



Youth Clinic

1200 E Elizabeth Street ~ Fort Collins, CO 80524 ~ Ph 970.416.6293 ~ Fax 970.416.6299

Authorization for Release of Information

Patient Name _____

LAST FIRST MI MAIDEN / OTHER NAME

Date of Birth _____ Medical Record # _____
(Office Use Only)

Address _____ City _____ State ____ Zip _____

Daytime Phone _____ Evening Phone _____

I hereby authorize the release of medical records as indicated below:

Released from:	Released to:
Name _____	Name _____
Address _____	Address _____
_____	_____
Phone _____	Phone _____
Fax _____	Fax _____

Information to be released

- History and physical exam
- Progress notes
- Lab reports
- X-ray reports
- Other: _____

Dates requested

ONLY THE PAST 5 YEARS OF RECORDS ARE PROVIDED UNLESS OTHERWISE REQUESTED

I specifically authorize the release of information relating to:

- Substance abuse (including drug and alcohol abuse)
- Mental health (including psychotherapy notes)
- HIV related information (AIDS related testing)

Signature of Patient, Parent or Legal Guardian Date

Purpose of Disclosure

Is patient transferring out of the practice _____ Yes _____ No

If **yes**, please indicate the reason

- Change of insurance Name of new insurance carrier _____
- Moving out of area
- Family consolidation
- Aged out
- Unhappy with care of service

If **no**, please indicate the reason

- Specialist Legal
- Consultation / second opinion Insurance request
- Personal use Verbal exchange only
- Other (please specify) _____

PLEASE NOTE - A fee will be charged for records copied for legal, personal and insurance company requests.
(continued)

I understand the following:

1. This authorization will expire one year after the date this form is signed.
2. I may revoke this authorization at any time by notifying the providing organization in writing and it will be effective on the date notified, except to the extent action has already been taken in reliance upon it.
3. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by Federal privacy regulations.
4. I am being requested to release this information by _____ (print name of provider) for the purpose of:

 - a. By authorizing this release of information, my health care and payment for my healthcare will not be affected if I do not sign this form.
 - b. I understand I may see and copy this information described in this form if I ask for it and that I will get a copy of this form after I sign it.
 - c. I have been informed that _____ (print provider name) will will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
5. Compliance with Colorado statute, I will pay a fee of \$ _____ (print fee charged). There is no charge for medical records if copies are sent to the facilities for ongoing care or follow up treatment.

****INCOMING RECORDS ONLY****

Your provider will review these records and the contents felt to be clinically useful will be scanned to your electronic health record. It is impractical for FCYC to store or scan the entire file. We encourage you to keep these records for your own files and future needs. Please select one of the following options. Option A is recommended.

____ **A. After selective parts of the transferred record are scanned to the electronic health record, I agree to pick these up within 30 days, after being notified, and retain for my own records.**

____ **B. After Selective parts of the transferred record are scanned to the electronic health record, I give my permission for FCYC to shred the entire copy of the record.**

Signature of Patient

Date

Signature of Parent or Legal Guardian

Date

Records Received By

Date

Relationship to Patient

FOR OFFICE USE ONLY

Date Request Filed _____

By _____

Identification Presented _____

Fee Collected _____

Youth Clinic Medical Financial Policy

Fort Collins Youth Clinic Financial Policies

The Providers and Staff of the Fort Collins Youth Clinic want to welcome you and your family to our Clinic. We want to make sure that every encounter you have with our Clinic from Patient Care to Billing is a positive and refreshing experience. In order to ensure this we have prepared the following financial policies.

Your Visit

You should be prepared to do the following:

- Present current insurance card and photo id at every visit.
- Produce payment for your visit. We accept; checks, cash, Amex, Visa, MasterCard, or Discover. All co-pays and co-insurances are due at the time of service or a minimum of \$50 towards your deductible.

If you do not have insurance, payment in full will be due for today's services. A 10% self pay discount will be applied.

Estimated Charges

To ensure that we accurately reflect and capture all charges provided during your visit, encounter forms are routinely reviewed for accuracy and appropriateness by trained Coding staff. As a result your charges for today are an estimate and may be subject to change upon further review.

