MICHAEL J. O'NEILL, MD, PLLC

Date: _____

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)		ADDRESS	
CITY, STATE	ZIP	HOME PHONE	CELL PHONE
PATIENT DATE OF BIRTH	PATIENT SSN	SEX ☐ Male ☐ Female	MARITAL STATUS ☐ Single ☐ Married ☐ Other_____
PATIENT EMPLOYER NAME	PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)		EMPLOYER PHONE

INSURED/RESPONSIBLE PARTY INFORMATION | RELATION TO PATIENT: ☐spouse ☐parent ☐guardian

NAME (FIRST -- LAST -- MIDDLE INITIAL)		ADDRESS (If different from patient)		
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER

INSURANCE INFORMATION

PRIMARY INSURANCE NAME		ADDRESS (STREET - CITY - STATE - ZIP)	PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE
SECONDARY INSURANCE NAME		ADDRESS (STREET - CITY - STATE - ZIP)	PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE

PRIMARY DOCTOR/FAMILY DOCTOR	REFFERING DOCTOR	
IN CASE OF EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER

ASSIGNMENT AND RELEASE : I hereby authorize my insurance benefits be paid directly to the physician and I am financiall responsible for non-covered services. I also authorize the physician to release any information required in the processing of th claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

SIGNATURE (Patient or, if minor Signature of parent or guardian)	DATE

Authorization to release health information to:

Name(s)		ADDRESS	
CITY, STATE	ZIP	HOME PHONE	DAYTIME PHONE
DATES OF SERVICE FROM: TO:		AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED) ☐ NEVER DATE:	

Release the following information:

☐ All Records ☐ Chart Notes ☐ Radiology Reports ☐ Operative Reports ☐ History & Physicals

RELEASE OF INFORMATION

I understand that:

- once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclos my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided i Federal Privacy Rule 45 CFR (164.524).
- my records are protected and cannot be disclosed without written permission
- this Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE	EMAIL
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (Optional):	

MICHAEL J. O'NEILL, MD, PLLC

Date: _____

PATIENT MEDICAL HISTORY

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)

_____

***** Preferred Pharmacy:**

_____

Allergies

- ☐ NONE/No Known Allergies
- ☐ Dairy Products
- ☐ Sulfa Drugs
- ☐ Adhesive Tape
- ☐ Iodine/Shellfish/Contrast Dye
- ☐ Wheat
- ☐ Anesthesia
- ☐ Latex
- ☐ Aspirin
- ☐ Morphine
- ☐ Codeine
- ☐ Penicillin

OTHER:

FAMILY HISTORY -- Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	FATHER	SIBLING (Brother/Sister)
Anesthesia Problems			
Arthritis			
Cancer			
Diabetes			
Heart Problems			
Hypertension			
Stroke			
Thyroid Disorder			

SOCIAL HISTORY

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

Occupation: _____ ☐ Retired ☐ Disabled (reason _____)

☐**Yes** ☐**No** - Do you drink alcohol? ☐ Daily ☐Weekly ☐Infrequently ☐ Recovering Alcoholic

☐**Yes** ☐**No** - Do you use tobacco? ☐ Smoke (____ packs per day) ☐ Chew

Surgical History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

Medical History: Have you ever had any of the following?

- ☐ NONE of the problems listed
- ☐ allergies
- ☐ anemia
- ☐ arthritis conditions
- ☐ asthma
- ☐ arterial fibrillation
- ☐ bleeding problems
- ☐ BPH
- ☐ CAD coronary artery disease
- ☐ cancer
- ☐ cardiac arrest
- ☐ celiac disease
- ☐ chest pain
- ☐ CHF congestive heart failure
- ☐ chronic fatigue syndrome
- ☐ depression
- ☐ diabetes
- ☐ drug/alcohol abuse
- ☐ erectile dysfunction
- ☐ fibromyalgia
- ☐ Gerd
- ☐ heart disease
- ☐ high cholesterol
- ☐ hyperinsulinemia
- ☐ hyperlipidemia
- ☐ hypertension
- ☐ hypogonadism male
- ☐ hypothyroidism
- ☐ infection problems
- ☐ insomnia
- ☐ irritable bowel syndrome
- ☐ kidney problems
- ☐ menopause
- ☐ migraines/headaches
- ☐ neuropathy
- ☐ onychomycosis
- ☐ organ injury
- ☐ osteoporosis
- ☐ pulmonary embolism/blood clot in l
- ☐ seizure disorders
- ☐ shortness of breath
- ☐ sinus conditions
- ☐ stroke
- ☐ syndrome X
- ☐ tremors
- ☐ wheat allergy

Medications: List any medications you are currently taking (please include over the counter medications):

PLEASE PRINT LEGIBLY -- NO CURSIVE PLEASE

MEDICATION	DOSAGE	PERSCRIBING DOCTOR

FOR PAIN SYMPTOM ONLY

Is this problem new or an old one that returned?

