Patrick L Mallory, DO
Shari Ritchie, PA-C
Lindsay Fry, PA-C

1548 N. Boise Avenue
Loveland, CO 80538
Telephone: (970) 669-9245
Fax: (970) 669-9247

Dear New Patient,

Welcome to Mallory Osteopathic Family Practice. We are a Family Practice clinic that provides medical care to patients of all ages. Our providers' philosophy is to provide comprehensive medical care in treating the whole body. We listen to our patient's medical concerns and provide ample opportunity to discuss them. Preventive care and screening are critical factors in your medical treatment to ensure optimal health and well being. We offer health maintenance exams, preventive care, screenings, and perform sport physicals as well as other services. For a complete list of our services, visit our website at www.docmallory.com.

In order to simplify and expedite your initial visit with us, please complete the attached forms completely. If any information does not apply to you; please note "N/A" for not applicable. Please arrive 10 minutes prior to your scheduled appointment and bring all forms in the **New Patient Packet** along with the documents listed below:

- Primary Insurance Card
- Secondary Insurance Card if applicable
- Photo ID (Driver's License, School Photo Id, Passport)
- Any prescribed medications you are currently taking
- X-Rays, MRI or other diagnostic films or reports pertaining to your injury that have been taken within the last 3 years

We look forward to your visit and hope we can be of service to you. If you have any questions, please do not hesitate to contact our clinic at (970) 669-9245.

Sincerely,

Staff and Providers at Mallory Osteopathic Family Practice

Mallory Osteopathic family practice

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PATIENT DEMOGRAPHICS

PLEASE PRINT IN INK

Legal Last Name ____________________________________ Legal First Name ____

Middle Name_____________ Nickname _________________ Date of Birth _________/__________ Sex: □ Male □ Female

Street Address ____

City ____ State _______________________ Zip Code ___________________________

Cell Phone (_____) ________________ Can we leave messages regarding your care (i.e. lab results, x-ray results) at this number? □ Yes □ No

Home Phone (____) ________________ Can we leave messages regarding your care (i.e. lab results, x-ray results) at this number? □ Yes □ No

Social Security # ______________________________Drivers License #___________________________________ State__________

Marital Status: □ Single □ Married □ Divorced □ Separated **Spouses Full Legal Name** ___________________________________

Employer ____ Occupation ______________________________

Employer Address _____________________________________ City ________________ State ________ Zip Code_____________

Work Phone (_____) _______________ Can we leave messages regarding your care (i.e. lab results, x-ray results) at this number? □ Yes □ No

PATIENT COMMUNICATION

Do you wish to receive communication about Mallory Osteopathic Family Practice, medical updates or appointment reminders by email or text messages? □ Yes □ No

Email Address ____Text Phone (_____) ____________________

EMERGENCY CONTACT (someone not living in your household)
Contact Name ____Relationship to patient __________________________

Home Telephone _________________________ Cell Phone ________________________ Work Phone _____________________

PHARMACY
Preferred Pharmacy Name ___________________________________ Phone (____) _____________ Fax (_____) ______________

NEW PATIENT REFERRAL

How did you hear about Mallory Osteopathic Family Practice? ____

Who can we thank for the referral? ____

____ _______________
Signature of Patient/Responsible Party Date

INSURANCE INFORMATON

PLEASE FILL OUT COMPLETELY

PRIMARY INSURANCE

Insured or responsible person or parent/guardian, if the patient is not responsible for payment

Policy Holder (who carries the insurance) ________________________________ Relationship to patient ___________________

Address (**if different from patient**) ____

City __________________________________ State ____________ Zip Code _______________

Cell Phone (_____) _______________Home Phone (____) _______________ Work Phone (_____) _________________

Social Security # _______ - _______ - _______ Date of Birth _________________________ Sex: □ Male □ Female

Insurance Policy Information

Insurance Company Name _____________________________________ Effective Date of Insurance ____________________

Insurance Policy Address ______________________________________ City _________________ State ________________

Employer (if different from patient info) ____________________________________ Employer Phone # (_____) ___________

Insured Party ID ______________________________ Insured Party Group # ___________________ Copayment ___________

SECONDARY INSURANCE

Insured or responsible person or parent/guardian, if the patient is not responsible for payment

Policy Holder (who carries the insurance) ________________________________ Relationship to patient ___________________

Address (if different from patient) ____

City __________________________________ State ____________ Zip Code _______________

Cell Phone (_____) _______________Home Phone (____) _______________ Work Phone (_____) _________________

Social Security # _______ - _______ - _______ Date of Birth _________________________ Sex: □ Male □ Female

Insurance Policy Information

Insurance Company Name _____________________________________ Effective Date of Insurance ____________________

Insurance Policy Address ______________________________________ City _________________ State ________________

Employer (if different from patient info) ____________________________________ Employer Phone # (_____) ___________

Insured Party ID ______________________________ Insured Party Group # ___________________ Copayment ___________

Is this a work-related injury? □ Yes □ No If your answer is yes, please complete the information below.

