Updated 12.28.20

Our Lady of Hope Medical Clinic

Welcome and thank you for your interest in our clinic. We are a full service, pro-life family medical clinic and see patients of all ages. We seek to provide high quality, moral, and compassionate medical services. Our goal is to minimize your waiting time for appointments, and in turn we ask that you arrive at least 10 minutes before your scheduled appointment time.

Dr. Anselmi is a board certified Family Medicine Physician who also provides obstetrical services, as well as a broad range of services. He attended medical school at Columbia University in New York City and completed a family practice residency while serving in the United States Army. Dr. Anselmi has also received formal training as a Natural Family Planning Medical Consultant, and is familiar with its use in medical diagnosis and treatment. He will be happy to discuss using NFP with couples who are interested.

The providers in our clinic **do not** prescribe or refer for contraception, sterilization, abortion, or in-vitro fertilization under any circumstances. Additionally, they **do not** treat erectile dysfunction.

As your primary care provider, please feel free to call our office as any medical questions arise; this may prevent the need to visit the emergency room. However, if you know that you are experiencing an emergency, we encourage you to go directly to the emergency room.

Thank you for trusting our clinic with your medical care.

Edwin T. Anselmi MD, NFPMC

I have read and understand the information above:

____
Signature   Date _________

____
Name

Welcome to Our Office

Patient Information

Name_______________________________________ Marital Status S M D W

Address_________________________________City__________ZIP_________

Home #_________________Cell #________________Work #________________

Date of Birth_______ Sex__________Email_______________________________

Responsible Party

(Guarantor on the Insurance policy; if same, write same)

Name____DOB___________

Address_____________________________________City__________Zip_________

Home #___________________Cell ___________________Work__________________

Relationship to patient__________ Spouse Name______________________________

DOB_____________ Work #____________________ Cell_______________________

*****Dependents*****

Name_____________________ DOB _________

Name_____________________ DOB _________

Name_____________________ DOB _________

Name_____________________ DOB _________

Name_____________________ DOB _________

Name_____________________ DOB _________

Name_____________________ DOB _________

Whom may we thank for referring you to us? _________________________________

Medical History Form

Name______________________________ Age _____ DOB ___________ Marital Status ____

Occupation _____________________________ Religious Preference__________________________

Spouse's Name_______________________Age_____Occupation____________________________

Please circle any of the following conditions that you have:

Heart Problems	Chronic Pain	Diabetes Type I or II
High Blood Pressure	Fractures	Hyperthyroidism
Asthma	Gout	Hypothyroidism
COPD	Allergies/Hay fever	Osteoporosis
Pneumonia	Rheumatoid Arthritis	Cancer
Sleep Apnea	Osteoarthritis	Depression
Tuberculosis	Rash	Anxiety
Kidney Stones	Stroke	High cholesterol
Kidney Disease	Headaches	
Urinary tract infections	Seizures	

Please give details for anything circled above: ____

____

____

Please list any surgeries	Month/ Year

Please list any medications	Dosage/ frequency

Are you allergic to any medication(s)? **Y** **N**

If yes, which medication(s)?____

Do you see any specialists? **Y** **N** If yes:

Please list provider	For what condition/ diagnosis

Name: ________________________

Family Medical History

Are your parents still living? Y N Mother's Age ________ Father's Age_________

If deceased, at what age? Mother _________ Father__________

What was the cause of death? Mother? ________________Father?____________

What medical problems did/do they have? Mother _____________________________________

Father____

Do you have any brothers? ________ How many? _________ Are they still living?___________

Do they have any medical problems? _____ If yes, what?________________________________

Do you have any sisters? _________ How many? __________ Are they still living?__________

Do they have any medical problems? ______If yes, what?_______________________________

Do you have any children? ______ How many sons? _______ How many daughters?________

Do they have any medical problems? _____If yes, what?________________________________

Social History

Do you or have you ever smoked? **Y** **N** Packs/ day: ______ Age started: ______ Age quit:________

How many days per week do you drink alcohol on average? ________ How many drinks do you have when you drink? _____________

Do you exercise? **Y** **N** Type of exercise:_________________________ Avg # days/ week: __________
Avg # minutes per session: _______

Do you or have you use(d) illicit drugs? **Y** **N** If yes, what drugs:________________ When:________

Are you satisfied with your weight? **Y** **N** If not, do you want to gain_______ or lose______ weight?

Have you ever suffered from a psychological problem? **Y** **N** (circle if any apply:)
Anxiety Depression Mood Disorder Diagnosed Sleep Disorder Eating Disorder
Other: ____

Do you carry any contagious diseases? **Y** **N** (circle if any apply:)
Tuberculosis Hepatitis HIV Other: ____

Have you ever had a sexually transmitted disease? **Y** **N** If yes, which disease? _______________________

Colorado Physician Partners, PLLC

HIPAA Consent/Acknowledgment of Privacy Practices Form

____ ________________________

(Name of Patient) (*Date of Birth)*

Authorization to Release Information

You may allow designated people, such as family members (spouse, parents, etc.) or friends to call to schedule appointments or to request lab results. **I authorize OLHMC to schedule with or release my laboratory/radiology results and reports to the following individuals:**

____Relation to Patient:___________________

____Relation to Patient:___________________

We do not give this information to anyone without your consent, and will always attempt to speak with you first. This consent form supersedes and negates all prior authorizations for our office to release information.

