Welcome to our office

Please print and complete all sections

GLENN E. HERRMANN, MD, FACS
Coal Creek Plastic Surgery
130 Old Laramie Trail, Lafayette, Colorado 80026

Today's Date	Patient Account Number

Patient Name (this section refers to PATIENT ONLY)

First	Middle Initial	Last

Address	City	State	Zip

Home Phone	Work Phone	Employer

Cell Phone

Date of Birth	Age	Sex	Social Security Number

Spouse	Employer	Work Phone

Email address

RESPONSIBLE PARTY (Person who should receive bill)

Name	Relationship to patient ☐ Self ☐ Spouse ☐ Parent ☐ Other

Address	City: State Zip

Home Phone	Work Phone

Auto Injury ☐	Claim #	Date of Accident
Work Comp ☐	Claim #	Date of Accident
Other Injury (Specify)		Date of Accident

REFERRED BY:

INSURANCE (Please complete thoroughly. We will need a copy of your insurance card and photo ID)

Primary Insurance	Secondary Insurance
Address	Address
City, State, Zip	City, State, Zip
Phone: Area Code ( )	Phone: Area Code ( )
Employer	Employer
Primary Insured Person	Primary Insured Person
ID/Policy #	ID/Policy #
Group #	Group #
Social Security Number	Social Security Number

NOTIFY IN CASE OF EMERGENCY **(Not living with you)**

Name	Home Phone
Address	Work Phone

Please sign by both X's

I authorize payment of medical benefits to physician or supplier for these services and all future claims.	I authorize the release of any medical information necessary to process this claim and all future claims.
X	X
Signed (Insured or Authorized Person)	Signed (Insured or Authorized Person)

For Office Use Only

Accept Assignment ☐ Yes ☐ No Accept Insurance ☐ Yes ☐ No Deductible ☐

Name	DOB	Age
Reason for the visit today		
Primary Care Physician or Referring Physician:		
Allergies to any medications ? ☐ Yes ☐ No (List medication and your reaction)	Latex Allergy ? ☐ Yes ☐ No	
HEIGHT	**WEIGHT**	
GENERAL HEALTH ?		

Medical History – *Do you have or have you had any of the following*?

Eyes	Yes ✓	**Genitourinary**	Yes ✓	**Other**	Yes ✓
Cataract		Pain with Urination		**Family History**	
Glaucoma		Kidney/Bladder Infection		Breast Cancer	
Visual Disturbance		Kidney Stone		Melanoma	
Diabetic Retinopathy		Hysterectomy		Other Cancer	
Ear, Nose & Throat		**Breast**		Bleeding problems	
Sinus Drainage		Breast Cancer		Diabetes	
Hearing Loss		Breast Infections		Blood Clot Problems	
Respiratory		Nipple Discharge		Arterial Disease	
Asthma				Stroke	
COPD		**Musculoskeletal**		High Blood Pressure	
Environmental Allergies		Arthritis		Problems with Anesthesia	
Anesthesia Problems		Back Pain		Varicose Veins	
Gastrointestinal		Back Injury		Depression	
Irritable Bowel Disease		Back Surgery		Heart Disease	
Crohn's Disease		**Vascular**		Other	
Ulcerative Colitis		Arterial Disease			
Gall Stones		Venous Disease			
Hepatitis		Varicose Veins			
Skin		Leg Ulcers			
Skin Cancer		**Endocrine**			
Melanoma		Diabetes			
Rosacea		Insulin Controlled			
Healing Problems		Oral Controlled			
Cardiac		Diet Controlled			
High Blood Pressure		Thyroid Disease			
Chest Pain/Angina		Diabetic Nephropathy			
Heart Failure		**Neurologic**			
Irregular Heart Rhythm		Stroke			
Pacemaker		Seizure			
Cardiac Cath		Depression or mental illness			
Coumadin/Blood Thinners		**Auto-immune**			
Hematology/Lymph		Taking Prednisone			
High Cholesterol		Lupus			
Swollen Legs		Rheumatoid Arthritis			
Bleeding/Bruising Disorder		HIV/AIDS			
Anemia					
Blood Clots in Legs		Scleroderma			
Pulmonary Embolus					

Previous Surgeries – please list any previous surgeries you may have had	

Date of Last Mammogram (*if applicable*):

Medications – please list any prescription, non-prescription and / or herbal medications/supplements you are taking. Please list the dose and how often you take the medication as well.	

Social History	
Do you smoke ☐ Yes ☐ No How many packs per day?_____	If you smoked in the past, when did you quit? _____

On average, how many alcoholic drinks do you have per week ?_____

Have you used marijuana, cocaine, heroin or excessive alcohol ?

If so, please describe

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Thank you for choosing Dr. Glenn E. Herrmann and Coal Creek Plastic Surgery for your healthcare needs.

We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form and return it to the front desk personnel to acknowledge that you have been provided with a copy of our Notice.

Name of Patient (please print)	Date of Birth
Signature of Patient or Legal Representative	Date
Signature of Staff Member	Date

GLENN E. HERRMANN, MD, FACS
COAL CREEK PLASTIC SURGERY ~ 90 HEALTH PARK DRIVE, SUITE 200, LOUISVILLE, CO 80027
Effective July 1, 2008

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We are required by the Federal Government to provide you with this notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for healthcare operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we also describe them in this notice.

