New West PHYSICIANS

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WELCOME TO OUR PRACTICE!

New West Physicians welcomes you to our practice. We are dedicated to providing you and your loved ones with high quality, patient centered care.

This New Patient Packet is designed to gather information about your health history, to help you understand the options for improved quality care that are available to you, as well as some expectations we have for you to assist us in your care.

We look forward to seeing you at your scheduled appointment. To save time on the day of your appointment, please read and complete all pages in this New Patient Packet and bring to your scheduled appointment check-in time. If you are unable to complete the packet prior to your visit, please plan to arrive 30 minutes before your scheduled time, so we may answer any questions and you can complete the forms. Please review the financial policy enclosed in this packet so you are aware of payments due at the time of service.

Please bring the following with you to your appointment:

- **Insurance Card (Please bring to every visit)**
- **Photo ID**
- **List of current medications with dosage**

We look forward to learning more about you and assisting you with your healthcare goals.

– New West Physicians Care Team

New West Physicians
Management Services Office | 1707 Cole Blvd, Suite 100 | Golden, CO 80401
Phone: (303) 763-4900 | Fax: (303) 763-5495
www.nwphysicians.com

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PATIENT REGISTRATION

Patient's Last Name: _____ First: _____ DOB: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____

Male ☐ Female ☐ Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Email Address: _____ Employer Name: _____
Work Phone #: (___) _____ Cell Phone #: (___) _____ Home Phone #: (___) _____

Insurance Information
Primary Insurance: _____ Subscriber's Name: _____ DOB: _____ Male ☐ Female ☐
Mailing Address (if different from above): _____
Policyholder's Employer: _____ Policyholder's Work Phone #: (___) _____
Policy # and Group #: _____ Customer Service Phone #: (___) _____

Secondary Insurance: _____
Mailing Address (if different from above): _____
Policy # and Group #: _____ Customer Service Phone #: (___) _____

Please complete this section if patient is a minor (if patient is under the age of 18)
Name: _____ DOB: _____
Relationship to Patient: _____ Primary Phone #: (___) _____
Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact
In case of an emergency, contact: _____ Phone #: (___) _____
Relationship to patient: _____

Insurance Authorization and Assignment of Benefits: I hereby authorize payment directly to New West Physicians and authorize the release of any medical information necessary to process insurance claims and for utilization review and quality assurance. I voluntarily consent to treatment for myself and/or dependents. I understand that I am financially responsible for all charges not covered or billed to any insurance or third party payor and/or not paid to New West Physicians. Should the account be turned over to collections, I will pay all costs of collection including, but not limited to, agency fees, attorney fees and court costs.

Patient/Guardian Signature: _____ **Date:** _____
(If patient is a minor, parent/legal guardian must sign on their behalf)

Relationship to patient: _____

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ADULT HEALTH HISTORY FORM

Patient Name: _____ **Today's Date:** _____

Date of Birth: _____ **Reason for Visit:** _____

Occupation: _____ **Marital Status:** _____

PERSONAL HEALTH HISTORY/CHRONIC MEDICAL PROBLEMS *(list all that apply)*

HEALTH MAINTENANCE *(if known, list the most recent date (month and year) for all that apply Ex: January, 2014).*
Date typing help: Type the three-letter abbreviation for the month, the four-digit year, and hit tab. The correctly formatted date will appear on the form.

NEW PATIENTS: PLEASE BRING A COPY OF YOUR VACCINATION RECORDS.

WOMEN ONLY:	**BOTH MEN AND WOMEN:**		**MEN ONLY:**
Menstrual Period:	Flu Shot:	Pneumonia Vaccine:	Digital Rectal Exam:
Last Pap Smear: Last Abnormal Pap Smear:	Tetanus Booster:	Hepatitis B Vaccine:	PSA (Prostate Blood Test):
Mammogram Date: Facility:	Zostavax (Shingles) Vaccine:	Bone Density (DEXA):	
Number of Children:	HgA1c (if diabetic):	Eye Exam:	
Number of Pregnancies:	Colonoscopy Date: Facility:		

CURRENT MEDICATION *(please include non-prescription OTC and herbal supplements)*	**DOSE AND STRENGTH**

ALLERGIES	**REACTION**

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ADULT HEALTH HISTORY FORM cont.

