



SMG Specialty Care, SMG Women's and Family Health, SMG Primary Care, SMG Mancos Valley, SMG Walk-In Care, SMG School-Based Health Center

**Please return or mail this packet to the New Patient Coordinator at 1311-A North Mildred Road, Cortez, CO 81321 in the medical office building on the Southwest Memorial Hospital Campus, or fax it to (970) 564-1134. New Patient Coordinator phone number: (970) 516-1616**

## **NOTICE TO OUR PATIENTS**

Thank you for choosing us as your healthcare provider. We look forward to providing an office environment and provider relationship that meets you and/or your family's medical needs.

### **Items to bring to your first appointment:**

1. Driver's license or other photo identification.
2. All insurance cards.
3. Co-pays or payment in full at the time of your visit if you are not covered by insurance.
4. Actual bottles of all medications (prescribed and over the counter) that you are currently taking.

### **No-Show Policy**

Our policy is to call patients the business day prior to their scheduled appointment to remind them of the appointment date and time. We perform these calls as a courtesy to our patients and to allow us the opportunity to reschedule the time slot should the appointment not be necessary. A phone call from you to cancel your appointment will allow us to schedule another patient that needs to be seen. Recognizing that everyone's time is valuable and that appointment time is limited, we ask that you provide **24 hours notice** if you are unable to keep your appointment. This will allow us to call one of our patients on a waiting list to fill the available slot on the schedule.

To improve care for our patients, we will track all "No-Show" visits. Each patient will be allowed to miss two scheduled appointments within a **one year period** without penalty. Once a third appointment is missed, the patient will be at risk of being discharged from the practice or the Southwest Medical Group. To prevent this from happening, patients shall receive a letter each time they no-show for an appointment reminding them of our no-show policy.

For the purposes of this policy, a no-show appointment is defined as follows:

1. An appointment which is missed by the patient without any advance notice.
2. An appointment that is cancelled less than 24 hours prior to the scheduled appointment time.
3. An appointment in which the patient arrives 10 minutes or more beyond the scheduled appointment time.

Due to the check-in process, we request patients arrive 20 minutes prior to their scheduled appointment time to spend their allotted time with their provider. Failure to show for the initial "new patient" appointment may eliminate your opportunity to establish care as a new patient.

### **Rx Refill Policy**

Our policy is to refill patient prescriptions within 72 (business) hours of receiving the request. Please do not wait until you are completely out of medication or you will likely do without until the refill can be processed.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signed (signature required): \_\_\_\_\_ Date/Time: \_\_\_\_\_

Patient, Parent or Legal Guardian: \_\_\_\_\_ Date/Time: \_\_\_\_\_



Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
                     First Name                      Middle Name                      Last Name

**Current Medications:**

*(include all over-the-counter drugs or products such as, aspirin, nose sprays, herbs, vitamins)*

Name of Drug	Dose	Times Per Day

**Preferred Pharmacy:** \_\_\_\_\_ **Address (City):** \_\_\_\_\_

**Allergies:** *(include medications, pollens, foods, and animals)*

Drug / Type	Reaction

**Past Medical Problems**

Disease or Condition	Duration /Year

**Past Surgical History:** *(include ALL surgeries and left or right side if applicable)*

**If you have ever had surgery, please list the types and approximate date(s):**

Year	Operation	Anesthesia	Any Complications with Surgery or Anesthesia?

## Family History

Is the child adopted?  No  Yes

Relation	Living?	Age	Age at Death (if deceased)	Cause of Death
Father of child				
Mother of child				
# Brother(s): _____	# living: ____			
# Sister(s): _____	# living: ____			

Please indicate who (if any) of your child's **IMMEDIATE BLOOD RELATIVES** have had any of the following:

*[Please list which relative(s) and the type of disease or condition if applicable, (ex.- grandmother, mother's side, lung cancer)]*

Disease or Condition	Relationship to You	Type (if applicable)*
Alcohol or Drug Dependency		*
Arthritis / Gout		*
Asthma / Hay Fever		
Cancer		*
Diabetes		*
Heart Disease / Attack		
High Blood Pressure		
High Cholesterol		
Kidney Disease		
Lung Disease / COPD		
Mental Health Problems or Depression		*
Migraines / Seizures		
Multiple Sclerosis		
Obesity / Weight Disorder		*
Osteoporosis		
Parkinson's		
Stroke		
Thyroid Disorders		
Tuberculosis		