☐ New problem ☐ returning problem

How would you describe your symptoms?

☐ Achy ☐ dull ☐ sharp ☐ burning
☐ stabbing ☐ other _____

When are your symptoms worse?

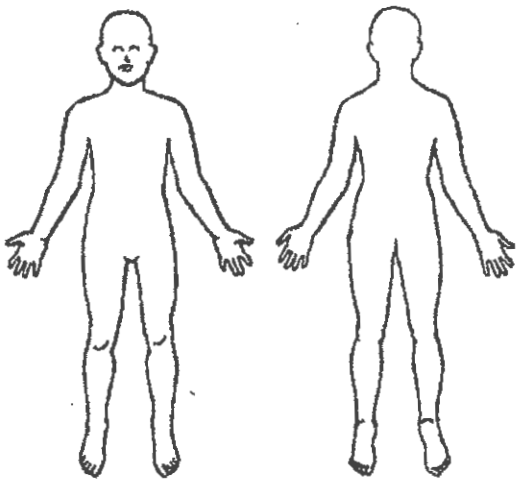
☐ Morning ☐ afternoon ☐ evening
☐ Neither (depends on activity)

How bad is your pain on a scale of 1-10?

1 2 3 4 5 6 7 8 9 10

(No pain) (Intense pain)

Mark an X on the picture where you have pain



Date Problem Began? How did the problem begin?

_____

What makes you're a symptoms better? _____ or worse? _____

Are your symptoms... ☐ constant ☐ intermittent ☐ traveling or radiating

Patient's Signature: _____ Date: _____

MICHAEL J. O'NEILL, MD, PLLC

PATIENT RESPONSIBILITIES AND STATEMENT OF UNDERSTANDING

In the current healthcare environment, it is increasingly difficult for medical providers to be paid for their services. Dealing with insurance companies is also becoming more confusing to our patients. As a result, we would like to clarify your responsibilities as a Michael J. O'Neill ,MD,PLLC patient

Insurance Coverage

- Your insurance policy is a contract between you and your insurance company, not your provider.
- Changes to your insurance coverage must be communicated to our office at the time of service upon check-in.
- Your insurance company may require you to choose a primary care physician in order to receive "in network benefits". If you have chosen **Michael J. O'Neill,MD,PLLC** as your PCP and his or her name does not appear on your insurance card, you must verify that your insurance company has the correct information before services are rendered.
- If your claim is processed incorrectly by your insurer, you give Michael J. O'Neill, MD,PLLC permission to appeal the claim on your behalf by your signature below.
- If your insurance plan requires a PCP and **Michael J. O'Neill,MD,PLLC** is not your PCP, you may be responsible for deductibles, co-insurance, and other non-covered services.
- If your plan requires referrals from **Michael J. O'Neill,MD,PLLC** to specialists, it is your responsibility to obtain the referral from our office prior to your appointment with the specialists. Please be aware that non-emergent referrals can take up to two weeks to process. In addition, referrals will **NOT** be dated retroactively.

Financial Obligations

1. Co-payments are due at the time of service.
2. Michael J. O'Neill, MD will bill participating insurance companies after verifying coverage. If claims are not paid, Michael J. O'Neill, MDwill bill you for services rendered.
3. Payment for non-covered services, deductibles, and co-insurance amounts are due within thirty (30) days of receipt of invoice.
4. If insurance payments are paid to you in error instead of Michael J.O'Neill, MD the payment must be forwarded to us. You may issue a personal check to Valley Medical Group. Be sure to include a copy of your insurance company's documentation or explanation of benefits.
5. If you do not have insurance thatMichael J. O'Neill, MD participates with, you are responsible for payment in full for today's services.
6. Processing fees may be imposed for non-payment of out-of-pocket expenses referenced in #1 and #5 above, and for checks returned by the bank for non-payment.
7. Michael J. O'Neill, MD bills an additional fee for weekend and holiday visits.
8. If requested, you are responsible for providing your insurance company with any other insurance coverage, details of an injury, dependent student information, and other non-medical information. Failure to comply with an insurance company request for information will result in your being responsible for payment.

I HAVE READ AND UNDERSTAND THE INFORMATION AND MY RESPONSIBLITIES AS STATED ABOVE:

Patient/Guardian:_____ Date: _____

Witness:_____ Date: _____

A copy of this form is available upon request.

Michael J. O'Neill, M.D., PLLC
Family Practice
www.michaeloneillmd.com

Phone: 719-419-7490
Fax: 719-309-6847

240 E. Beacon Lite Road
Monument, Colorado 80132

CONSENT NOTICE

PLEASE DO NOT SIGN THIS NOTICE UNTIL YOU HAVE COMPLETELY * READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to my Protected Health Information and how it is used. I understand that this information can and will be used by Michael J. O'Neill M.D. and staff to carry out treatment, payment or healthcare operations.