Patient Name: _____

Date of Birth: _____

PREVIOUS HOSPITALIZATION/SURGERY/MAJOR TRAUMA *(not including normal births)*	DATE AND LOCATION

FAMILY HISTORY Please indicate if any family members (parents, siblings, grandparents) have the following conditions. Use the following abbreviations to illustrate who: **M** = Mother; **F** = Father; **S** = Sister; **B** = Brother; **MGM** = Maternal Grandmother; **MGF** = Maternal Grandfather; **PGM** = Paternal Grandmother; **PGF** = Paternal Grandfather; **O** = Other

YES	WHO	CONDITION	YES	WHO	CONDITION
		Diabetes			Lung Cancer
		Heart Disease			Alcoholism
		High Cholesterol			Mental Health
		Cervical Cancer			High Blood Pressure
		Breast Cancer			Skin Cancer
		Colon Cancer			Prostate Cancer

SOCIAL HISTORY *(Choose "Yes" or "No")*	IF "YES", HOW OFTEN OR WHEN?
Do you consume alcohol?	
Do you use recreational drugs?	
Do you use Tobacco Products?	
If you answered "Yes" to the use of Tobacco Products, are you interested in quitting?	
Did you recently quit using Tobacco Products? When?	
How often do you exercise?	

ADULTS 65 AND OVER – DETAILS
Have you fallen lately?
Do you have an advance directive?

LIST OTHER HEALTHCARE PROVIDERS AND THEIR SPECIALTY

Local Pharmacy (Name, Address, City, Phone Number):

Additional Information and Continuations:

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ADULT HEALTH HISTORY FORM cont.

Patient Name: _____

Date of Birth: _____

REVIEW OF SYMPTOMS (Please check all that you are **currently** experiencing)				
GENERAL	☐ Fever	☐ Chills	☐ Recent Weight Loss or Gain	☐ Fatigue/Tired
HEAD AND FACE	☐ Facial Pain	☐ Facial Pressure		
EYES	☐ Eye Pain ☐ Red Eye	☐ Discharge from Eye	☐ Eye Itch ☐ Blurred Vision	☐ Eyesight Problems
EAR NOSE THROAT (ENT)	☐ Earache ☐ Hearing Loss	☐ Nasal Congestion ☐ Nasal Discharge	☐ Sneezing ☐ Sore or Scratchy Throat	☐ Hoarseness
HEART	☐ Pain in Chest ☐ Palpitations	☐ Heart Rate ☐ Heart Rate Slow	☐ Lightheadedness	☐ Swelling of Legs
LUNGS	☐ Shortness of Breath (SOB)	☐ Wheezing	☐ Cough	☐ Coughing at Night
GASTROINTESTINAL	☐ Abdominal Pain ☐ Abdominal Bloating/ Cramping	☐ Menstrual Pain ☐ Nausea ☐ Vomiting	☐ Diarrhea ☐ Constipation	☐ Dark Stool or Blood in Stool (melena)
GENITOURINARY	☐ Dysuria (pain while urinating) ☐ Urinary Frequency ☐ Urinary Urgency	☐ Pelvic Pain ☐ Dark Urine ☐ Blood in Urine ☐ Nocturia (waking up at night to urinate)	☐ Vaginal Discharge ☐ Problems with Menstrual Cycle	☐ Abnormal Vaginal Bleeding ☐ Lumps or pain in testicles
ORTHOPEDIC	☐ Joint/Limb Pain ☐ Muscle Aches	☐ Back Pain ☐ Joint Swelling	☐ Joint Stiffness ☐ Back Muscle Spams	☐ Swelling in Limb ☐ Limping
SKIN	☐ Rash ☐ Lesions	☐ Wound ☐ Itching	☐ Mouth Sores ☐ Genital Lesions	☐ Breast Lump ☐ Breast Pain
NEUROLOGICAL	☐ Headache ☐ Confusion	☐ Dizziness ☐ Fainting	☐ Leg Numbness ☐ Tingling	☐ Difficulty Walking ☐ Tripping/Falling
PSYCHIATRIC	☐ Insomnia	☐ Irritable	☐ Anxiety ☐ Depression	☐ Suicidal
ENDOCRINE	☐ Hot Flashes	☐ Night Sweats	☐ Muscle Weakness	☐ Generalized Weakness
BLOOD AND LYMPH	☐ Swollen Glands	☐ Easy Bleeding	☐ Easy Bruising	☐ Jaundice (yellowing of skin)
ADDITIONAL INFORMATION				

I certify that the information on this form is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for errors or omissions that I may have made in the completion of this form.