WAYS IN WHICH WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION:

The following paragraphs describe different ways that we use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive. We assure you that all of the ways we are permitted to use and disclose your health information fall within one of these categories.

TREATMENT:

We may use and disclose your protected health information to provide, coordinate, or manage you're health care and any related services. We may also disclose your health information to other physicians who may be treating you. Additionally, we may from time to time disclose your health information to another physician who we have requested to be involved in your care. For example, we would disclose your health information to a specialist to whom we have referred you for a diagnosis to help in your treatment.

PAYMENT:

We may use and disclose your protected health information to obtain payment for the health care services we provide you. For example, we may include information with a bill to a third-party payer that identifies you and your diagnosis, procedures performed, and supplies used in rendering the service.

HEALTH CARE OPERATIONS:

We may use and disclose your protected health information to support the business activities of our practice. For example, we may use medical information about you to review and evaluate our treatment and services, or to evaluate our staff's performance while caring for you. In addition, we may disclose you're health information to third party business associates who perform billing, consulting, or transcription services for our practice.

OTHER WAYS WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION:

APPOINTMENT REMINDERS:

We may use and disclose your protected health information to contact you as a reminder about scheduled appointments or treatment.

TREATMENT ALTERNATIVES:

We may use and disclose your protected health information to tell you about or to recommend possible alternative treatments or options that may be of interest to you.

OTHERS INVOLVED IN YOUR CARE:

We may use and disclose your protected health information to a family member, a relative, a close friend, or any person you identify that is involved in your medical care or payment for care.

RESEARCH:

We may use and disclose your protected health information to researchers provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

AS REQUIRED BY LAW:

We may use and disclose your protected health information to federal, state, or local law enforcement. You will be notified of any such disclosures.

TO AVERT A SERIOUS THREAT TO PUBLIC SAFETY:

We may use and disclose your protected health information to a public authority that is permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by that health authority, we will also disclose your protected health information to a foreign government agency that is collaborating with the public health authority.

WORKERS COMPENSATION:

We may use and disclose your protected health information to a correctional institution or law enforcement official if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with health care; to protect the safety of others; or for the safety and security of the correctional institution.

YOUR HEALTH INFORMATION RIGHTS:

Although your health record is the physical property of the health care practitioner or the facility that compiled it, the information belongs to you. You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling our office and asking us to mail you a copy. If we maintain a website that provides information about our entity, this **NOTICE** will be posted on our website.

INSPECT AND COPY.

You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or for copying by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request.

If you wish to inspect or copy your medical information, you must submit your request in writing to the office manager at 90 Health Park Dr., #200, Louisville, CO 80027. You may also mail in your request, or bring it into our office, or fax it to our office. We will have 30 days to respond to your written request for your health care information that we maintain at our practice site. If the information is stored off-site, we are allowed 60 days to respond but must inform you the patient of this delay.

REQUEST RESTRICTIONS:

You have the right to request a restriction or limitation of how we use or disclose your medical information for treatment, payment, or health care operations. For example, you could request that we not disclose information regarding a prior treatment to a family member or friend who may be involved with your care or payment for care. Your request must be submitted in writing to our practice manager. We are not required by law to agree to your request if we feel it is in your best interest to use or disclose that information. However, if we do agree, we will comply with your written request unless that information is needed for emergency treatment.

AN ACCOUNTING OF DISCLOSURES:

You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for treatment, payment, or health care operations. Your request must be submitted in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003 (the compliance date for the federal regulation) nor for a period of time greater than six years (our legal obligation to retain information)

Your first request for a list of disclosures within a twelve-month period will be free of charge. If you request an additional list within twelve months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of any costs and afford you the opportunity to withdraw your request before any costs are incurred.

REQUEST CONFIDENTIAL COMMUNICATIONS:

You have the right to request how we communicate with you to preserve your privacy. For example, you may request that we only telephone you through your work number, or by mail, or by mail at a special address or postal box. Your request must be submitted in writing and must specify how and where we are able to contact you. We will accommodate all reasonable requests.

FILE A COMPLAINT:

If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our practice manager or directly to the Secretary of Health and Human Services. The address for the Secretary of Health and Human Services is: Office for Civil Rights U.S Department of Health and Human Services- 200 Independence Avenue South West- Room 509F- HHH Building- Washington, DC 20201. To file a complaint with our practice manager, you must submit your complaint in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to: Attn: Office Manager- Coal Creek Plastic Surgery- PO Box 767, Lafayette, CO 80026. You should be aware that no retaliation will ensue for filing a written complaint.

USES or DISCLOSURES NOT COVERED:

Uses or disclosures of your health information not covered by this notice or the laws that apply to us may only be made with your written authorization. You may revoke such authorization in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

FOR MORE INFORMATION:

If you have any questions or would like additional information, you may contact our office manager at (303) 664-9400 during regular business hours. Monday through Friday 8:00 am to 5:00 pm.