



Provider: Furr Snook Hepp Heisser Schoenholtz

10455 Park Meadows Drive Unit 102
Lone Tree, Colorado 80124
(303) 708-0246 / (303) 708-0247 (Fax)

Patient Information
PLEASE PRINT CLEARLY

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SS NO: _____ DOB: _____ Email: _____

Employer: _____

Marital Status: Married Single Divorced Widowed Other Spouses Name: _____

Preferred Language: _____ Ethnicity: **Hispanic/Latino or Not Hispanic/Latino**

Race (circle one) **American Indian/Alaskan native** **Asian** **Black/African American** **Caucasian**

Native Hawaiian/Pacific Islander **Hispanic** **Prefer not to answer**

IF MINOR: Responsible Party/ Parent Info:

Parent/ Guardian Name: _____ DOB: _____ SSN: _____

Address If Different From Above: _____

INSURANCE INFORMATION

Who is the policy holder of your insurance plan: (Self*, spouse, mother, father, other) *If self, skip to signature section below

Policy Holder: _____ **DOB:** _____ **Insurance Company** _____

ID/SSN #: _____ **Group #:** _____

Relationship to pt _____

Please give your insurance card(s) and a picture ID to the receptionist.

Assignment of Benefits: I hereby authorize payment of benefits due from my insurance company be paid directly to
Advanced Integrative Medicine, PC, for all services rendered.

Release of Information: I hereby authorize Advanced Integrative Medicine, PC, to release any information required to processes
my visits through my insurance company.

Signature

Printed Name

Date

Pharmacy phone and/or location: _____



10455 Park Meadows Drive, Suite 102
Lone Tree, Colorado 80124
Phone: (303) 708-0246 Fax: (303) 708-0247

POLICIES AND PROCEDURES

EMERGENCIES:

After normal office hours coverage for emergency situations is available. If your emergency is life threatening please dial 911. Otherwise, call the main office line at (303) 708-0246 to reach the answering service who will contact the physician on call. Please do not use this service for prescription refills or referrals, prescription refills and referrals should be handled during normal office hours.

PRESCRIPTION REFILLS:

Prescription refills require 48 hours to process. If you need medications for the weekend, please call your pharmacy by Thursday morning and ask them to send us a request so it will be ready before the weekend. The on call physician will not be able to refill them for you. Please remember to call a few days before your medication runs out in order for us to have time to call in your prescription. We cannot handle walk in prescription refill requests.

REFERRALS:

Referrals to another office or specialist require 5 days to process. Referrals will not to be handled after hours or on weekends. Please notify us at least 5 days prior to your appointment. Failure to get the required referral could cause denial by your insurance company, making you responsible for any fees associated with your visit.

INSURANCE:

We require a copy of the front and back of your ID card to process your claim. If your insurance requires a PCP (Primary Care Physician) to be listed, you must contact the insurance carrier to make sure our physician is on your policy. Without this information you will be responsible for any charges. You will also be responsible for charges on services considered “not a covered benefit” or “not medically necessary” by your insurance company. Please keep in mind, we do not know that particulars of each policy, so it is your responsibility to find out about your policy. By signing below, you acknowledge that you understand your physician may recommend you have labs or scans done that may not be covered. Legally, we are unable to change diagnostic or procedure codes. Ultimately, the contract for insurance benefits is between you and your insurance carrier.

COPAYMENTS:

Copayments are due at the time of service. If you are unable to pay your copay at the time of service and wish to be billed, a \$10 billing fee will be added to your bill.

APPOINTMENT CANCELLATION POLICY:

If you need to cancel an appointment, please notify us 24 hours prior to your appointment time so that we may offer your appointed time to another patient. Failure to give 24 hours notice of cancellation will result in a charge of \$50 for a regular visit and \$100 for a physical.

NO SHOW FEE:

You will be charged a \$50.00 fee for a regular visit and \$100 for a physical if you do not show up for your appointment.

I have read and understand the above policies and procedures

Signature of Patient or Legal Guardian

Date

Printed Name of Patient



PRIVACY POLICY

It is the office policy of Advanced Integrative Medicine and their staff not to release any confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. We will not leave messages on an answering machine that does not have the name or telephone number on the recorded message when returning phone calls, unless written consent is given.

Information will not be left with any unauthorized person who may answer the telephone.

I authorize the staff at Advanced Integrative Medicine to contact me by any of the following methods and assume the responsibility to notify them whenever this information changes:

- | | | |
|------------------------------|------------------------------|-----------------------------|
| Home telephone | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Answering machine | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Work telephone | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Voice mail | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Cell phone and/or voice mail | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Pager | <input type="checkbox"/> yes | <input type="checkbox"/> no |

Fax medical records for referrals to another medical practice? yes no

I authorize Advanced Integrative Medicine and/or their staff to leave medical information pertaining to:

- Labs Lab Results Appt. info Billing
- Billing Medications

If you would like to have information released to anyone other than yourself please complete the following:

Please list names of people that you authorize and what type of information we may release to them:

| | |
|-------|--------------------|
| _____ | Relationship_____ |
| | Type of info._____ |
| _____ | Relationship_____ |
| | Type of info._____ |
| _____ | Relationship_____ |
| | Type of info._____ |

I have received and understand the Notice of Privacy Policy.

Patient/Guardian Signature:_____ Date_____

Print Patient Name: _____

Patient name:

Date:

Other than the services that you are coming in for, what additional services would you like to learn about? Please circle all that apply:

Skin Care Advice

Facial Veins

Facial Redness

Skin Care Products

Injectable Treatments/Cosmetic

Thin Lip

Length/ Fullness of Eye Lashes

Juvederm/Fillers

Facial FineLines/Wrinkles

Please answer the following questions on a scale by circling the appropriate response.

When I look in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than

True Age

Older Than

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned
Concerned

Somewhat Concerned

Very

If you circled anything listed above, please let our front staff know immediately and/or let your provider know for more information on how you can benefit from the services we offer here at A.I.M.