Patient Signature: _____ **Date:** _____

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PROVIDER NOTICE OF PRIVACY PRACTICES

Notice for Medical Information: Pages 1-5

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.

We[1] are required by law to protect the privacy of your health information. We are also required to provide you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice. The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information. We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, and if we maintain a website, we will post a copy of the revised notice on our website nwphysicians.com. If we maintain a physical delivery site, we will also post a copy in at our office. The notice will also be available upon request. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

HOW WE USE OR DISCLOSE INFORMATION

We must use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information for your treatment, to bill for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment.** We may use or disclose health information to obtain payment for health care services. For example, we may disclose your health information to your health plan in order to obtain payment for the medical services we provide to you. We may ask you for advance payment.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care. For example, we might analyze data to determine how we can improve our services.
- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Reminders.** We may use or disclose health information to send you reminders about your care, such as appointment reminders with providers who provide medical care to you or reminders related to medicines prescribed for you.

[1] This Medical Information notice of Privacy Practices applies to the following provider that is affiliated with Optum, INC.: New West Physicians, Inc.

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We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority. We may also disclose your information to the Food and Drug Administration (FDA) or persons under the jurisdiction of the FDA for purposes related to safety or quality issues, adverse events or to facilitate drug recalls
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licenser, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

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- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and pursuant to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract and permitted by law.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information as well as state laws that often protect the following types of information:

    1. HIV/AIDS;
    2. Mental health;
    3. Genetic tests;
    4. Alcohol and drug abuse;
    5. Sexually transmitted diseases and reproductive health information; and
    6. Child or adult abuse or neglect, including sexual assault.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law. Attached to this notice is a "Federal and State Amendments" document.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out how to revoke an authorization, use the contact information below under the section titled "Exercising Your Rights."

WHAT ARE YOUR RIGHTS

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction other than with respect to certain disclosures to health plans as further described in this notice.
- **You have the right to request that we not send health information** to health plans in certain circumstances if the health information concerns a health care item or service for which you or a person on your behalf has paid us in full. We will agree to all requests meeting the above criteria and that are submitted in a timely manner.

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- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests. In certain circumstances, we will accept your verbal request to receive confidential communications; however, we may also require you confirm your request in writing. In addition, any request to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and obtain a copy** of certain health information we maintain about you such as medical records and billing records. If we maintain a copy of your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect or obtain a copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as medical records and billing records if you believe the information is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. If we maintain a website, we will post a copy of the revised notice on our website. You may also obtain a copy of this notice on our website, nwphysicians.com or by calling **1-303-763-4900 Ext. 61500**.

EXERCISING YOUR RIGHTS

- **Contacting your Provider.** If you have any questions about this notice or want information about exercising any of your rights, please call **1-303-763-4900 Ext. 61500**.
- **Submitting a Written Request**. You can mail your written requests to exercise any of your rights, including modifying or canceling a confidential communication, requesting copies of your records, or requesting amendments to your record, to us at the following address:

  Privacy Administrator
  New West Physicians
  1707 Cole Boulevard, Suite 100
  Golden, Colorado 80401

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

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You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

CORHIO PATIENT NOTIFICATION

New West Physicians endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the <CORHIO> HIE, or cancel an opt-out choice, at any time.

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NEW WEST PHYSICIANS, INC.

