Colorado Colon & Rectal
SPECIALISTS

Lisa A. Perryman, MD
9397 Crown Crest Blvd., Suite 301 • Parker, CO 80138 • Phone 303-840-8822 • Fax 303-840-8824

PATIENT REGISTRATION

Patient Last Name _____ First Name _____ Middle Initial _____

Home Address _____ City_____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Gender _____ Marital Status _____

Preferred Language _____ Race _____ Ethnicity _____ □ Decline to Answer

Please note that by providing us with your email address, you will be invited to register for the patient portal.

Email Address _____

Referring Physician Name _____ Phone _____

Primary Care Physician _____ Phone _____

Preferred Pharmacy _____ Address _____ Phone _____

Emergency Contact _____ Phone _____

I authorize Lisa A. Perryman MD, PC to obtain/have access to my medication history.
I also authorize patient chart sharing.

Signature _____ **Date** _____

INSURANCE INFORMATION

Primary Insurance

Insurance Name _____ Insurance Address: _____

Member ID# _____ Group #: _____

Customer Service number: _____

Name of Insured _____ Relationship _____

Insured's Date of Birth _____

Secondary Insurance

Insurance Name _____ Insurance Address: _____

Member ID# _____ Group #: _____

Customer Service number: _____

Name of Insured _____ Relationship _____

Insured's Date of Birth _____

I hereby authorize Dr. Perryman and providers of Lisa A. Perryman, M.D., P.C. to treat the patient identified above. I acknowledge that I am responsible to pay all charges for all treatments administered by the physician to the patient. I understand that insurance may not pay for all charges and I understand that I am obligated to pay for all charges not paid by insurance.
Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims.

Signature of Patient / Authorized Person _____ Date _____

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PATIENT QUESTIONNAIRE

I. Please list any family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations) **OR** circle **NONE**:

_____

II. Please select how you would like to be contacted for the following topics (text messaging and data rates may apply):

	Text	Phone	Email
Health Notifications (lab results, health reminders)	☐	☐	☐
Appointment Reminders	☐	☐	☐
Updates & Announcements	☐	☐	☐
Billing	☐	☐	☐

III. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information:

( )_____

* **I am fully aware that a cell phone is not a secure and private line.**
** **I am fully aware my health information can be transmitted by facsimile (fax), mail or the internet.**

IV. Can confidential messages (i.e. appointment reminders, lab/Xray results) be left on your answering machine or voicemail?

YES_____ NO _____

V. Can we email you personal health information (i.e. appointment reminders, lab/Xray results, surgical prep)? Please circle **YES** or **NO.** If yes, please write your email:_____

VI. Do you agree to receive AUTOMATED phone calls from this practice to your phone regarding test results, appointments, etc. YES_____ NO_____

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Provider's Notice of Privacy Practices with the effective date of September, 2013.

_____ _____
Signature of Patient/Patient Representative Date Signed

CONSENT FOR TREATMENT

I, the undersigned, voluntarily agree to treatments and/or procedures which Dr. Perryman and I have discussed and deem necessary. These will be performed by Dr. Perryman or under the direction of Dr. Perryman by a qualified healthcare professional.

PRINT NAME: _____ DATE OF BIRTH:_____

SIGNATURE: _____ DATE: _____

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TERMS AND AGREEMENTS

Thank you for choosing us as your healthcare provider. We value you as a patient and are committed to making your experience with us as successful and comfortable as possible. In order to provide the highest quality of care it is important that you understand our financial policies which we ask you to read and sign prior to treatment.

Payments
You are responsible to pay for the allowable amount of charges deemed by your insurance plan, or, if you are uninsured, the amount which was agreed you would pay. **We cannot determine, be responsible for, nor render an opinion as to whether or not there is insurance coverage for a particular service rendered, nor the amount, if any, which your insurance company will pay for a particular service nor the amount for which you will be responsible.** There are too many insurance plans with different and frequently changing coverages for us to do that. Coverage issues are to be determined solely between you and your insurance carrier. Lisa A. Perryman, MD PC, Colorado Colon & Rectal Specialists, its physicians and staff are not responsible for insurance company pre-authorizations, insurance company coverage or payment decisions. **Similarly we have no control over and cannot provide an estimate of charges made by assistant surgeons, hospital or surgical facilities, anesthesiologists, pathologists, radiologists, or diagnostic laboratories.** Please contact your insurance company with all questions regarding your insurance coverage prior to appointments or procedures. It is your responsibility to contact your insurance company with all questions regarding your benefits, coverage, and out of pocket costs prior to appointments or procedures.

