HOME OF THE HEALING ARTS, PC:

Dr Gloria P. Oberbeck ,MD Alison Hoffmaster, PAC
636 Kattell Street , Erie, Colorado 80515 phone: 303-828-9200 , fax 303-828-9204
Tax ID 202894964

Patient Information:

Date:: _____Social Security Number:_____(for billing purpose only)

PATIENT NAME:: _____ **Date of Birth :** _____/_____/_____ **Gender:** F M

Race: Asian, Pacific Islander, Black/African American, American Indian/Alaska Native, White,(non hispanic), Hispanic or Latino(all races), other, unwilling **Ethnicity :**non-hispanic, hispanic

Preferred language_____

Home Address: _____ **City** _____ **State** ____ **Zip**_____

Home phone: _____**Cell Phone**_____**Marital Status**_____

Email: _____ **Occupation**: _____

Employed by: _____ **Employer phone:** _____

SPOUSE or PARENT (if married or a minor)
Name: _____ **Home Phone**: _____

Address: _____ **City** _____ **State** ___ **Zip** _____

Employed by: _____**Work Phone:** _____

IN CASE OF EMERGENCY, PLEASE NOTIFY: _____

Relationship: _____ **Phone**: _____

Insurance Information

Name of the POLICY HOLDER: _____ DOB____/____/___

Relationship to patient: _____

Social Security Number policy holder _____Phone Number:_____

Name of the INSURANCE COMPANY: _____

ID or POLICY NUMBER: _____ Group Number: _____

Name of POLICY HOLDER or SUBSCRIBER'S EMPLOYER: _____

Agreement for Payment of Services :

I, the undersigned, in consideration for services rendered to me by Home of the Healing Arts,PC: Dr.Gloria Oberbeck MD , understand and agree to the following:

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

2. Payment for charges is due on the date of service with the exception of insurance carriers for which Gloria Oberbeck MD is under contract to file directly.

3. My insurance coverage may not provide payment for all charges incurred in obtaining treatment from Gloria Oberbeck MD . I will be responsible for any co-payment, deductible, coinsurance, or service not covered by my insurance provider. If I do not have insurance coverage for services rendered by Gloria Oberbeck MD, I agree to

pay all charges resulting from such services on the day of service.
4.I understand that I am responsible for notifying the office of any changes in insurance coverage, address or phone number(s). Failure to notify Gloria Oberbeck MD of these changes will make me responsible for claims not accepted by the insurance company.
5. I hereby authorize Gloria Oberbeck MD , to file with my insurance carrier, and I assign payment of medical benefits to Gloria Oberbeck MD and in addition I authorize release of any and all medical records and information necessary to process any claim generated by services I receive from Gloria Oberbeck MD.

6. I authorize the office and its employees to release any and all medical records and information necessary for treatment, payment and operational purposes as indicated in the posted Notice of Privacy Practice.

7.Please note that we only use your Social Security Number for billing purposes only.

CONSENT FOR TREATMENT

I, the undersigned, voluntarily agree to the tests, procedures, and/or treatments which the physician has deemed necessary and which are administered to or performed on me under the direction of the physician.

CONSENT TO RELEASE MEDICAL RECORDS

1.Ÿ I understand that my insurance carrier, short and long term disability insurance may require copies of my medical records in order to process claims. I hereby agree to such release of my records.
2.Ÿ I understand that in the course of its own business Home of the Healing Arts staff members will have access to my medical record. I hereby agree to such sharing of my personal health information.

CONSENT TO COMMUNICATE MEDICAL RESULTS

Persons with whom Gloria Oberbeck MD may discuss my medical condition (other than for purposes of treatment, payment or operations):
Name_____ Date_____
If you do not reach me directly you may leave a detailed message at this number_____
Signature _____ **Date** _____
A photocopy of these assignments shall be as valid as the original. Please attach all pertinent insurance ID cards for photocopying.

Acknowledgment of Privacy Consent Form

I hereby give consent to Home of the Healing Arts to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

Our Notice of Privacy Practices provides more detailed information about how we may use and disclose your protected information. You have the right to review our Notice of Privacy Practices before you sign this consent.

We reserve the right the change the terms of our Notice of Privacy Practices. You may obtain a copy of the current notice by request.

You may revoke this consent at any time. Your revocation must be in writing, signed by you or on your behalf and delivered to Gloria Oberbeck MD PC , P.O. Box 445, 636 Kattell Street, Erie, Colorado . You may deliver your revocation by any means you choose, personally or by mail, but it will be effective only when we actually receive it. Your revocation will not be effective to the extent that we or others have acted in reliance upon this consent.

Sign: _____ Date: _____

Print name of patient: _____

If you are signing as the patient's representative:

Print you name: _____

Describe your relationship to patient : _____