



# NEW PATIENT INFORMATION

*All fields must be filled out completely!*

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

Name: \_\_\_\_\_ Circle One (Mr. Ms. Mrs. Miss)

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ SSN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M / F Status: Single / Married / Divorced / Widowed

Race: White African American American Indian Asian Pacific Islander Other: \_\_\_\_\_

Languages Spoken: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Circle one (Cell / Home / Work / Other)

Secondary Phone: \_\_\_\_\_ Circle one (Cell / Home / Work / Other)

Other Phone: \_\_\_\_\_ Circle one (Cell / Home / Work / Other)

E-mail: \_\_\_\_\_ Driver's License #: \_\_\_\_\_ State: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact, Primary: \_\_\_\_\_

(Name, Phone, & Relationship)

Emergency Contact, Secondary: \_\_\_\_\_

(Name, Phone, & Relationship)

Next of Kin: \_\_\_\_\_

(Name, Phone, & Relationship)

**\*Please List Any Numbers Below That You Give East West Permission To Leave "Normal" Test Results On...**

## Consent To Care

I, \_\_\_\_\_ hereby grant permission to East West Health Centers and its clinicians to perform such examinations and therapeutic treatments as are considered necessary or advised for my diagnosis and treatment plan. Clinicians who may treat me include, but are not limited to: Medical doctors, Naturopathic physicians, Acupuncturists, Massage therapists, Rolfers, Yoga

East-West Health Centers, Inc.

8200 E. Belleview  
Suite 202-c, Central Tower  
Greenwood Village, CO 80111

Office: (303) 694-5757  
Fax: (303) 741-1387  
Email: info@east-west-health.com

[east-west-health.com](http://east-west-health.com)



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therapists, Herbologists, Nutritionists, Psychologists, Biofeedback therapists, Nurse midwife and/or Chiropractors.

I understand that my records will be kept confidential and will not be released to others unless they are involved in my care plan. I understand that I may look at my medical record at any time and can request a copy of it. I understand that my medical records are only required to be stored for seven years.

I understand that the nature of the recommended medical treatments for my care will be explained to me. I understand that I will have the opportunity to ask questions of those involved in my care. I am not being forced by anyone to accept medical treatment.

### **Payment Agreement**

**YOU ARE RESPONSIBLE FOR KNOWING YOUR OWN INSURANCE BENEFITS AND ELIGIBILITY!**

I hereby authorize my insurance benefits to be paid directly to East West Health Centers Inc. I assume full responsibility for and agree to pay all costs, charges, and expenses of every kind and description for services furnished by East West Health Centers. I must pay charges and services not covered by any insurance or other third-party payer and/or not paid to East West Health Centers for any reason within a time period East West Health Centers deem reasonable. The amount of the bill shall be due and payable upon presentation to the patient, his/her agent, guardian, conservator or third-party responsible for payment of the charges.

### **Cancellation/No Show Notice**

**I will kindly give 24-hour notice if canceling. No shows are subject to a \$50 fee.**

\_\_\_\_\_  
(Signature of Patient or Legal Guardian)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Date)



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## Provider Notice Of Privacy Practices

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY!

East West Health Centers, Inc. and all other health care clinics are required to inform you, the patient, how medical information about you may be used and disclosed. The following also outlines how you can access your health care information.

### ***Read Carefully and sign below...***

As your health care provider, we use your health information for evaluation, treatment, to obtain payment for treatment and to evaluate the quality of care that you receive. If you are referred to another health care provider, or at your request, your medical records may be shared with those providers via paper mail, electronic mail, fax or other methods.

We may use your health care information without your authorization for the following reasons:

- 1) *Public Health Safety*
- 2) *Auditing Purposes*
- 3) *Emergencies*
- 4) *At the Request of Your Insurance Carrier*
- 5) *When Required By Law*

In all other circumstances, we will ask your written permission to release your medical information in the form of a "Release of Medical Records" form. If you choose to sign such a form, you have the right to revoke that authorization at any time.

If at any time we change our policies in regard to your medical information, you will be informed with a new "Notice of Privacy Practices" form and will be asked to sign it.

You have the right to view and obtain a copy of your medical record. You also have the right to know to whom we have disclosed your medical records. If you believe the information in your medical record is not correct or missing information, you have the right to request that such information is corrected or added to your medical record.

If you have questions or concerns about your medical records, please contact Jill Howell at East West Health Centers, Inc. @ (303) 694-5757, or you can file a written complaint with the U.S. Department of Health and Human Services.

East West Health Centers, Inc. is required by law to protect your medical information and to provide this notice to you, along with your signature acknowledging your receipt of this information.

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(Signature of Patient or Legal Guardian)

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(Print Name)

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(Date)



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## Electronic Payments and Modern Payments

At East West Health Centers, Inc. our goal is to provide you with the best, most current quality health care in a positive and supportive environment. East West is a small business, locally owned and operated with the owners on-site. While providing excellent health care, we must also strive to reduce and minimize our cost of doing business. Because of the changing insurance environment, with more and more costs for health care being on the patient, we must maximize our efforts to collect what the patient actually owes in a timely manner, which include co-payments, deductibles, maximum out-of pocket limits and non-insurance billable items and services.

In an effort to streamline this collection effort, we are asking all of our patients to provide us with a credit card, debit card or voided check at the time of service. This is the same system used at hotels, rental car companies, gasoline stations, PayPal

and your mail order pharmacy. It is also a system being adopted by more and more physicians' offices. We will use the system of charging your credit card or bank account for patient balances, such as co-payments, deductible amounts) once we have received the Explanation of Benefits from your insurance company and a "patient due" is listed), herb and supplements and other patient balances due to East West. You will receive an E-mail notification from our office when your credit card, debit card or bank account will be charged.

This system will greatly reduce our overhead expenses and help keep health care costs as low as possible for everyone. Because we are a small business, we cannot, unfortunately, continue to provide extended "credit" to our patients. We very much appreciate your cooperation and understanding.

### **AUTHORIZATION TO CHARGE MY CREDIT CARD, DEBIT CARD, OR CHECKING ACCOUNT FOR "PATIENT RESPONSIBILITY" PORTIONS DUE TO EAST WEST HEALTH CENTERS, INC.**

I authorize East West Health Centers, Inc. and Modern Payments, Inc. to charge my credit card, debit card or checking account with the "patient responsibility" balance due. I understand that my account information will be stored in a safe, secure system. I also understand that I have the right to dispute charges to my account at any time.

\_\_\_\_\_  
(Signature of Patient or Legal Guardian)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(E-mail)

\_\_\_\_\_  
(Date)