PROVIDER NOTICE OF PRIVACY PRACTICES: FEDERAL AND STATE AMENDMENTS

The first part of this Notice, which provides our privacy practices for Medical Information (pages 1 - 5), describes how we may use and disclose your health information under federal privacy rules. There are other laws that may limit our rights to use and disclose your health information beyond what we are allowed to do under the federal privacy rules. The purpose of the charts below is to:

1. Show the categories of health information that are subject to these more restrictive laws; and
2. Give you a general summary of when we can or cannot use and disclose your health information without your consent.

If your written consent is required under the more restrictive laws, the consent must meet the particular rules of the applicable federal or state law.

SUMMARY OF FEDERAL LAWS

Alcohol and Drug Abuse Information
We are allowed to use and disclose alcohol and drug abuse information that is protected by federal law only (1) in certain limited circumstances, and/or disclose only (2) to specific recipients.

General Health Information	
We are allowed to disclose general health information only (1) under certain limited circumstances, and /or (2) to specific recipients.	AR, CA, DE, FL, IN, MN, MT, NE, NJ, NY, PR, RI, TN, TX, WA
You may be able to restrict certain electronic disclosures of health information.	NC, NV
We are not allowed to use or disclose health information for certain purposes.	CA, FL, IA, MT, NH, TN
We will not use and/or disclosure information regarding certain public assistance programs except for certain purposes	AL, CA, MO, MT, NV, NJ, SD, TX
We are allowed to disclose certain immunization records only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients	FL, IL NE, NV, SC
We must restrict access to records of minors subject to a court protective order	IL
We must comply with additional restrictions prior to using or disclosing your health information for certain purposes	KS, MO, VI
We are allowed to disclose your health information only for limited research purposes	WA
Prescriptions	
We are allowed to disclose certain prescription-related information only (1) under certain limited circumstances, and/or (2) to specific recipients.	AL, CO, CT, FL, GA, ID, IN, KY, MI, NE, NV, NH, NY, OH, RI, SC, TN, UT, VA, WV, WY
We must limit the amount of certain of your health information that we can include on a prescription or other medical certification document	ME

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Communicable Diseases	
We are allowed to disclose communicable disease information only (1) under certain limited circumstances, and /or (2) to specific recipients.	AZ, IA, IN, KS, MI, MT, NE, NV, NY, OK
Sexually Transmitted Diseases and Reproductive Health	
We are allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited circumstances and/or (2) to specific recipients.	AZ, CA, CO, FL, IL, IN, IA, KS, MA, MI, MT, NV, NJ, NM, OK, WA, WV, WY
We are not allowed to identify certain abortion patients in legal proceedings	OK
Alcohol and Drug Abuse	
We are not allowed to disclose alcohol and drug abuse information without your written consent.	WV
We are allowed to use and disclose alcohol and drug abuse information (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AR, CA, CT, FL, GA, IL, IN, IA, LA, MD, MA, MI, MN, MS, NV, NC, OH, OK, PA, TN, VA, WI
Genetic Information	
We are not allowed to disclose genetic information without your written consent.	KS, NH, NY
We are allowed to disclose genetic information only (1) under certain limited circumstances and/or (2) to specific recipients.	AK, AZ, FL, IL, LA, MA, ME, MO, NH, NV, NJ, NM, OR, RI, TX, VT, WA, WY
Restrictions apply to (1) the use, and/or (2) the retention of genetic information.	AK, DE, NM, WY
HIV/AIDS	
We are allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.	AZ, CA, CO, CT, DE, FL,GA, IA, IL, IN, KS, KY, ME, MD, MA, MI, MO, MT, NE, NV, NH, NM, NY, NC, OH, OK, OR, PA, PR, RI, TX, WA, WV, WI, WY
Certain restrictions apply to oral disclosures of HIV/AIDS - related information.	CT, FL
Mental Health	
We are not allowed to disclose mental health information without your written consent.	PR, UT
We are allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients	AK, AZ, CA, CT, DC,IA, IL, IN, ME, MD, MI, MS, NV, NH, NJ, NM, NC, OK, PA, SC, SD, TN, TX, UT, WA, WI
Certain restrictions apply to oral disclosures of mental health information.	CT
Child or Adult Abuse	
We are allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AR, IL, MD, WI

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ **Patient Date of Birth:** _____

"I acknowledge that I have received a copy of the New West Physicians' Notice of Privacy Practices."

