# *Welcome To Our Office*

**CREEKSIDE ENDOCRINE ASSOCIATES**
**Leonard R. Zemel, M.D.**
**Kristen Scheckel, MMS, PA-C**

**PLEASE PRINT and COMPLETE ALL PARTS**

**Today's Date**_____

**PATIENT: (This section refers to PATIENT ONLY)**

Name_____

Address_____City_____State_____ Zip_____

Home Phone_____Work Phone_____Employer_____

Date of Birth_____Age____Sex_____Social Security #_____Occupation_____

Spouse_____Employer_____Work Phone_____

Relationship to Responsible Party (circle one): Self Spouse Son Daughter Other

**RESPONSIBLE PARTY: (Person or company who should receive the bill)**

Name_____

Address_____City_____State_____Zip_____

Home Phone_____Work Phone_____

Auto Injury / Work Comp (circle)_____Claim #_____Date of Accident_____

Other Injury (Specify)_____Date of Accident_____

**REFERRED BY:**_____

**INSURANCE: (Please complete thoroughly. We will need a copy of your insurance card.)**

Primary Insurance_____Secondary Insurance_____

Primary Insured Person_____Primary Insured Person_____

Employer_____Employer_____

Copayment $_____Copayment $_____

**NOTIFY IN EMERGENCY:**

Name_____Home Phone_____

Address_____Work Phone_____

**PLEASE SIGN BY BOTH X'S**

| | |
|---|---|
| I authorize payment of medical benefits to physician or these supplier 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 _____ |

## CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

**Help us communicate with you better.**

Please use this form to tell us when you would like us to leave messages or discuss your health with others, and how we should contact you with non-urgent news such as lab results or appointment reminders.

What name I prefer to be called_____

When/Where is it okay to leave a message about my health (please check only one):
__Never

__On my voicemail at home. Number_____

__On my voicemail at work. Number_____

__On my voicemail on cell phone. Number_____

__Email labs Email_____

**EMAIL IS ONLY USED TO SEND COPIES OF RESULTS-PLEASE CALL FOR ANY QUESTIONS REGARDING LABS.**

**Who you may discuss my health with:**

__No one

__Any of the people listed below:

_____

Name Relationship Phone Number

_____

Name Relationship Phone Number

_____

**Patient's Name (print)** **Signature** **Date**

# Creekside Endocrine Associates

4101 East Louisiana Avenue #200
Denver, CO 80246
(303) 388-6410
Fax (303) 388-1069

## Consent to Treatment

I, _____ voluntarily consent to receive any medical and healthcare services by Dr. Leonard Zemel and staff including diagnostic procedures, examinations, treatments, and laboratory work.

## Financial Responsibility

It is your responsibility to know your insurance benefits (co-pay, referral, deductible and coverage). Your insurance plan is a contract between you and your insurance company. It is impossible for our office to be familiar with all insurance plans. If you have any questions please consult your insurance company directly.

I agree to pay all charges for medical and healthcare services and laboratory services not covered by my insurance company. In case of default payment, I agree to pay any and all costs of collecting this account including, but not limited to, attorney fees and court costs.

I certify that I understand and agree to the contents of this form.

_____ _____

Signature of Patient (or legally authorized person) Date

**CREEKSIDE ENDOCRINE ASSOCIATES, PC.**
Leonard Zemel, M.D.
4101 East Louisiana Avenue #200
Denver, CO 80246

## NOTICE AND ACKNOWLEDGEMEMT OF PRIVACY POLICY AND PROCEDURES

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), Leonard Zemel, MD, may not use or disclose your personal health information without your authorization.

THE PRACTICE HAS POLICIES AND PROCEDURES TO COMPLY WITH HIPAA LAW. EVERY ATTEMPT HAS BEEN MADE TO KEEP THE PROCESS FOR PATIENTS AND STAFF AS EFFICIENT AS POSSIBLE. HOWEVER, THE REQUIREMENTS ARE EXTENSIVE AND TAKE TIME, EFFORT AND COOPERATION TO PROCESS REQUIRED TASKS.

All patients are presented with certain notices and must sign certain forms. Depending on the course of treatment, some patients may be required to sign additional forms. The following is a summary of the most common notices and forms:

**Notice of Privacy Practices** - This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

**Authorization for Use or Disclosure of Protected Health information**- The Practice may not use or disclose your health information for purposes other than treatment, payment or health care operations, without your authorization. Your signature on this form indicates that you are giving permission to the people listed on this form, for the use and disclosure of the health information listed on the form, for the purposes listed on the form, to the people/organizations listed on the form. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to this office.

**Complaint**- You have the right to complain about the Practice's privacy policies, procedures, or actions. The Practice will not engage in any discriminatory or other retaliatory behavior against you because of a complaint.

**Request to Amend Protected Health Information** - You have a right to request that health information that pertains to you be amended if you believe that it is incorrect or incomplete. The practice will review your request and either grant your request or explain the reason why it will not be granted. In the event that your request is not granted, you have the right to submit a statement of disagreement that will accompany the information in question for all future disclosures.

**Request for Inspection of Protected Health information** - You have a right to request the opportunity to inspect and copy health information that pertains to you. The Practice will evaluate your request and will either grant it or explain the reason why the request will not be granted. In the event that your inspection request is not granted, you may request that the decision be reviewed by someone other than the person who originally denied the request.

**Request for Accounting of Disclosures of Protected Health Information** - You have a right to request an accounting of disclosures of health information that pertains to you.

**Confidential Channel Communication Request-** You have a right to request that communications concerning your personal health information be made through confidential channels. The Practice will do its best to accommodate all reasonable requests.

**Designation of Personal Representative-** You have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By making this request, you are informing the Practice of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office.

**Electronic Health Information Exchange:** Creekside Endocrine Associates 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 a patients' clinical information electronically with other physicians and healthcare providers that participate in the HIE network. Using HIE helps your healthcare 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 healthcare 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.

**Acknowledgement of Receipt of Notice of Privacy Practices:**

I acknowledge that I have received and read the above Notice of Privacy Policy and Procedures and that I have had any questions regarding this notice answered to my satisfaction.

_____ _____

Patient/Patient Representative Signature Date

_____ _____

Print Name Representative & Title