It is often necessary for representatives of OLHMC to leave voice messages for patients to notify the patient that lab or procedure results are available, or to ask patients to call OLHMC. We do not leave health information on messages without a direct request from the patient to do so.
I authorize OLHMC to leave voicemails on my (check all that apply):

☐ Home ______________________ ☐ Cell ______________________ ☐ Work ______________________

Acknowledgment of Notice of Privacy Practices

I hereby acknowledge that I am aware of and have been offered a copy of the Colorado Physician Partners, PLLC, Notice of Privacy Practices:

____ ______________________

Signature of Patient/Patient Representative ***Date***

Financial Policy

You are valued as a patient within our practice and we feel it is important to keep you informed that there are ongoing changes in the healthcare industry. These changes may affect you in the services that you may receive that are covered by your insurance carrier, or in services that you receive that are determined to be due and payable directly by you.

Cancellation Policy

Please be aware that our office may *charge* a fee of $25.00 if 24 hours' notice is not given for cancellations. A patient may be charged $25.00 for no show appointments. The doctor has set aside a significant amount of time for your appointment. In order to be able to accommodate the needs of all of our patients, we need adequate notice if you cannot keep your scheduled appointment. A patient with chronic no shows may be dismissed from the practice.

Insurance Identification

We will make every effort to properly identify your coverage and to submit claims on your behalf to your insurance carrier to obtain their prompt payment. The terms of your insurance coverage may limit the specialists you see and what hospitals and laboratories you need to use. Please assist us in helping you to meet the terms of your coverage by presenting your current insurance card at the time of each and every visit.

Non-Covered Services

The terms of your insurance coverage have specific guidelines that indicate services that are covered and services that are not covered under your health insurance policy. It is possible that your insurance may not cover services that our physicians feel to be necessary in maintaining your health. We ask that you become familiar with your insurance policy and identify for your own knowledge services that are not a benefit of your policy.

Preventative Health Services

Preventative health services, such as annual exams, well woman checkups, complete physical exams, etc., vary in coverage from carrier to carrier. There are many carriers who do not provide benefits for routine care and preventive medical services. We feel strongly that screening for a potential health problem is an essential component of maintaining your health and do request that you schedule and receive these important services when recommended by your physician. It is your responsibility to understand the terms of your policy with regards to preventative and routine services. Management of past or current health problems or treatment of new problems discovered during your physical may result in an office visit copay or deductible. We will bill you after the insurance processes your claim.

Telehealth

Colorado Physician Partners is pleased to provide an option for patients to see their provider virtually through a secure video platform. Virtual visits (telehealth) use telecommunications technology to provider real-time health care to patients. Virtual appointments must be approved by your PCP. Telehealth visits may not be a benefit of your insurance policy and you may be liable for the service performed. Patients will be liable for charges which may include co-pays, co-insurance and/or deductibles for this service.

Non-Physician Services

There may be times within our practice when you receive services such as injections, blood pressure checks, drawing of blood for evaluation of a condition and not see a physician directly on the same day. These nurse services are processed as a minimal office visit within our practice as outlined under the American Medical Association's current procedural guidelines for correct coding procedures. Some

insurance carriers do not require patients to make co-payments for minimal office visits. However, there are some that do require a co-payment from you for these services. If your insurance carrier is one that requires co-payment for minimal office visits, you may be billed for this at a later date.

Compliance with Guidelines and Requirements of Health Insurance Carriers
It is our office goal to accurately and clearly identify to your health insurance carrier the services that you receive and the reason you received these services. Please do not ask our physicians or our staff to alter our reporting of the services you receive or are about to receive. Any alteration in our coding system would be considered fraudulent and we simply are not able to alter our coding in any way.

Out of Pocket Expenses
All out of pocket expenses, which are based upon the terms of your coverage, are due and payable at the time services are rendered. Co-Payments, under the terms of your coverage, must be paid at the time of service. Patients that have not met deductible will be required to pay minimum of $50 at time of service. We do require that patients without health insurance coverage make full payment or payment arrangements at the time of service. Our billing office will submit to you a statement of your balance due based on the information we receive from your insurance carrier. If you disagree with their determination, you will need to contact the insurance directly.

Patient Paper Work
The office may charge a flat fee of $30.00 to complete patient paper work. The fee must be paid when you pick up your documents.

Thank you for your support in complying with our financial policy.

Insurance claims are filed as a courtesy, but it is my responsibility to see that claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance. I fully understand that I am responsible for all costs of collection including attorney fees, collection fees, interest assessed on unpaid balances and court costs.

My signature below indicates that I have been provided the opportunity to read the office financial policy and ask questions, and that I agree to comply with this policy in providing payment for services rendered.

______________________________ ________________________
Clearly Print Name Patient's Date of Birth

______________________________ ________________________
Signature Date