_____ _____

Signature of Patient/Patient Representative **Date**

DOCUMENTATION OF GOOD FAITH EFFORTS

To obtain patient's acknowledgment that they received provider's Notice of Privacy Practices.

(For use when acknowledgment cannot be obtained from the patient.)

The patient present to the office/hospital on _____ (date) and was provided with a copy of the New West Physicians' Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgment was not obtained because:

☐ Patient refused to sign
☐ Patient was unable to sign or initial because:

_____

☐ The patient had a medical emergency, and an attempt to obtain the Acknowledgment will be made at the next available opportunity.
☐ Other reason (describe below):

_____

Signature of Employee Completing form: _____

Date Signed: _____

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NONDISCRIMINATION NOTICE AND ACCESS TO COMMUNICATION SERVICES

New West Physicians does not discriminate on the basis of sex, age, race, color, national origin, or disability.

Free services are available to help you communicate with us. Such as, letters in other languages, or in other formats like large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free number **303-763-4900 Ext. 61500** TTY 711.

If you think you weren't treated fairly because of your sex, age, race, color, national origin, or disability, you can send a complaint to:

New West Physicians Civil Rights Coordinator
1707 Cole Blvd., Suite 100
Golden, CO 80401
Fax: 303-763-5495

If you need help with your complaint, please call the toll-free number **303-763-4900 Ext. 61500** TTY 711.
You must send the complaint **within 60 days** of when you found out about the issue.

You can also file a complaint with the U.S. Dept. of Health and Human services.

Online: **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**
Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201

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LANGUAGE ASSISTANCE SERVICES AND ALTERNATE FORMATS

This information is available in other formats like large print. To ask for another format, please call 303-763-4900 Ext. 61500. TTY 711.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call 303-763-4900 Ext. 61500.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 303-763-4900 Ext. 61500

請注意：**如果您說中文 (Chinese)**，**我們免費為您提供語言協助服務。請致電**：303-763-4900 Ext. 61500.

XIN LƯU Ý: Nếu quý vị nói tiếng Việt **(Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 303-763-4900 Ext. 61500.

알림: 한국어**(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니 다. 303-763-4900 Ext. 61500.번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 303-763-4900 Ext. 61500

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по номеру 303-763-4900 Ext. 61500.

. 303-763-4900 Ext. 61500.
فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الأتصال ب **(Arabic)** تنبيه: إذا كنت تتحدث العربية،

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 303-763-4900 Ext. 61500.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 303-763-4900 Ext. 61500.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 303-763-4900 Ext. 61500.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 303-763-4900 Ext. 61500.

ATTENZIONE: in caso la lingua parlata sia **l'italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 303-763-4900 Ext. 61500.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 303-763-4900 Ext. 61500. an.

Revised 04/2021

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LANGUAGE ASSISTANCE SERVICES AND ALTERNATE FORMATS (CONT.)

注意事項：日本語 **(Japanese)** を話される場合、無料の言語支援サービスをご利用いただけ ます。303-763-4900 Ext. 61500. TTY 711 にお電話ください。

(Farsi) توجه: اگر زبان شما فارسی 303-763-4900 تماس بگیرید. Ext. 61500. است، خدمات امداد زبانی هب طور رایگان در اختیار شما می باشد.

(Hindi) भाषी ह◻ तो आपक` ◻लए भाषा सहायता सेवाएं :◻शनुलक उपल ध ह◻। कपृ ा पर काल कर◻ 303-763-4900 Ext. 61500 कृपा धयान द◻: य◻द आप ◻हदं ◻

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 303-763-4900 Ext. 61500.

(Khmer)ស ជំនួយភាសាដោយឥតគិតថ្ល គឺមានសំរ ប់អ ក។ សូមទូរស័ព ទ លេខ 303-763-4900 Ext. 61500. ចំណ ប់រម ណ៍: ប្រើសិនអ កនិយ យភាសាខ្ម រ

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 303-763-4900 Ext. 61500.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' 303-763-4900 Ext. 61500 hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 303-763-4900 Ext. 61500.