I understand that I may refer to the Notice of Privacy Practices for a more complete description of these uses and disclosures. I acknowledge that I have been informed and read the Notice of Privacy Practices in its entirety prior to signing this consent.

I understand that I may request in writing that you restrict how my private information is used and disclosed. I also understand that the office of Michael J. O'Neill M.D., PLLC. is not required to agree to my requested restrictions, but if they do agree then they are bound to abide by such restrictions. I understand that if this request is granted and information needed to carry out payment for treatment is restricted, this office exercises its right to collect payment for those services in full prior to services being rendered. I also understand that it will be my responsibility to seek reimbursement for those services from my insurance company.

I understand that Michael J. O'Neill M.D., PLLC. reserves their rights to amend their Notice of Privacy Practices from time to time and that I may at any point request a copy of the current Notice at the address listed above.

I understand that I may revoke this consent in writing at any time, except to the extent that the covered entity has taken action in reliance of poor consent and authorization. I understand the consent must be signed in person with the Privacy Officer or in written form and sent via certified return receipt mail to the attention of the Privacy Officer named.

_____ _____

Signature of Patient/Personal Representative Date (MM/DD/YYYY)

_____

Printed Name

Michael J. O'Neill, M.D., PLLC
Family Practice
www.michaeloneillmd.com

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Fax: 719-309-6847

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HIPAA NOTICE OF PRIVACY PRACTICES

Health Information Covered By This Notice
Personal health information or health information is information we create or receive that identifies you and relates your past, present or future physical or mental health or condition; the provision of health care to you; or the past, present or future payment for health care furnished to you.

Our Pledge Regarding Health Information
We understand that health information about you is personal. We are committed to protecting the privacy of your health information by complying with all applicable federal and state privacy and confidentiality laws. We are required by law to maintain the privacy of your health information and to provide you with this Notice about the ways in which we may use and disclose health information about you, our legal obligations and privacy practices and your privacy rights.

How We May Use and Disclose Health Information About You
The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures, we explain what we mean and give an example. Not every use of disclosure in a category will be listed; however, all of the ways we are permitted to use and disclose information under federal law will fall within one of the categories. Except in certain limited cases such as emergencies, we are required to obtain your written consent prior to releasing your medical records to another party.

Treatment
We may use health information about you to provide you with health treatment or services. We may disclose health information about you to physicians, nurses, technicians, medical students or other personnel who are involved in taking care of you. This facility may share health information about you for care coordination, such as prescriptions, lab work and x-rays. We also may disclose health information about you to a specialist who is consulted about your treatment or care. It is also our practice to provide information about the care and treatment we provide to you referring physician of record so that he or she has appropriate information for providing future care to you.

Payment
We may use and disclose health information about you in order to obtain payment for services. For example, we may provide your health plan with information about services you received so your health plan will pay us or reimburse you for the clinic visit. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your health plan will cover the treatment.

Family Practice

Phone: 719-419-7490
Fax: 719-309-6847

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Monument, Colorado 80132

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION
ADULT

This release expires 90 days from the date of signature or upon written request

Patient's Name:_____
Date of Birth:_____ Social Security Number:_____
Previous Name Under Which Records May Be Filed:_____
Patient's Current Address:_____
Patient's New Address if Moving:_____
Patient's Current Phone Number:_____Patient's New Phone Number if Moving_____

I specifically authorize:
Name of Doctor/Facility:_____
Address:_____
To release all or part of my medical records as described on this form for the following reason_____

I understand that when the information is released, it may be subject to re-disclosure by the recipient and may no longer be protected Personal Health Information (PHI)

Please release my Medical Records to: *Michael J. O'Neill, M.D., PLLC*

Phone: 719-419-7490
Fax: 719-309-6847

240 E. Beacon Lite Road
Monument, Colorado 80132

Please Do Not Fax Records!

Please initial the ~~appropriate box~~ to indicate which records you wish to be released and be charged for:

_____Immunization records only.
_____Records generated in this office only (not including x-rays, fetal monitor strips, Electrocardiograms,old records, outside lab results) If no box is initialed, this option will be used
_____Records generated in this office only (including x-rays, fetal monitor strips, electrocardiograms, old records, outside lab results, which may incur an additional charge).
_____Other:_____
(specific dates of treatment or specific parts of the record).

Patient Signature_____Date_____
(Patients 18 years and older must sign for themselves)

OR

Signature of Legal Representative_____Date_____
Relationship to Patient_____

****PLEASE READ BELOW SECTION****

I understand that this separate, expressed consent is required to release sensitive healthcare information in my record, and I specifically request that you release any information in my medical record pertaining to discussion, testing, diagnosis, or treatment regarding sexual activity, reproduction, birth control, sexual- or reproductive-related diseases, and addiction to or use of drugs.

Patient Signature_____Date_____

OR

Signature of Legal Representative_____Date_____
Relationship to Patient_____