers.**

Initial

Release of My/Dependent Personal Information

Please select and complete each section

I authorize PFP and it's associates to release Protected Health Information (PHI) including visit information, diagnosis, diagnostic and test results and claims/billing information rendered to those listed below. *(Please note: previously providing an "Emergency Contact" does not authorize our PFP to give access to your PHI - you must list an individual below).*

***This information may be released to:** **(Please provide first and last name)**

[ ] Spouse: Phone:

[ ] Children: Phone:

[ ] Parent/Step Parent: Phone:

[ ] Other: Phone:

[ ] Information is not to be released to anyone ***(if nothing else is selected, PFP will select this option for you)***

[ ] **I acknowledge that this Release of Information will remain in effect until terminated by me in writing.**

Initial

Acknowledgement and Receipt of Notice of Privacy Practices

- Pinon Family Practice's Notice of Privacy Practices is available on our website (www.pinonfamilypractice.com), on the bulletin board in our waiting room and at the front desk, please ask a receptionist if you need assistance.
- The undersigned Patient or legally authorized representative (or "Agent") of the Patient acknowledges that he or she personally received a copy or was offered a copy of Pinon Family Practice, LLP's Notice of Privacy Practices on the date indicated below .
- I agree that a photocopy or digital image of this agreement shall be as valid as the original.

If patient is under 18 years of age, a parent or legal guardian must sign below*

Patient Name: **(please print)**	**DOB:**
Signature of Patient, Guarantor or Agent:	**Date:**

If the above named patient is over 18 and is not able to acknowledge the above consents and notices, court documentation (e.g., POA) must be provided. Please print the name/relationship of the "Agent" below.

Agent : Title/Relationship:

Patient Portal - Informed Consent

If patient is under 18 years of age, a parent or legal guardian must sign below*

Pinon Family Practice (PFP) does not have secure, HIPAA compliant email. Use of the provided **Patient Portal** is highly encouraged for patients 18+. PFP does not allow portal access for patient 13-18. When using the portal, you are responsible for taking steps to protect yourself from unauthorized use of online communications, such as keeping your username and password confidential. Pinon is not responsible for breaches of confidentiality caused by you or an independent third party. You agree to take steps necessary to keep your Patient Portal and subsequent medical information confidential including:

- Signing up for and consenting to use of the Patient Portal, you agree to accept messages, results and any other notifications deemed appropriate by PFP in lieu of phone messages and will accept the terms and conditions outlined in the Patient Portal sign-in process. Such messages will be sent by Providers and/or staff of PFP on behalf of your Provider.
- Do not download or store your personal information on your employer-provided computer; otherwise personal information could be accessible or owned by your employer.
- Use screen savers or close your portal instead of leaving your open chart on the screen for passersby to read and keep your password safe and private.
- Do not allow other individuals or other third-party access to the computer(s) upon which you store your personal medical information.
- Update your contact information as soon as it changes including any changes to your regularly used email address. Pinon will not use your standard email account for security reasons, but notifications are sent to your standard email address when a message has been sent to you and is waiting for you on your Patient Portal.
- **You agree not to send Urgent or Emergent medical questions or requests.** PFP is not able to monitor the patient portal for Urgent or Emergent concerns or messages sent outside of normal business hours. Portal messages received will be reviewed by PFP medical staff and sent to your Provider following our internal policies. Portal messages will be handled within 2-3 business days. If you feel your matter is more urgent, you agree to call the office.
- PFP providers will not treat acute medical concerns or send new prescriptions via online portal messaging. At the discretion of the PFP provider, you may be asked to schedule a telemedicine or in-office visit to appropriately evaluate, document and develop a plan of care.

Withdrawal of this informed consent must be done by written online communications or in writing to Pinon Family Practice.

_____ *Initial*

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the Patient Portal and consent to the conditions outlined herein. I agree to the instructions and guidelines detailed while entering the portal as well as any other instructions my physician may impose or communicate with me (my dependent) via online communications. I have had a chance to ask questions and received answers.

Appointment Reminder Calls & Follow-up Communication

TEXT MESSAGE, EMAIL AND INFORMED CONSENT: In order to enhance patients' care and experience, Pinon Family Practice may send appointment reminder calls/text messages/e-mails for Annual Physicals or appointments scheduled 5 or more days in advance. PFP may also have important announcements to send, such as when it's time for flu shots or return appointments, bloodwork or vaccine notifications. PFP may also contact you after your visit in order to request feedback on your experience by SMS text message, e-mail, voicemail, or mobile application, some of which may be via automated means. By signing below, you understand and agree to be contacted in this manner with communications related to this visit, and any future visits.