WC Insurance _______________________________ Claims Adjuster _____________________ Phone _______________

Claim#_____________ DOI__________ Were you seen at an Urgent Care, ER or provider for your injury □ Yes □ No

Please list: ____

MOFP2010al

PATIENT AUTHORIZATION AND GUARANTEES

ASSIGNMENT OF INSURANCE BENEFITS

I authorize payment directly to Mallory Osteopathic Family Practice and/or Patrick Mallory, D.O. for any service/benefits that are reimbursable by Medicare or any third party sources.

CONSENT AND DISCLOSURES

I voluntarily consent to medical treatment for myself and/or my dependents.

RELEASE OF INFORMATION

I authorize Mallory Osteopathic Family Practice to release (verbally or in writing) confidential medical information to any person or entity which may be liable to me or my Practitioner(s) for charges for medical treatment, and for quality management, utilization review, transfer of medical care, and follow-up purposes. I understand that a copy of this agreement maybe used with the same effectiveness as an original.

PATIENT CONTACT INFORMATION

The HIPPA privacy rule provides the patient with the right to protect the patients Protected Health Information (PHI). We are unable to share your Protected Health Information (PHI) with any family members, friends or other persons of interest without your written permission. Please list the following persons you give permission for Mallory Osteopathic Family Practice to share your Protected Health Information (PHI) with.

Please Print

Name	Relationship to patient	Phone
Name	Relationship to patient	Phone
Name	Relationship to patient	Phone
Name	Relationship to patient	Phone

VALUABLES

I understand that Mallory Osteopathic Family Practice and/or Patrick Mallory, DO are not responsible for valuables and personal property brought to the facility.

I fully understand all of the above policies and procedures and agree to these terms and conditions by signing below.

____ _______________
Signature of Patient/Responsible Party Date

Mallory Osteopathic
family practice

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PATIENT FINANCIAL AGREEMENT

WE ARE HAPPY TO FILE YOUR INSURANCE CLAIMS FOR YOU. PLEASE THOROUGHLY REVIEW ALL INFORMATION LISTED BELOW SO YOU UNDERSTAND THE FOLLOWING CONDITIONS. YOU MAY WANT TO MAKE A COPY FOR YOUR RECORDS. DO NOT HESITATE TO ASK QUESTIONS.

- I accept responsibility for providing Mallory Osteopathic Family Practice with a current valid insurance card(s) when the policy renews for the purpose of identification and verification of my insurance benefits.
- My co-payment is required as part of a contractual agreement between me and my insurance company that I agreed to pay at the time of service. **If you are unable to pay your co-payment at the time of service, you will be charged a $15.00 missed co-pay fee. Alternatively, you may reschedule your appointment.**
- I understand that I am financially responsible for any health insurance deductibles and co-insurance and agree to pay all of the charges that are not paid by the covered insurance policy or any other third party payer.
- If my claim is denied because of lack of coverage under my policy and/or because my insurance company does not pay for the service(s) rendered, I will be responsible for the entire balance on my account. **Any outstanding balances on your account will need to be paid before seeing a provider at Mallory Osteopathic Family Practice.**
- If my account balance is more than 90 days past due, my account will be reviewed for collections processing and any legal/collection fees incurred will be my responsibility when transferred to a collections company hired by Mallory Osteopathic Family Practice. **There is a $5.00 collection fee assessed to your account each time we must re-bill for outstanding balances.**
- We offer a 10% discount rate for patients that do not have medical insurance and are considered self-pay. These patients must **pay for services in the form of and estimated deposit prior to seeing the medical provider.** Any additional services provided during the examination must be paid **in full** at the end of the visit.
- We accept most forms of payment, including credit, Care Credit, checks and cash. **Any returned checks will be assessed a $25.00 insufficient fund fee. The amount of the check and the fee are to be paid within two weeks by another form of payment.** After the second check is returned for insufficient funds, we will no longer accept a check in the form of payment and your account will be alerted.
- We require a 24 hour notice for cancellation of appointments. If you are unable to make your appointment, please call and re-schedule so that other patients can be accommodated. **If you do not show up for your appointment and do not call during business hours to cancel at least 24 hours prior to your appointment, you will be considered a no show. You will be charged a $50.00 no show fee for a regular office visit.**
- A fee will be assessed for lengthy form completion (disability forms, etc.) and letters that you request from the provider. The fee for the first 2 pages is $10.00. After the first two pages, the flat-rate fee is $40.00. Alternatively, you may schedule an appointment with the provider to have the forms completed at an office visit. For completion of forms outside an office visit, payment will be collected at the time the forms are picked up. Forms require 3-5 business days to be completed.

