**Cisneros Center OBGYN and Family Medicine**   
Rosa J. Cisneros M.D.  
9981 North Washington St. Ste. 22, Thornton, CO 80229  
Phone: 303-252-1247  
Fax: 844-849-2160  
**Authorization for Disclosure**

Patient Name: [[name]]

Date: [[date]]

I authorize my physician to discuss my protected health information with the following people:

|  |  |  |
| --- | --- | --- |
| My Guardian: |  | DOB: [[date]] |
| My Caretaker: |  | DOB: [[date]] |
| Other person: |  | DOB: [[date]] |

I also give my consent for person listed above to be present during my examination.

Patient Signature

[[date]]  
Date

**Authorization of Care**

PRINT Patient Name [[name]]                                                                        DOB [[dob]]

**I authorize the Physician to the use and disclosure of health information for treatment, payment, or healthcare operations.**

**I authorize payment of medical benefits to the Physician for services as described understanding that I am responsible to pay non-covered services.**

**I authorize the Physician and her designated staff to access any and all medical records from St. Anthony's North Hospital (including all Centura facilities) and North Suburban Medical Center (including all Health One facilities) for the purpose of continuity of care.**

**Signature of Patient**

**[[date]]  
Date**

**Responsible Party Signature**

**[[date]]  
Date**

**Notice of Privacy Policy Acknowledgment**

**I understand that as part of my healthcare, Cisneros Center of OBGYN and Family Medicine originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.**

**I understand that without my written authorization, Cisneros Center of OBGYN and Family Medicine will not disclose my protected health information for any reason except for the purpose of treatment, payment or healthcare options.**

**I have read the ‘Notice of Privacy Policy' from Cisneros Center of OBGYN and Family Medicine and if I have any questions or concerns regarding this information I will contact your office.**

**Signature of Patient**

**[[date]]  
Date**

**Payment Agreement:**

I, the undersigned, in consideration for services rendered to me by CCOG, understand the following binding agreement.  
  
**Initial each**

1. Any co-payments are required to be paid on the day services are rendered. \_\_\_\_\_\_

  2. Payment for the charges is due on the date of service with the exception of insurance carriers for which CCOG is under contract to file directly. \_\_\_\_\_\_\_

3. A current insurance card must be presented at each and every visit to the office. \_\_\_\_\_\_\_

   4. My insurance coverage may not provide payment for all charges incurred in obtaining treatment from CCOG. I will be responsible for any co-payments, deductibles, coinsurance, or services not covered by my insurance provider. I understand CCOG will require a credit card authorization be obtained and kept on file to be charged once each claim has been processed by my insurance. If I do not have insurance coverage for services rendered by CCOG I agree to pay all charges resulting from such services on the day of service. \_\_\_\_\_\_

   5. As a patient, it is my personal responsibility to verify with my insurance company that CCOG physicians and providers are part of my provider network (HMO,PPO, etc.). I understand that I am responsible for notifying the office of CCOG of any changes in insurance coverage. Failure to notify CCOG of these changes will make me responsible for claims not accepted by the insurance company. \_\_\_\_\_\_

6. I hereby authorize CCOG to file with my insurance carrier, and I assign payment of medical benefits to Cisneros Center of OBGYN and Family Medicine and in addition l authorize release of any and all medical records and information necessary to process any claim generated by services I receive from CCOG. \_\_\_\_\_\_

7. A credit card authorization is required by all patients upon their first visit to be kept on file and will be used only for patient balances after adjudication of each claim by my insurance carrier. I may further authorize all co-payments be made in the same manner at each visit. \_\_\_\_\_\_

8. I authorize release of any all medical records and information necessary for treatment, payment and operational purposes as indicated in CCOG’s notice of privacy practices. \_\_\_\_\_

 9. Time slots for appointments and medical testing are reserved for me alone, therefore not showing up for an appointment creates a hardship on CCOG staff and practice. I agree to pay a **$40.00** cancellation fee if I fail to give 24 hour advanced notice of my already scheduled appointment. I hereby authorize payment of cancellation fee to the credit/debit card on file after I am informed of such charge. \_\_\_\_\_