If you are **not** interested in these services, please select the "**Opt out**" option at the bottom of this form. If in the future you would like to opt-out, you may do so by notifying us in writing Standard telephone minute and text messaging charges may apply when we contact you.

MOBILE SAFETY TIPS: While we work hard to protect your information, remember that electronic communication is never 100% secure. It's very unlikely, but information you send via text, email or mobile application, or that you leave on your mobile device, could be exposed to people other than your doctor. Here are a few safety tips to follow:

- Use a password on your mobile device to prevent strangers from seeing what is on your phone.
- **DO NOT** send sensitive health information to us and do not REPLY to messages sent. Replies will not be responded to and are immediately deleted. Please send a portal message or call us to discuss something private or sensitive.
- If you are worried about those close to you seeing your messages, you can delete them from your email or messaging app. This won't erase them completely, but will make it hard for others to see them.

(Please select one)

_____ I choose **to receive** calls/text messages (PFP will use the primary mobile listed on the Patient Information form)

~OR~

_____ I choose **to opt-out** of receiving calls/text messages (**No reminder calls/text messages!**)

If patient is under 18 years of age, a parent or legal guardian must sign below*

Patient Name: (please print)	**DOB:**
Signature of Patient, Guarantor or Agent:	**Date:**

Telemedicine Consent and Terms of Service

To better serve our patients, we offer virtual visits to established Pinon Family Practice (PFP) patients. A virtual visit or "telemedicine" visit is a two-way interactive video communication and involves electronic transmission of pertinent medical information (medical records, medical images, live two-way audio and video, etc.). We can use the video conferencing tools and the electronic transmission of information platform to assist us in the evaluation and treatment of certain medical conditions. These virtual visits are called "telemedicine" or "telehealth" visits/encounters.

This platform enables the PFP providers to provide medical care for the purpose of delivering safe, convenient, efficient, and effective patient care when appropriate. Telemedicine visits are only for certain circumstances and cannot replace in-person office visits. The PFP clinical team has developed very specific criteria by which standards of medical practice and safety guidelines can be followed to benefit our entire patient community. The clinical team takes the responsibility to care for all patients, including infectious/contagious acute concerns while also caring for at-risk, non-infectious immunocompromised, elderly, new-born, chronically ill and/or terminal conditions very serious. For this reason, the clinical team may require a telemedicine visit encounter for select acute concerns before clearing a patient to be seen in-office. Only a PFP provider, during a scheduled telemedicine visit can over-ride this policy. Similarly, the clinical team may have specified criteria in place for which a telemedicine visit is not appropriate and an in-office visit will be required. Our team will always do it's best to guide you and provide transparency of these policies and procedures.

The telemedicine platform is accessible on the PFP website: **www/pinonfamilypractice.com>telehealth**. Detailed instructions are provided within the body of the TELEHEALTH webpage and include a check-in flyer, how-to video and system requirements. Each individual PFP providers' telemedicine waiting-room is listed on this webpage. This is the only way to access/enter a providers waiting room for your visit. **Please note:** Telemedicine visits are not available via the Patient Portal. The telemedicine platform is a completely separate application and does not require use of the Patient Portal.