Cancelled Appointments

We require 24 hours notice for cancellation of any well care or medication check. We ask for one hour cancellation of any other appointment. If not given appropriate cancellation notice, or the appointment is missed you will be charged one fourth of that visit. The charge for missing a nurse visit will be \$ 10.00. These charges are the patient's responsibility. The third time you miss an appointment without cancelling, your account will be directed to the appropriate Provider for possible dismissal. Appointments can be cancelled by calling (970) 482-2515.

Complete Insurance Information

In order to file your insurance we must have complete insurance information including;

- Insured's Name ■ SS#
- Group Number ■ Plan Address

All of the above information is listed on your insurance card which you will be asked for at every visit. If you are unable to supply us with a valid insurance card, we will ask for payment in full at the conclusion of your visit.

Changes In Insurance Coverage

If you have a change in insurance coverage, it is your responsibility to make sure we have all of the pertinent information on file including effective dates. Any medical expenses not covered by your insurance plan will be billed to you.

Non-Participating Insurance Plans

If the Fort Collins Youth Clinic does not participate with your insurance plan several options are available.

Non-Participating Insurance Plans (Cont.)

- You may pay the balance in full today and request an itemized statement of the visit and file it with your insurance company.
- The Fort Collins Youth Clinic can file a claim to your insurance company on your behalf.
- You may contact our Business Office to set-up a payment arrangement at (970) 416-6271.

New-Born Insurance Coverage

If your child is a newborn, there may be a delay in the processing of claims. It is your responsibility to make sure your newborn child is added to your insurance. If you do not have your child added to your insurance plan, you will be considered a self-pay patient and payment in full will be expected from you.

Primary Care Physician Assignment

Many insurance plans require a Primary Care Physician be assigned to manage your child's healthcare. It is your responsibility to ensure your child's Primary Care Physician is assigned. You may see any Provider at FCYC regardless of Primary Care assignment. Any non-covered services due to Primary Care Physician assignment will be billed to you.

Insurance Payment Delays

The Fort Collins Youth Clinic is committed to partnering with its patients to resolve insurance payment delays. You may be called on to assist us in resolving issues with your insurance company. If we experience delays in payment beyond 60-days you will be notified. It is important that you contact us immediately so we can resolve any issues and avoid holding you responsible for unpaid claims. Please call (970) 221-3489

Coordination Of Benefits

Coordination of benefits will be the responsibility of the parent. The Fort Collins Youth Clinic will mail an insurance claim to your secondary carrier but will not provide copies of Explanations Of Benefits.

Responsible Parties

Parents who maintain custodial care of their children will be listed as the Guarantor of the patient. Billing statements and other correspondence will only be sent to the address listed under the custodial parent. FCYC will not provide joint statements due to joint custody arrangements. Insurance information from other responsible parties may be added to the patients account however responsibility for the payment of bills owed to the Fort Collins Youth Clinic will be the responsibility of the custodial parent. Joint payments are the responsibility of both parents and the copay, co-insurance or deductible payments are due at the time of service.

Billing Statements

Statements are sent out by the Youth Clinic on a monthly basis. Any patient responsible balances due on your account may be reflected on your statement.

Returned Checks

A ten dollar service charge will be added to all checks returned for Non-Sufficient Funds.

Service Charges

If your account has a patient balance over 60 days old, there will be a \$5 service charge added to your account monthly until the balance is paid in full.

Collection Letters

If you receive a collection letter from us the most important thing you can do is contact us. We have courteous helpful staff that can assist you in setting up satisfactory payment arrangements.

Payment plans are available by contacting our Business Office at (970) 221-3489 Monday through Friday between the hours of 8:00 AM and 4:30 PM.

Collections/Termination

Balances not paid within ninety days will be reviewed for placement with an outside collection agency. Patients whose accounts are placed with an outside collection agency are terminated from the practice. Patients who are terminated from the practice may be reinstated by contacting the Business Office at (970) 221-3489 and requesting a reinstatement application.

Bankruptcies

Parents who file for Bankruptcy on behalf of patients attending the Youth Clinic may be subject to termination from the practice. Patients who are terminated from the practice may be reinstated by contacting the Business Office at (970) 221-3489 and requesting a reinstatement application.