10. **Any insufficient fund returns** will incur a **$30.00** fee and may be prosecuted in civil court for three times the amount of the face value plus court costs and attorney's fees. Accounts turned to collections will be charged a collection fee and statutory interest rates (not less than 8%) compounded annually. \_\_-\_\_\_\_

11. There is a **$25.00** charge for each disability, FMLA, or other medical form to be completed. We require 14 business days for completion. Expedited (2 business days) service is available for $50.00 per form. Payment must be received prior to the completion of the forms. \_\_\_\_\_

12. A late/rebilling fee of **$15.00** will be charged for balances over 30 days. \_\_\_\_\_\_

Patient Name: [[name]]

Date: [[date]]

Responsible party, Print name if not patient: 

Signature

**CREDIT/DEBIT CARD CONSENT**

I, [[name]], authorize CCOG and FM to charge my credit card for the balance of charges not paid by my insurance which are patient responsibility. This authorization is valid through the expiration date on the card. I understand that a receipt will be mailed to me upon my request.

I hereby additionally authorize that each visits co-pay, due at the time of service be charged.

|  |  |
| --- | --- |
|  | [[date]] |
| Minor Patient's Signature | Date |
|  |  |
| Patient Name(s) [[name]] | |
|  |  |
| Cardholder Name | |
|  |  |
| Cardholder Address       City | State         Zip |
|  |  |
| Type of card: Visa MasterCard American Express Discover | Expiration Date / |
|  | mm       yy |
| Credit Card Number ---       Card code (last 3-4 digits on back of signature line) | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **HEALTH HISTORY SURVEY** | | | | | | | The more we know about you, the better we can provide medical care. Please complete the following items as completely and accurately as possible. If you have a question, please ask one of our staff members. None of this information will be released to any other person without your consent. | | | | | | |  | | | |  | Today's Date: [[today]] | | NAME: | | | | BIRTHDAY: [[date]] |  | | ADDRESS: | | | | AGE: |  | | MARRIED | SINGLE | WIDOW(ER) | DIVORCED | OCCUPATION: |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | |  | | | | | | | | **FAMILY HISTORY**       If any blood relative has suffered any of the following, please indicate which relative. | | | | | | | | TUBERCULOSIS |  | EPILEPSY |  | ARTHRITIS | HYPERTENSION |  | | STROKE |  | DIABETES |  | GOUT | HEART ATTACK |  | | MIGRAINE |  | CANCER |  | KIDNEY DISEASE |  |  | | MENTAL ILLNESS |  | ALLERGY |  | GLAUCOMA |  |  |  |  |  |  |  | | --- | --- | --- | --- | |  |  |  |  | |  | Age, if living | Cause of Death | Age at time of death | | Father |  |  |  | | Mother |  |  |  | | Brothers       No. living  No. dead |  |  |  | | Sisters     No. living  No. dead |  |  |  | | Spouse |  |  |  | | Children |  |  |  |  |  | | --- | |  | | **PERSONAL HISTORY** | | **FIRST DAY OF YOUR LAST PERIOD:** |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **MAIN PROBLEMS:** | **(1)** | **(2)** | **(3)** | **(4)** | | | Decreased Hearing | Palpations | Urine Infections- Frequent | Headaches- Frequent | Germ. Measles | | | Ringing in Ear | Irregular Pulse | Painful Urination | Arthritis/Rheumatism | Rheumatic | | | Ear Infection- Frequent | Swollen Ankles | Blood in Urine | Back Pain- Recurrent | Scarlet Fever | | | Dizzy Spells | Fainting Spells | Overnight Urination-More Than 2 | Bone Fracture/Joint Injury | Mumps | | | Failing Vision | Leg Pain when Walking | Control in