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TRANSFER OF MEDICAL RECORDS

Patient Name: _____

Date of Birth: _____

Phone Number: _____

REASON FOR RELEASE:

☐ Moving: ☐ Out of State ☐ Within Colorado ☐ Provider Retiring/No longer at New West

☐ Dissatisfied with Practice/Provider ☐ Insurance ☐ Continuity of Care

☐ Other: _____

RELEASE FROM:

Name: _____

Address: _____

_____

_____

_____

Phone: _____

Fax: _____

RELEASE TO:

Name: _____

Address: _____

_____

_____

_____

Phone: _____

Fax: _____

I request and authorize this transfer and release of my medical record to and from the medical practice listed above. I understand that this documentation includes all forms of Protected Health Information (PHI) and is also applicable to the electronic transfer of records if the if the requested recipient is able to accept and access encrypted information from the New West Physicians' Electronic Medical Record. I understand that I may not be denied treatment or payment for health care services if I do not sign this form.

☐ **Entire Record - OR:** ☐ **X-Ray Reports** ☐ **Medications**

☐ **Doctor's Notes** ☐ **Laboratory Reports** ☐ **Diagnoses**

☐ **Pathology Reports** ☐ **Diagnostic Studies** ☐ **Other** _____

Due to the sensitivity of the following information, please check off and initial if you would like the following information to be released:

☐ Notes and reports related to STDs including HIV/AIDS _____ Initial

☐ Psychiatry/Mental Health Notes _____ Initial

☐ Notes related to Drug/Alcohol Abuse _____ Initial

I understand that New West Physicians will no longer be responsible for the protection of the PHI except in its original format in their records. I understand that my health information may be subject to re-disclosure by the recipient and if the recipient is not a health plan or health care provider, the information may not longer be protected by the federal privacy regulations. This authorization will expire one year from the date I sign it. I understand the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present the written revocation to the Site Practice Manager. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

PLEASE NOTE: THERE MAY BE A CHARGE FOR THE COPYING OF RECORDS

In Accordance with Chapter 2, Part 5, sections 5.2.3.4 of the Colorado Regulations of Health Facilities, the cost of this information cannot exceed $18.53 for the first 10 or fewer pages and $.85 per page for pages 11 through 40, $.57 per page after 40 pages. Actual postage or shipping costs and applicable sales tax, if any, may be charged. We will not be able to process your request until the following payment is received.

_____ _____

Signature of Patient **Date**

Signature of authorized Representative (if patient is a minor or unable to sign)

Attach copy of Durable Power of Attorney if patient is adult

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RELEASE OF MEDICAL INFORMATION CONSENT FORM

Patient Name: _____ **Date of Birth:** _____

At times New West Physicians may need to contact you. By filling out the information below we will better be able to serve you. If you want to allow us to leave messages and/or to speak with a trusted individual regarding your medical care we need written authorization in order to do so.

Please indicate if we have your permission or not to leave phone messages regarding your medical care:

☐ I authorize New West Physicians to leave phone messages containing my Personal Health Information on the following telephone numbers (s):
Phone Number: _____ Phone Number: _____

☐ No, I do not authorize New West Physicians to leave phone messages containing Personal Health Information on any of my telephone number (s).

☐ I authorize the verbal release of my Protected Health Information (PHI) to the person (s) listed below at my request. These individuals are family and/or trusted friends that New West Physicians has my permission to share my medical care and treatment information, test results, and billing matters with **their** verbal request (not including sensitive health information). You also have my permission to leave a telephone message directly with the person(s) and telephone numbers listed below. I understand that by leaving this section blank, it indicates that I do not grant permission for New West Physicians to speak with a family and/or trusted friend.

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present the written revocation to the Site Practice Manager. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that I may not be denied treatment or payment for health care services if I do not sign this form.

This authorization will expire one year from the date I sign it. ***I understand that my information may be subject to redisclosure by the recipient and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations.*** I release New West Physicians from any and all liability and claims of any nature pertaining to the disclosure of requested information once a disclosure takes place.

Patient Signature: _____ Date: _____

Witness: _____

If patient is unable to sign, please document reason:

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FINANCIAL POLICY OF NEW WEST PHYSICIANS

EFFECTIVE JANUARY 1, 2020

We are dedicated to providing excellent service, every patient, every time. The following information is provided to ensure clarity and avoid misunderstandings concerning payment for the professional services you need.

