Welcome To Our Office

PLEASE PRINT and COMPLETE ALL PARTS

The Care Group, PC
830 Potomac Cir Ste 150
Aurora, CO 80011
(303) 343-3121 FAX: (303) 343-3514
www.thecaregrouppc.com

Today's Date ______________________________

PATIENT INFO: (This section refers to PATIENT ONLY)

Name ____ Referred By ___________________________

Address ___________________________________ City ________________ State _____ Zip _______________

Home Phone ____________________ Cell Phone _____________________ Work Phone _____________________

Date of Birth ____/____/_____ Age _______ Sex _______ Race _______ Religion ________________________

Social Security# ______-_____-_______ Email ____

Employer ____ Primary Language _____________________________

Spouse _________________________ Employer ______________________ Work Phone _____________________

Relationship to Responsible Party: Self Son Daughter Spouse Other

RESPONSIBLE PARTY: (Primary insurance carrier)

Name ____

Address ___________________________________ City _____________ State _____ Zip _______________

Home Phone ____________________ Work Phone ____________________ Date of Birth ____________________

EMERGENCY CONTACT: (NOT LIVING WITH YOU)

Name __________________________ Home Phone ___________________ Work Phone _____________________

Address __________________________________ City ______________ State _____ Zip _______________

INSURANCE INFORMATION:

Primary Insurance ______________________ Policy ID ______________________ Group# __________________

Secondary Insurance ____________________ Policy ID ______________________ Group# __________________

PHARMACY INFORMATION:

Primary Pharmacy _________________________________ Phone# _____________________________________

Secondary Pharmacy _______________________________ Phone# _____________________________________

PLEASE SIGN BOTH X'S

I authorize payment of medical benefits go directly to The Care Group for these services and all future claims.	I authorize the release of any medical information necessary to process this claim and all future claims.
X ____	**X** ____
Signed (Insured or Authorized Person)	Signed (Insured or Authorized Person)

*****This signature on file is valid until revoked by the patient or their power of attorney*****

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Name ______________________________ Date ______________________

In order to better serve you, please read and initial the following information:

We participate with most insurance plans. Please check your insurance to verify plan participation for The Care Group.

BENEFITS/REFERRALS

It is your responsibility to know your insurance benefits. If we are not able to verify insurance coverage, **payment in full is expected at your visit**. If your insurance requires that you have a referral to a specialists you are responsible for making sure your referral is at the specialist office before your visit. You also need to make sure that the specialist participates with your insurance group.

INTIALS: ________________

ANNUAL PHYSICALS

Many insurance plans do **NOT** cover physical exams. You must verify that your insurance covers this type of service, as well as the frequency of service. After a claim is submitted, we will **NOT** be able to change a diagnosis or procedure code so that your insurance carrier will pay your claim. **You will be financially responsible for any services denied by your carrier.**

INITALS: ________________

MEDICARE

This office accepts Medicare assignment. Medicare pays 80% of the amount they approve after you meet your deductible. You are responsible for your deductible and the remaining 20%. If you have insurance that covers the remaining 20%, please provide us with that information.

INTIALS: ________________

FINANCIAL RESPONSIBILITY

Co-payments are collected at the time service is rendered. Any balance your insurance company states is your responsibility is due upon receiving your statement. Returned checks will result in a fee of $15.

INTIALS: ________________

MISSED APPOINTMENTS

Please notify us 24 hours in advance if you are unable to keep your scheduled appointment. Missed appointments will result in a charge of $75.

INTIALS: ________________

I had the opportunity to read and understand The Care Group, P.C.'s Notice of Privacy Practices and have read all of the above information.

By signing this agreement, you agree to pay your co-pay, co-insurance, deductible and any fees that your insurance company does not cover, at the time of service.

Signature ______________________________ **Date** ______________________

The Care Group

HIPAA AUTHORIZATION FORM

Consent for Treatment of Minors

I, the undersigned, understand that a minor child (17 and under) must have my consent to be treated. I understand that I must be present at each appointment for any child aged 14 and under. If the child is between the ages of 15 and 17, I understand that I must send a note with the child to the appointment consenting for the child to be treated. I also understand that Colorado Law provides minors to seek care without parental consent for certain issues.

E-Mail Communication

I, the undersigned, understand that e-mail communication is optional and does not replace traditional means of communication. I understand that I may receive information on my e-mail confirming my appointment times, or literature from my provider that relates to The Care Group.

PLEASE LIST BELOW ALL AUTHORIZED PERSONS THAT MAY RECEIVE YOUR TEST RESULTS, OR DISCUSS YOUR MEDICAL ISSUES.

Name	Relationship	Age	Phone Number
Name	Relationship	Age	Phone Number

PLEASE LIST THE PHONE NUMBER YOU WOULD LIKE THE CARE GROUP TO CALL TO LEAVE TEST RESULTS OR CONFIRMATION CALLS, ETC.

Phone Number ____

I authorize The Care Group to leave medical results on my voicemail. ______Yes _______No

____ ________________________________

Name (print) **Date**

____

Signature