Urination | Gout | Tuberculosis | | | Double or Blurred Vision | Varicose Veins/Phlebitis | Decrease in Force of Urination | Foot Pain | Alcohol         oz. per week | | | Eye Pain | Loss of Appetite- Recent | Kidney Stones | Cold Numb Feet | Coffee/Tea    cups per day | | | Eye Infections- Frequent | Difficulty Swallowing | Venereal Disease | Rashes | Sodas           per day | | | Nose Bleeds- Recurrent | Indigestion or Heartburn | Urethral Discharge | Hives | Smoking       per day | Pipe  Cigar  Cigarettes | | Sinus Trouble | Persistent Nausea/Vomiting | Chronic Fatigue | Psoriasis | # of years smoked | I quit smoking as of [[date]] | | Sore Throats- Frequent | Peptic Ulcers | Weight Loss- Recent | Eczema | **Females  -  Menstrual History** | | | Hay fever/Allergies | Abdominal Pain- Chronic | Anemia | Sleeping- Difficulty | Age of Onset | Regular   Irregular | | Hoarseness- Prolonged | Change in Bowel Habits- Recent | Bruise Easily | Nervousness | Flow Heavy   Mod   Light | Pain/Cramps with Menstrual Flow | | Pneumonia/Pleurisy | Diarrhea | Cancer | Depression | Days of Flow | Length of Flow | | Bronchitis/Chronic Cough | Constipation | Diabetes | Memory Loss | Pain/Bleeding After Sex | No. of Pregnancies | | Asthma/Wheezing | Diverticulosis | Thyroid Disease | Moodiness- Excessive | No. of Live Births | No. of Miscarriages | | Shortness of Breath | Bloody or Tarry Stools | Convulsions/Seizures | Phobias | Birth Control Method | B.C. Pill (name) | | On Exertion     Lying Flat | Hemorrhoids | Stroke | Mental Illness | Flushing/Menopause | | | Chest Pain | Gall Bladder Trouble | Tremor/Hands Shaking | Chicken Pox | Other Symptoms or Diseases | | | High Blood Pressure | Jaundice/Hepatitis | Muscle Weakness | Polio |  |  | | Heart Murmur | Hernia | Numbness/Tingling Sensations | Measles |  |  |  |  | | --- | | Do you have any bleeding problems?    Yes No                                                   If yes, please explain: | | Do you keloid (develop thick scar tissue)? |  |  |  |  |  | | --- | --- | --- | --- | | **HOSPITALIZATIONS** | | |  | | YEAR | ILLNESS OR OPERATION | YEAR | ILLNESS OR OPERATION | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  | | |  | | **MEDICATIONS** (Please include vitamins, aspirins, birth control pills, etc.) | | |  | | NAME OF MEDICATION | DOSAGE | LENGTH OF TIME YOU HAVE TAKEN MEDICATION |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | | **ALLERGIES** |  |  |  | | ALLERGIC TO... | REACTION YOU GET... |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  |  |  | | --- | | **DIET** | | Are you on any kind of special diet? Yes   No                                                                         If yes, please explain. | |  | | **EXERCISE** | | Do you exercise regularly? Yes   No                                                                                        If yes, please indicate what type of exercise | | How often / per week you exercise?                                                   For what duration of time? | |  | | REFERRED BY: | |  | | THANK YOU FOR COMPLETING THIS FORM. | |

**Cisneros Center OBGYN and Family Medicine**   
Rosa J. Cisneros M.D.  
9981 North Washington St. Suite 22  
Thornton, CO 80229  
Phone: 303-252-1247 Fax: 844-849-2160

**PATIENT INFORMATION**

Please present a Photo ID and ALL insurance cards to receptionist. If items are not presented, full payment will be due at time of service. Please know ALL Co-Pays are due at time of Check-in. As the patient, it is your responsibility to know the coverage of your insurance.