While our office participates in most health plans, the following are reminders:

- It is your responsibility to verify that New West Physicians participates with your health plan prior to scheduling your visit.
- It is your responsibility to verify what services (lab, diagnostic testing and preventative) are covered under your health plan.
- Bring your insurance card with you to each visit and be prepared to update your health information.
- Be prepared to pay your insurance co-pay at the time of your visit as well as any previous, outstanding balance on your account.

Co-Payments

- Commercial Plans With Established Co-Pays – The co-pay amount listed on your insurance card is due in full at time of service. If a co-pay is not listed, contact your insurance plan prior to your visit to determine the amount due at time of service.

Self-Pay Patients

- Patients Without Insurance - The estimated charges of the visit are due at the time of service. At that time, a 20% discount will be applied.

No Shows and Cancellations

When you schedule an appointment, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment.

- 1st and 2nd no show or cancellation/reschedule without a 24 hours' notice will be charged a $75 fee
- 3rd no show or cancellation/reschedule without a 24 hour notice will result in dismissal from New West Physicians and a $75 fee.

I have read and understand the Financial Policy of New West Physicians and agree to its terms.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Today's Date: _____

New West Physicians does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs and activities. ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Please call 303-763-4900 Ext. 61500. ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 303-763-4900 Ext. 61500.
請注意：如果您說中文(Chinese)，我們免費為您提供語言協助服務。請致電：303-763-4900 Ext. 61500.

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WE ARE CHANGING THE WAY WE COMMUNICATE WITH YOU!

As a New West Physicians patient we invite you to partner with us to take charge of your health by signing up for our state-of-the-art online patient portal, *"MyHealth Connection"*.

Once signed up for MyHealthConnection you will be able to:

- Video Visits from the comfort of your home
- Message your provider on non-urgent issues
- Request appointments electronically
- Request prescription renewals
- View laboratory data, vital signs, and other important parts of your medical record
- Update your demographic information prior to coming to the office

No more phone tag or long hold times!

We will use MyHealth Connection to communicate with you regarding:

- Normal lab and test results
- Appointment reminders
- Non-urgent health issues and general communication

We will continue to contact you by telephone regarding abnormal results or urgent health issues.

Please let us know if you do not have access to a computer or do not feel comfortable with emailing and we will be happy to continue to provide care via telephone.

COMPLETE THIS FORM TO RECEIVE AN INVITATION TO REGISTER!

Full Name: _____

Date of Birth: _____

Email Address: _____

*You will also receive New West Physician's Quarterly Newsletter, and may unsubscribe at any time.

Signature: _____

Print Name: _____

***You will receive an invitation to register within 24-48 hours – look for it in your email!**
***If you don't receive your invitation as expected, check your Junk/Spam Folder.**
***Please call your clinic if you still have not received it.**

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HOW DID YOU HEAR ABOUT US?

Welcome! Please take a moment to tell us how you heard about New West Physicians.

Please select the category(s) that apply:

1. I was referred by a:
   - ☐ Friend/Relative
   - ☐ New West Employee

   Please provide us with the name of your referral source so that we may thank them:
   Name: _____
   Address: _____

2. ☐ I am a returning patient.

3. ☐ I have transferred from another New West Physician office.

4. ☐ I was referred by the following Medical Office or Specialist:
   Name _____

5. I found you on the following Website:
   - ☐ New West Physicians
   - ☐ Insurance Company
   - ☐ Health Grades
   - ☐ Other (Please specify): _____

6. I learned about you through advertising:
   - ☐ Publication - Print or Online Versions (newspaper, newsletter, flyer, postcard, or similar)
   - ☐ Radio
   - ☐ Driving by / New West Physician Sign
   - ☐ Yellow Pages - Book or Online

7 None of the above - Please specify referral source: _____

New West Physicians
Management Services Office | 1707 Cole Blvd, Suite 100 | Golden, CO 80401
Phone: (303) 763-4900 | Fax: (303) 763-5495
www.nwphysicians.com

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