I acknowledge that by signing this financial agreement, I understand and agree to all of the stated terms as they apply.

_______________________________________ _______________
Signature of Patient/Responsible Party Date

_______________________________________ _______________
Print Legal Name Date

Mallory Osteopathic family practice

Notice of Privacy Practices for Protected Health Information

This notice describes how medical information about you may be used and disclosed, and how you can access this information. Please read it carefully.

At Mallory Osteopathic Family Practice, we will always keep your healthcare information secure and confidential. We are required by law to continue maintaining the privacy of your health information, also known as “Protected Health Information” or PHI, by providing you this notice and to comply with this notice.

Mallory Osteopathic Family Practice is permitted by federal HIPPA privacy laws to use and disclosure your electronic health record for purposes of medical treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Please review the examples below on how your Health Information may be used at Mallory Osteopathic Family Practice.

PHI for Medical Treatment:

- Medical staff obtains medical treatment information about you and documents into your electronic health record.
- During the course of medical treatment, the provider may consult with a specialist who may be involved in your medical care.

PHI for Payment Purposes:

- We submit medical claims to your health insurance company.
- We may use or disclose your PHI for payment-related activities.
- We may send medical notes along with the claims for claim-processing to insurance associate or utilization review for authorization.

PHI for Health Care Operations:

- We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines, training programs, credentialing, medical utilization review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.
- If this practice is sold, your PHI will become the property of the new owner.

You’re Health Information Rights

The health and billing records we maintain are the physical property of Mallory Osteopathic Family Practice. Your medical record belongs to you. You have a right to:

- Know of any uses or disclosures we make with your PHI beyond the above normal uses.
- Request a restriction on certain uses and disclosures of your health information by providing a written request to our clinic – we are not required to grant the request, but we will comply with any request granted.
- See and receive a copy of your PHI and billing record, with a few exceptions. You may exercise this right by completing a Medical Records Release Request. We charge a reasonable fee for the copies. In certain situations, we may deny your request. If we do, we will notify you in writing the reasons for the denial. You may revoke, at any time, a previously written release.
- Appeal a denial of access to your PHI information, except in certain circumstances; request that your PHI be amended to correct incomplete or incorrect information by delivering a written request to our clinic. We may deny your request if you ask us to amend information that;
    - Your PHI was not created by us, unless the person or entity that created the information is no longer available to make the amendment.
    - Is not part of the health information kept by or clinic;
    - Is not part of the information that you would be permitted to inspect and copy or is accurate and complete.
- Transfer your PHI to another practice.
- You have a right to receive a copy of this privacy notice.

Our Responsibilities

The clinic is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you in writing if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate your health information with you.
- We reserve the right to amend, change or eliminate provisions in our privacy practices and access practice information and to enact new provisions regarding the PHI we maintain. If we amend any of the details of this notice, you are entitled to receive a revised copy that will be provided to you in writing.

To Request Information or File a Complaint

If you have any questions or comments about our privacy practices or want information or assistance regarding your PHI privacy, please contact our Office Manager. If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary, Department of Health and Human Services, 200 Independence Ave, SW, Room 509F, HHH Building, Washington D. C. 20201.

We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the clinic.

We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Disclosures and Uses of PHI

Communication with Family, Relatives or Friends

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your medical care or payment for such care if you do not object or in an event of an emergency.

- Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for you care, about your location, and about your general condition, or your death.

Public Health

- As authorized by law, we may disclose your protected health information to public health or legal authorities in charge of or preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

Abuse & Neglect

- We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Workers Compensation

- If you are seeking medical care for a work-related injury, we may disclose your PHI to the extent necessary to comply by and with the laws of the Workers Compensation Act.

Other Uses

- Other uses and disclosures, besides those identified in this Notice, will be made only as otherwise required by law or with your written authorization and you may revoke the authorization previously provided in the Notice listed under "*Your Health Information Rights*".

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____ ________________

Please print Legal Name Date of Birth

I hereby acknowledge that I read and/or received Mallory Osteopathic Family Practice Notice of Privacy Practices.

____ ________________

Signature of Patient/Responsible Party Date

Documentation of Good Faith Efforts
To obtain patients' acknowledgement that they received Mallory Osteopathic Family Practice Notice of Privacy Practices.

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

The patient presented to the clinic on ____ and was provided with a copy of Mallory Osteopathic Family Practice 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 acknowledgement was not obtained because:

_____ Patient refused to sign the Notice of Privacy Practices.

_____ 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