Payment for insurance co-pays and deductibles are due at the time of service. We do not set up payment plans for co-pays or deductibles. If you are having a procedure, a portion or all of your deductible will be due prior to your procedure. You will be notified by our office if you need to prepay your deductible prior to your procedure. Please present your insurance card and ID (such as a driver's license) at the time of registration. Please complete all registration and insurance forms prior to seeing Dr. Perryman.

If you are unable to keep your scheduled office appointment, kindly give us 24 hours notice so we may offer the time to another patient. If you fail to cancel your office appointment ahead of time, a $50 no show fee may be charged to you.

Methods of Payment
We accept cash, checks and most major credit cards. We can also accept credit card payments over the phone.

Uninsured
We offer a discount for patients who do not have health insurance coverage. Payment for office visits are expected at the time of service. For most procedures a simple payment plan can be offered. Please call our office at 303-840-8822 for more information.

I, the undersigned, in consideration for services rendered to the patient by Dr. Lisa Perryman, understand and agree to the following:

1. I understand that Lisa A. Perryman, M.D., P.C., will file charges directly with my insurance carrier and that my copayment is due on the date of service. If I do not have insurance coverage, I understand that a percentage of the expected charge will be due on the date of service.
2. I understand that my insurance coverage may not provide payment for all charges incurred in obtaining treatment from Lisa A. Perryman, M.D., P.C. I will be responsible for any co-payment, deductible or service not covered by my insurance carrier. Additionally, if I do not have insurance coverage, I agree to pay all charges incurred in receiving treatment**._____(Initial here)**
3. I authorize Lisa A. Perryman, M.D., P.C., to file charges with my insurance carrier and I assign payment of medical benefits to Lisa A. Perryman, M.D., P.C.
4. I authorize release of any and all medical records and information necessary to process any claim generated by services I receive in the office or hospital.
5. I will keep my account current as to charges for which I am responsible.

My signature below indicates that I have read, understand, and agree to the terms outlined above.

PRINT NAME: _____

SIGNATURE: _____ DATE: _____

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COLONOSCOPY AND SURGERY SCHEDULING GUIDELINES

Our office tries to schedule colonoscopies and surgical procedures at a time convenient to the patient. In order to facilitate the scheduling process, we have reserved dates with facilities where we perform procedures. Dates are limited, which means it is very important patients make every effort to keep their appointments.

We realize there are times when unforeseen circumstances arise, and you must reschedule your procedure. However, it is important we have timely notice of your cancellation. Cancellations affect other patients, other physicians, the facility, and most times require notifying your insurance company again. Last minute cancellations are very disruptive and costly to all concerned. In order to keep the scheduling process working and give all patients an opportunity to schedule a procedure, we have instituted the following policies:

- Procedures, colonoscopies, and surgeries must be cancelled at least 48 hours prior to the scheduled date. This will permit us to notify all others concerned and/or offer that time to someone else.
- Cancellation of a procedure, colonoscopy, or surgery **with less than 48 hours' notice will result in a $200.00 fee**, which is payable before we reschedule you.
- If you do not show up for your procedure, you will be assessed a $200.00 fee. It will be considered a no-show if we are not notified prior to 3:00 PM the business day before your scheduled procedure.
- Cancellation **or** rescheduling of a procedure, colonoscopy, or surgery more than two times will result in a $100.00 fee, which is payable before we reschedule you.

We want you to know we value you as a patient. We have implemented these guidelines in order to provide the highest quality of service to all our patients.

I have read and understand the guidelines.

PRINT NAME: _____

SIGNATURE: _____ DATE: _____