|  |  |  |
| --- | --- | --- |
| Today's Date [[date]] | I do not currently carry insurance (initial) |  |
| Patient's Last Name: |  | |
| Patient's First Name: | **MEDICAL INSURANCE** | |
| Social Security #: | Insurance Company: | |
| Date of Birth:  [[date]] | Subscriber Name: | |
| Age: | Relationship to Patient: | |
| Address: | Subscriber's DOB: [[date]] | |
| City, State, Zip: | Subscriber's ID: | |
| Please list numbers where we may leave voice messages: | Subscriber's Group #: | |
|  | **SECONDARY INSURANCE** | |
| Email Address (Medical and Office Information may be sent to this address: | Insurance Company: | |
|  | Subscriber Name: | |
| Place of Employment: | Relationship to Patient: | |
| Emergency Contact: | Subscriber's DOB: [[date]] | |
| Relation to you: | Subscriber's ID: | |
| Phone: | Subscriber's Group #: | |
| Marital Status:   Single             Married       Widowed      Separated      Divorced |  | |
| Spouse's Name (if applicable): | **PRIMARY CARE PHYSICIAN** | |
| Reason for Visit: | Name: | |
| How did you hear about us or who were you referred by: | Phone: | |

Thank you for choosing Cisneros Center for your recent health care needs. We would like to provide a little explanation of the billing process which sometimes can be complex. If you are unable to provide insurance information, please speak with our office manager.

**Payment Process**

Our policy is that payment is due at the time service is provided, however for your convenience a claim will be sent to your insurance company. After receiving the claim, the insurance company may contact you for more information, you must respond quickly so that they can process your claim timely. It usually takes 30-45 days for the insurance company to pay your claim. Please keep in mind that your policy is a contract between you and your insurance company. If you do not follow your insurance plans terms, they

may not pay for all or part of your care. After we receive your insurance payment, we will provide you with the statement showing the insurance payment and any amount you may owe. We ask that you provide a form of payment such as a debit card to facilitate timely payment. No charges will be made until after you receive a statement from our office. We will contact you if your insurance company does not pay your claim timely.

**Other/Multiple Bills**

You may receive separate bills from other health care services, provided by other physicians, hospitals or testing facilities, while you were in our care. These bills are separate from your bills to our clinic. If you have questions about these bills please contact the billing company phone listed on the statement.

**Customer Service**

We are pleased to answer your questions or provide more information. Patients: please provide your date of birth, social security number, insurance card and debit card. If you are not the patient please obtain written consent from the patient prior to contacting our office. We cannot release information without written consent from the patient.

|  |  |
| --- | --- |
|  | [[date]] |
| Print Name | Date |
|  |  |
|  |  |
| Responsible party, print name if not patient | Parent/Guardian Signature |

|  |  |  |
| --- | --- | --- |
| **Authorization to Release/Disclose Medical Records/Health Information** | | |
| Patient: [[name]]                                 DOB [[dob]] | | |
|  | | |
| **Records Requested From:** | | |
| Name of Doctor, Hospital or other Agency | | |
|  | | |
|  |  |  |
| Street Address | City | Zip Code |
|  | | |
|  |  | |
| Office Phone Number | **Office Fax Number** | |
|  | | |
| Purpose of Disclosure | | |
|  | | |
| Send copies of:          All Records | | Date of Service: [[dos]] through [[date]] |
| Office notes | | |
| Hospital Reports | | |
| Lab Reports | | |
| U/S Reports                         Include HIV      Do not include HIV | | |
|  | | |
| **I hereby request that ALL REQUESTED medical records for the above named patient be furnished to:** | | |
| **Cisneros Center OBGYN and Family Medicine: Rosa J. Cisneros M. D 9981 N. Washington St. Ste. 22, Thornton, CO 80229 Phone 303-252-1247 Fax: 844-849-2160** | | |
|  | | |
| * A copy of this authorization shall be utilized with the same effectiveness as the original. * Treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining the individuals authorization.      * I understand that I may revoke this authorization at any time in writing.      * I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on the authorization.      * I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.      * I understand that this authorization will expire one year from the date of this document or [[date]] (Date of Expiration)      * I understand that charges may be incurred for copying costs. | | |

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_