- I am voluntarily requesting PFP providers, as deemed necessary, to treat my medical condition(s) through telehealth services and understand that like in-office visits, no result can be guaranteed or assured.
- I understand that a telemedicine encounter with a PFP provider does not guarantee issuance of prescription. I further understand that PFP providers will practice evidence-based medicine and best practices and will prescribe medication therapy only as he/she feels appropriate.
- I understand that telemedicine-based services and care may not be as complete as face-to-face encounters.
- I agree that if the PFP provider providing the telemedicine service believes I would be better served by another form of service or follow-up care (e.g., in-office visit, drive-up exam) I will be directed to schedule as such.
- I understand that I can refuse care through telemedicine at any time and request an in-person (following my PFP providers acute care guidelines) encounter at a future date. As such, I understand my care may be delayed for reasons stated above. Refusing care through telemedicine will not affect my right to care or treatment in the future.
- I understand that transmitted/electronic data may be kept, viewed and used for the purposes of monitoring treatment and guiding provider or staff interventions. Transmitted data may become part of my medical record.
- I understand that PFP providers can only provide medical and advice to existing patients with scheduled visits. For example: spouses, partners, children, friends etc., will not be seen or treated without a scheduled visit.
- I understand Telemedicine visits are subject to the same privacy protections as in-person healthcare services.
- I understand that while I may be scheduled for a specific telemedicine visit time, the PFP provider may run late as he/she finishes up with a pressing, urgent or emergent patient matters. I agree to call PFP schedulers to inquire should the provider be more than 10 minutes late to avoid an possible misunderstanding.
- I agree that it is my responsibility to take security steps for my visit by using a personal, secure device while in a private setting where no other person is present. I agree that PFP is not responsible for breaches of confidentiality caused by me or an independent third party.
- I understand that I have will have access to all medical information resulting from telehealth services as if this was an in-person visit. I understand that I can access this through my Patient Portal account or, I can request to pick up a copy of the visit note.
- If I am unable to communicate via the face-to-face telemedicine platform for any reason (e.g., a technological or lack of appropriate equipment or equipment failure) requiring a telephone call visit with my provider, I agree that a telephone discussion will constitute a complete telemedicine encounter.
- I understand that just as with in-office encounters, I am meeting with a provider for medical care, advice and treatment considerations and an encounter for these services will be billed as agreed upon in the PFP Financial Policy. I understand that all terms and conditions within the signed Financial Policy will apply.
- I understand that I am responsible for copay, co-insurance, deductible and/or any other out-of-pocket amount assessed by my health insurance carrier.

I acknowledge that I have read and understand the above terms and conditions. By entering a telehealth visit, I further declare that I have read, understand and agree to the above terms of service. I acknowledge that I have had opportunity to discuss this with a PFP representative and all of my questions have been answered to my satisfaction.

If patient is under 18 years of age, a parent or legal guardian must sign below*

Patient Name: (please print)	**DOB:**
Signature of Patient, Guarantor or Agent:	**Date:**

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Personal Medication List

Patient Name:	Patient DOB:	Primary Care Physician:

Prescription Medications	Purpose or Reason Taken	Dose	Time(s) per Day	Form (liquid, capsule, tablet)	Special Directions

Over the counter medications	Purpose or Reason Taken	Dose	Time(s) per Day	Form (liquid, capsule, tablet)	Special Directions

Drug Allergies and Reaction:		
Local Pharmacy:	Address:	Phone:
Mail Order Pharmacy:	Address:	Phone:

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Pinon Family Practice

Authorization For Release of Medical Records

Patient Name:	Date of Birth:
Address:	Phone(s):

*This Authorization applies to all of the following information:

****Please select one++**

[_____] **All Information**; I understand that the information may contain psychiatric/psychological, alcohol/drug abuse, and/or AIDS/HIV information and I expressly consent to the release of the information.

[_____] **Only** the following records or types of Information:

[___] Office Visits [___] Labs [___] Radiology [___] ETOH/substance abuse

[___] Mental Health record [___] HIV/STD records [___] EKG, Spirometry

[___] Other (Please specify) _____

[_____] ***Release all of the above approved records or, only for the following treatment dates: _____ to _____**

*Disclose information **FROM**: (Facility Name and Address)	***Phone:**	***Fax:**

Disclose information TO:	**Phone:**	**Fax:**
Pinon Family Practice **9895 West Remington Place** **Littleton Colorado 80128**	**303-948-2676**	**303-904-9151**

***Purpose of release: [___] Change in Primary Care Provider [___] Other (Please specify) _____**

*This authorization ends on: [_____] (date) *If no date is specified, this authorization will end after 180 days from date of signature.*

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, or treatment for alcohol and drug abuse. I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or obtain copies of the information to be used or disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact Pinon Family Practice.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by Pinon Family Practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

I agree that a photocopy or digital image of this agreement shall be as valid as the original.

***If under 18 years of age, you must have a parent or guardian sign below.*

***Signature of Patient, Guarantor or Agent:** **Date:**

If the above named patient is over 18 and is not able to acknowledge the above consents and notices, court documentation (e.g., POA) must be provided. Please print the name/relationship of the "Agent" below.

Agent/Guarantor:_____Title/Relationship:_____