## Prior Exams History

Prior Exams	Date of Last Exam
Dental Exam	
Vision Exam	

**Child Living With:** Mother / Father / Siblings / Grandparents / Foster Care / Other

**Education:** Current grade level \_\_\_\_\_

**Birth History:** Vaginal / C-section / AnyComplications \_\_\_\_\_

**Tobacco Use in Home:**  No  Yes

**Exercise:** Does your child exercise regularly?  No  Yes If yes, what activities? \_\_\_\_\_

Days/week: \_\_\_\_\_

**Safety:** Does your child wear a seat belt?  No  Yes

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**For females** (if having periods) : **Age of first period:** \_\_\_\_\_ **Last menstrual period:** \_\_\_\_\_

**Birth control** (if using): \_\_\_\_\_



**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

Patient Name: _____	Phone Number: _____
Address: _____	Date of Birth: _____
	Last 4 digits SSN#: _____ (optional)

I, \_\_\_\_\_, hereby authorize disclosure of my protected health information as follows:

**RELEASE FROM:**

Facility, Person, Provider: _____	Phone Number: _____
Address: _____	Fax Number: _____ *
	E-mail: _____ (e-mailed information will be encrypted)

**RELEASE TO:**

Facility, Person, Provider: _____	Phone Number: _____
Address: _____	Fax Number: _____ *
	E-mail: _____ (e-mailed information will be encrypted)

**\*SHS DOES NOT FAX PERSONAL HEALTH INFORMATION TO HOME FAX MACHINES**

**Information to be released:** From (date) \_\_\_\_\_ to (date) \_\_\_\_\_

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Treatment Records-Hospital  | <input type="checkbox"/> Laboratory Reports         | <input type="checkbox"/> Emergency Room Records | <input type="checkbox"/> History and Physical |
| <input type="checkbox"/> Office Visit Notes - Clinic | <input type="checkbox"/> Diagnostic Imaging Reports | <input type="checkbox"/> Discharge Summary      | <input type="checkbox"/> Pathology Reports    |
| <input type="checkbox"/> Consultation Reports        | <input type="checkbox"/> Operative Reports          | <input type="checkbox"/> Ambulance Run Reports  | <input type="checkbox"/> Sleep Lab Reports    |
| <input type="checkbox"/> Other, list below: _____    |   |   |   |

**Purpose of Release:**  Medical Care  Transferring Care  Attorney  Personal Records  Other: \_\_\_\_\_

**Sensitive Information:** I understand by checking any boxes below, I have given permission to release confidential information related to HIV, Mental Health Care, or Drug and Alcohol Treatment, which is protected by federal law 42 CFR Part 2. (If the boxes are not checked, this information will **NOT** be released.)

- Diagnosis and/or treatment relating to drug or alcohol abuse
- Diagnosis and/or treatment relating to mental health conditions
- Diagnosis and/or treatment relating to HIV testing, infection or diagnosis and/or treatment for AIDS

**Right to Revoke:** I understand that I may revoke this Authorization at any time by notifying Southwest Health System, Inc., in writing. I understand that revocation will not have any effect on actions taken prior to receipt of the revocation.

**Expiration:** This Authorization will automatically expire 180 days from the date of my signature, unless otherwise specified as follows: \_\_\_\_\_(date).

**Re-Disclosure:** I understand that the information used and/or disclosed according to this Authorization may no longer be protected by federal privacy law also known as HIPAA, and the recipient of the health information may potentially re-disclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

**With my signature below, I acknowledge and authorize Southwest Health System, Inc., to use and/or disclose my protected health information as described above. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on signing this Authorization.**

Patient name printed: \_\_\_\_\_ Date of Signature: \_\_\_\_\_/Time: \_\_\_\_\_

Patient signature: \_\_\_\_\_

Patient representative name printed: \_\_\_\_\_

Patient representative signature: \_\_\_\_\_ / Relationship to Patient: \_\_\_\_\_