Medicaid Patients

Parents of Medicaid patients enrolled in a Primary Care Physician program must ensure that a Youth Clinic Provider is selected as the Primary Care Physician. Failure to do so will result in delayed/cancelled appointments until the situation is corrected. If FCYC is unable to verify eligibility you may be asked to reschedule.

Phone Charges

As an extension of our total care our providers are committed to be available to patients by phone 24 hours a day. After hours phone calls or prescription calls to a pharmacy may result in a charge at the Providers discretion. If the Provider is called after hours, there is a minimum \$10.00 charge and/or a \$15.00 charge if a prescription needs to be called into a pharmacy. Even though the patient care occurred on the telephone, the Provider still takes responsibility for your child's healthcare at that time.

I have read and understand the above policies. I hereby agree to the terms outlined above

Signature: _____ Social Security # _____ Date: _____

Failure to sign Financial policy will result in dismissal from the practice.

**Patient Consent Form for Use and Disclosure of Protected
Health Information
Fort Collins Youth Clinic**

By signing this Consent Form, you give us permission to use and disclose protected health information about you for treatment, payment, and healthcare operations except for any restrictions specified below to which we have agreed. *Protected health information* is individually identifiable information we create or receive, including demographic information, relating to your physical or mental health, for provision of healthcare services to you, and to the collection of payment for providing healthcare services to you.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to receive a copy of our Notice of Privacy Practices before signing this Consent Form. As provided in our Notice, the terms of the Notice of Privacy Practices may change. If we change our Notice, you may obtain a revised copy by contacting our information Privacy Officer at 970-416-6286, who is also available to respond to any questions or receive any complaints you may have concerning your protected health information.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. ***We are not required to agree to any restrictions, but if we do, we are bound by our agreement.*** If you wish to make a restriction, please request a copy of our Form to Request Restrictions.

If you do not sign this Consent form, we have the right to refuse you treatment unless a licensed healthcare professional has determined that you require emergency treatment or we are required by law to treat you. We are required to document any circumstances in which we do not obtain your consent, yet carry out treatment. We will offer you a copy of this documentation should you decide not to sign this Consent Form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. You may request to use our Authorization for Release of Information Form for purposes of requesting your revocation, or you may simply send us a letter in writing.

PRINT PATIENT NAME

DATE OF BIRTH

PRINT PATIENT PERSONAL REPRESENTATIVE NAME

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

DATE OF SIGNATURE

This consent form references our Privacy Policies Dated 4-14-03

This consent is valid for six years from date of signature or from the date the consent was last in effect.



Youth Clinic

PATIENT INFORMATION AND CONSENT FORM

Date _____

Account # _____

Child's Name	_____	Date of Birth	_____
	First M.I. Last		
Ethnicity	<input type="checkbox"/> Hispanic or Latino	Gender	M / F
	<input type="checkbox"/> Not Hispanic or Latino	Religion	_____
Race	<input type="checkbox"/> White	<input type="checkbox"/> Black or African American	
	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Native Hawaiian	
	<input type="checkbox"/> Asian	<input type="checkbox"/> Other Pacific Islander	
Language	Is English your child's primary language?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Please specify	_____

Child lives with Both Parents Mother Father Other

Parents relationship to each other Married Divorced Separated Widowed Other

Are there any custodial restrictions we need to be aware of? No Yes - Please specify _____

Do we have a custodial agreement on file? Yes No - If no, please provide agreement to our office.

Other adults(s) involved in child's life

Name _____
First M.I. Last

Relationship _____

Name _____
First M.I. Last

Relationship _____

AUTHORIZATION FOR TREATMENT IN CASE OF EMERGENCY: In case of emergency, if I cannot be reached, the Youth Clinic has my permission to treat the members of my family as necessary.

Signature

Date



Youth Clinic

FAMILY CONTACT INFORMATION

Date _____

Account # _____

Children Names	DOB	Gender	School	Goes By	Cell Phone #
_____ First M.I. Last	_____	M / F	_____	_____	_____
_____ First M.I. Last	_____	M / F	_____	_____	_____
_____ First M.I. Last	_____	M / F	_____	_____	_____
_____ First M.I. Last	_____	M / F	_____	_____	_____
_____ First M.I. Last	_____	M / F	_____	_____	_____

Email Address _____

Mother's Name _____
First M.I. Last

Mother's Employer _____ Occupation _____

Primary Phone # _____ Alt Phone # _____ Alt Phone # _____

Father's Name _____
First M.I. Last

Father's Employer _____ Occupation _____

Primary Phone # _____ Alt Phone # _____ Alt Phone # _____

FAMILY MEDICAL HISTORY

Patient Name _____ Date of Birth _____ Date _____ Account # _____

There are some medical conditions or illnesses that can be passed on to family members. To treat your child, we need to be aware of any of the following conditions.

*Family members include child's parents and siblings, Mother's parents and siblings, and Father's parents and siblings.

MEDICAL CONDITION	Patient's Mom	Patient's Dad	Patient's Siblings	Patient's Grandparents	Patient's Aunts and Uncles	Other	Reviewed
ADD/ADHD							
Alcoholism							
Allergies							
Lazy Eye (Amblyopia)							
Asthma							
Bipolar							
Blood Clots or Clotting Disorders							
Cancers							
Specify type of cancer							
Celiac Disease							
Cystic Fibrosis							
Stroke							
Drug Addiction							
Born with Heart Disease							
Depression							
Diabetes-Type 1 (juvenile)							
Diabetes- Type 2 (adult)							
Eating Disorder							
Glaucoma							
Hearing Loss (under 60 yrs of age)							
Heart Disease at less than age 50							
High Cholesterol							
High Blood Pressure							
Hyperthyroid (overactive)							
Hypothyroid (low)							
Inflammatory Bowel Disease (Crohn's or Ulcerative Colitis)							
Kidney Disease							
Learning Disabilities (Math, Reading)							
Lupus							
Migraines							
Multiple Sclerosis							
Neurologic Diseases							
Specify type							
Newborn with dislocated hip							
Rheumatoid Arthritis							
Schizophrenia							
Seizure Disorder							
Sickle Cell Anemia							
Scoliosis							
Thalassemia							
Unexplained Sudden Death							
Other conditions that run in the family							

If you have other children with the same Family Medical History, please include their names on the bottom of this form.

Siblings Names _____

TB/LEAD SCREENING QUESTIONNAIRE

PATIENT NAME: _____ **DOB:** _____ **DATE:** _____

Tuberculosis remains a significant health risk for certain populations. Lead poisoning in Colorado is rare but a potentially dangerous environmental toxin that is treatable if discovered early. The following questions will help us identify if your child is at risk for these problems and needs to be screened. Thank you for completing the questionnaire.

- | YES | NO | |
|-------|-------|---|
| _____ | _____ | 1. Has anyone in your family, anyone living with you, or anyone in frequent contact with your family had tuberculosis or unexplained chronic lung disease or been treated for TB infection. |
| _____ | _____ | 2. Are you from Africa, Asia, Latin America, Eastern Europe or Russia? Have you traveled or lived in these areas of our world? If so, when and for how long? |
| _____ | _____ | 3. Are you an American Indian? |
| _____ | _____ | 4. Have you lived in a shelter for the homeless or worked in such an institution? |
| _____ | _____ | 5. Are you, or is a member of your family, a health care worker? |
| _____ | _____ | 6. Does anyone in your household have a positive Tb test? Had a chronically abnormal x-ray? |
| _____ | _____ | 7. Is anyone in your household or family infected with the AIDS virus? |
| _____ | _____ | 8. Has anyone in your family worked in or been incarcerated in a prison facility? |
| _____ | _____ | 9. Do you currently have symptoms of blood tinged/productive cough, fever, night sweats, loss of weight, loss of appetite lasting longer than 2 weeks? |
| _____ | _____ | 10. Do you have a condition that could suppress your immune system or do you take medicine that suppresses your immune system (not including inhaled steroids)? |

LEAD

- | YES | NO | |
|-------|-------|--|
| _____ | _____ | 1. Does your child live in or regularly visit a house or childcare facility built before 1950? |
| _____ | _____ | 2. Does your child live in or regularly visit a house or childcare facility built before 1978 that is being, or has recently been renovated or remodeled (within the last 6 months)? |
| _____ | _____ | 3. Does your child have a sibling or playmate that has or did have lead poisoning? |

(Revised 05/09)