Janice L. Birney M.D.

Patient Information Form – Page 1

Today's Date: ____________________

Patient's Name: ____ Birth Date: __________________________

Height: _________ Weight: ______________ Pharmacy Phone #: ______________________

List of ALLERGIES to Medications or Over the Counter Medications:

____
____
____

Current Medications or Over the Counter Medications – Include Dosage and Directions of Taking Medication:

____
____
____

History of Smoking Now – How many packs per day: _________________________

History of Smoking in the Past – How many packs per day: ____________________

Alcohol use (Average): ____

Medical Problems: ____
____
____

Heart Problems: ____

Lung Problems: ____

Surgeries and approximate dates: ____
____
____

History of bleeding problems: ____

Family history of medical problems: ____
____
____

HIPPA POLICIES

PLEASE answer the following by circling yes or no:

Do you give our office permission to leave messages at home regarding test results as well as appointments? YES NO

With family members? YES NO __________________________

With friends or others? YES NO __________________________

Patient or guardian signature: ________________________ Date: ______________

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Patient Information Form – Page 2

Please Complete All Portions

Patient's Name: ____ Birth Date: _________________________

Mailing Address: ____

City: ____ State: ________ Zip Code: _______________

Do you check your email often? YES NO Email address: ____

Home Phone: ____

Business Phone: __________________________________ Cell Phone: ____________________________________

Age: ______________ Sex: MALE FEMALE

Patient's Social Security Number: ____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Person Responsible for Payment: ____________________________ Social Security Number: _____________

Relationship to Patient: ____

Address (If Different Than Above): ____ Phone: _____________

Occupation of Responsible Party: ____________________ Employer: _____________ Phone: ______________

Spouse's Name: _____________________________________ Employer: _____________ Phone: ______________

Local Friend or Relative to Contact in Case of Emergency

Name: ____ Phone: ______________________________________

Primary Care Doctor: _________________________________ Phone: ______________________________________

Insurance Company Name and Address: ____

____

Insured's Name: ____ Subscriber's Number: _________________

Group #: ______________________________________

Authorization to pay benefits to physician: I hereby authorize payment to be made directly to my physician for medical and/or surgical benefits, if any, otherwise payable to me for his services and all future claims. A copy of this authorization shall be as valid as the original. I also hereby agree to pay and all charges that exceed or that are not covered by my insurance.

Signature: ____ Date: ___________________________

Janice L. Birney M.D.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION SECTION A:

PATIENT GIVING CONSENT

Name: ____

Address: ____

Telephone: ______________________________E-mail________________

Purpose of Consent**: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.**

Notice of Privacy Practices**: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:**

Contact Person**: Janice L. Birney M.D.**
Telephone**: 303-933-9050** Fax: **303-973-5616**
Address**: 6169 S. Balsam Way #380 Littleton, CO 80123**
Website: www.janicebirney.com

Right to Revoke**: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.**

SIGNATURE:

I, ____ , have had full opportunity to read and consider the Contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information To carry out treatment, payment activities and health care operations.

Signature: ____**Date:**_____________________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative Name: ____

Relationship to Patient: ____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT