755 South Perry Street, Suite 100
Castle Rock, CO 80104
303-688-8989 Fax: 303-688-3482

Castle Rock Family Physicians

Established Patient Registration Form

Please help us bill your insurance company correctly by filling out this form in its entirety. Please provide our staff your insurance card, and be prepared to pay your co-payment and balance on account (if applicable).

PATIENT INFORMATION:

Patient Name: _____ Today's Date:_____

Patient Social Security No: _____ Drivers License State / #: _____

Address: _____ Occupation: _____

_____ Employer: _____

City / State / Zip: _____ Employer Address:_____

DOB: _____ Age: _____ City / State / Zip: _____

Gender: Male___ Female___ Marital Status: S M D W

Race:_____ Ethnicity:_____ Preferred Language:_____

Home Phone:_____Cell:_____ Work:_____

Emergency Contact: _____ Relationship: _____ Phone No: _____

INSURANCE INFORMATION: **Please give your insurance ID card to our receptionist to photocopy. Please note that we will bill secondary insurance one time only.**

Primary Insurance:_____

Policyholder's Name: **Same as Patient**____ **Other**_____

Secondary Insurance:_____

Policyholder's Name: **Same as Patient**____ **Other**_____

□ No, do not leave me any voice messages regarding my medical results but I agree to everything else below:

□ Yes, I authorize the following:

Castle Rock Family Physicians, and their representatives have my permission to leave a message regarding my medical care, lab test results and billing information on the following telephone number/s for date of service _____ with Spouse or Significant Other _____. I authorize Castle Rock Family Physicians to leave a message at the phone number/s below thru end date _____.

Preferred phone number to contact me:_____

Home Phone Voice Mail: _____ Cell Phone Voice Mail: _____

Work Phone Voice Mail: _____ Spouse / Significant Other:_____

_____ _____

Signature (or Parent Signature if Patient is a Minor) Date

Staff Use Only: Updated Yes □ No □

PLEASE UPDATE YOUR INFORMATION WITH THE RECEPTIONIST STAFF WHENEVER IT CHANGES

I AUTHORIZE Castle Rock Family Physicians to use, disclose and release my Protected Health Information (PHI) for the purpose of carrying out Treatment, Payment, or healthcare Operations (TPO) according to The Privacy Rule of our Federal Government during all visits to The Practice. I understand that I have a right to review the Practice's Privacy Notice, request restrictions and to revoke my consent in writing at any time. Additionally, I authorize the physician to discuss my treatment with other doctors and professionals involved in my treatment.

And,

I AGREE TO PAY for any requested healthcare provided to me by the Castle Rock Family Physicians at the time any services are rendered for non-HMO insurance. I understand that managed care HMO's, Point-Of-Service and Preferred Provider Organization health plans may have co-pays that I am responsible for when services are rendered to me and I agree to pay these on the day of service. I authorize payment directly to Castle Rock Family Physicians for any insurance benefits.

And,

AUTHORIZATION TO TRANSMIT MEDICAL INFORMATION ELECTRONICALLY: By signing this, you are agreeing to have medical information regarding your medical care with Castle Rock Family Physicians transmitted electronically in a highly secure and encrypted manner. This information is transmitted using HCFA and HIPPA healthcare guidelines for transmission to the parties authorized by you for your paper or electronic record to receive your health insurance claim.

_____ _____

Date **Patient / Parent Signature as agreed to above**

MINOR'S CONSENT: I permit my healthcare provider to allow my parents access to my medical record.

_____ _____

Date **Minor 12 to 21 years of age sign here if you agree to the above statement.**