Registration

Patient Information

Last Name | First Name | M.I

Mailing Address | City/State | Zip

Home Phone: ______ Cell Phone: ______ Work Phone: ______

Preferred Method of Contact ☐ Home ☐ Cell ☐ Work ☐ Text

Can we leave a message regarding your medical care or test results? ☐ Yes ☐ No

DOB: ______ Gender: ☐ Male ☐ Female SSN: ______

Emergency Contact ______ Phone ______ Relationship ______

Race
- ☐ White
- ☐ Hispanic
- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Asian
- ☐ Native Hawaiian or Pacific Islander
- ☐ Other ______
- ☐ Decline

Preferred Language
- ☐ English
- ☐ Spanish
- ☐ Sign Language
- ☐ Other ______

Responsible Party Information (only to be filled out if Patient is a Minor)

Last Name | First Name | Relationship

Mailing Address | City/State | Zip

Phone: ______ DOB: ______ SSN: ______

Preferred Pharmacy

Name | Address | Phone

Insurance Information

Primary

____

Insurance Company Name　　　　　　　　Relationship with Policy Holder

Policy Holder's Information

DOB: __________ SSN: ________________ Name: ______________________________

Secondary

____

Insurance Company Name　　　　　　　　Relationship with Policy Holder

Policy Holder's Information

DOB: __________ SSN: ________________ Name: ______________________________

I certify that I have read and agree to Hopelight Medical Clinic's (HMC) payment Policy. I am eligible for insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to HMC all money to which I am entitled for medical expenses related to the services performed from time to time by HMC, but not to exceed my indebtedness to HMC. I authorize HMC to release any medical information to my insurance carrier or third-party payer to facility processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $20.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from HMC by the above-mentioned methods, including but not limited to communications about appointments, treatment, and payment. I understand that such communications may not be secure and there is risk that they may be read by a third-party. **Initials:** _____________

Medicare beneficiaries: I request that payment of authorized Medicare benefits be made to HMC. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services. **Initials**: _____________

I have reviewed a copy of Hopelight Medical Clinic's Privacy Notice. **Initials**: ______________

____

Signature of Patient or Responsible Party　　　　Date

Hopelight
Medical Clinic

Name DOB Date

Medical History

Personal History

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Blood Clots
- ☐ Cancer: Type ____________
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Gallstones
- ☐ GERD
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Lung Problems
- ☐ Lower Back Pain
- ☐ Neurologic Problems
- ☐ Mental Illness
- ☐ Osteoporosis
- ☐ Palpitations
- ☐ Pancreatitis
- ☐ Sleep Apnea
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thyroid
- ☐ Other: __________________

Past Surgeries

Type of Surgery:	Year of Surgery:

Allergies to Medications

Medication:	Type of Reaction:

Name **DOB** **Date**

Current Medications

Medication:	Dose:	Times Per Day:

Social History

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

☐ Children	# of Sons	________	# of Daughters	________
☐ Tobacco Use:	Type	________	PPD	________
☐ Alcohol Use:	Drinks/day	________	Drinks/week	________
☐ Other Drug Use:	Type	________	Frequency	________
☐ Exercise	Type	________	Frequency	________
☐ Sexually Active	Contraception	________	Frequency	________

Family History

Please limit to parents, grandparents and siblings

	Who and What Age?
☐ Coronary Artery Disease	
☐ Hypertension	
☐ Stroke	
☐ Diabetes	
☐ Kidney Disease	
☐ Breast Cancer	
☐ Colon Cancer	
☐ Prostate Cancer	
☐ Mental Illness	
☐ Other: ________	

Consent for Treatment

I, the undersigned, hereby give consent to the provision of care, diagnosis and/or treatment by Hopelight Medical Clinic (HMC) and the Longmont Community Health Network (LCHN). I hereby acknowledge that such consent will remain in effect unless and until I cancel such consent in writing. I hereby acknowledge and confirm that I am mentally capable of giving informed consent to the provision of the care, diagnosis and/or treatment and am not subject to duress or under undue influence. I understand that this authorization applies to all routine health maintenance services and to all services available for acute and chronic medical and behavioral conditions. Furthermore, I acknowledge that no guarantees have been made to me as a result of treatment through HMC.

The services authorized by this consent include those provided under the auspices of HMC by, but not limited to: Medical Staff including physicians, nurse practitioners, physician assistants, nurses, health educators, medical technologists, and medical assistants, and Behavioral Health Staff including behavior analysts and counselors. I further consent to treatment by health professionals-in-training, which are under the supervision of responsible health professionals of HMC.

I understand that HMC will keep my protected health information confidential as directed by law. However, I understand that HMC providers may be required to report to authorities if they have reasonable cause to believe that child abuse or neglect has occurred or is occurring, or if they believe, in good faith, that disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of me or another person. I understand that HMC has contracts and agreements with the State of Colorado which allows for certain sharing of clinical and financial information. These programs include, but are not limited to, the Colorado Indigent Care Program and the State Infectious Disease Control Program.

Name of Patient (Print) Date

Signature of Patient or Person Authorized to Consent Date

Financial Policy

Thank you for choosing Hopelight Medical Clinic (HMC) as your health care home. Please understand that payment for services provided to you and your family are part of your patient responsibilities. Collecting our co-pays provides HMC with the needed financial resources to continue providing quality health care to you and your family at an extremely low cost. The following is HMC's Financial Policy which we require that you read and sign prior to treatment.

Sliding Fee Schedule

HMC offers a sliding fee plan to allow uninsured patients to receive health care services at an affordable cost. The cost is determined by the income and size of your family. The sliding fee schedule is based on the United States Department of Health and Human Services Guidelines. We do require the payment of any co-payments when services are rendered.

Insurance

It is the responsibility of the patient or legal guardian to provide HMC with current insurance information. HMC accepts assignment of benefits; however, we do require that you pay any co-payments when services are rendered.

Payment for Services

Payment is required at the time of service for all healthcare services that were rendered. HMC does not restrict services based on your ability to pay. Any patient with a past due balance will be required to consult with HMC's business manager to set up a payment plan.

Assignment of Benefits (if Medicaid is an insurance policy)

By signing this financial policy I am requesting payment of Medicaid or Medicare insurance benefits to Hopelight Medical Clinic (HMC). I understand that I am financially responsible for all charges not covered by insurance. I acknowledge responsibility to provide HMC with current patient and insurance information. I

Name of Patient (Print) Date

Signature of Patient or Person Authorized to Consent Date

Dear New Patient,

We would like to thank you for choosing Hopelight Medical Clinic. We want to welcome you to our clinic which we hope you find a family-like atmosphere as a new patient. At Hopelight you will receive outstanding medical care and services. We don't just strive to treat your medical needs but to improve your overall health through education and mental services as well.

We'd like to share with you a brief history:

Hopelight began in 2014 as a result of a handful of volunteer medical professionals coming together to brainstorm about how to serve the needs of patients who had no insurance or other medical resources. We began by offering primary medical care in the building of Longmont Church of Christ, one afternoon a week. Since then, Hopelight Medical Clinic has grown to five days a week, with a volunteer staff of more than 40 professionals including doctors, RNs, MAs, specialists, and other dedicated people serving the community.

We are members of the National Association of Free Clinics, and a registered Colorado Safety Net Clinic. Since the beginning, our core mission has been to serve people who could not afford these services elsewhere. We value each patient, and throughout our history we have been the primary care provider for a broad range of people with various needs.

Hopelight quickly grew as a medical clinic, and soon began adding other programs to our organization. Today, patients at Hopelight can take advantage of our many community programs and resources including Hopelight Behavioral Health, Hopelight Fitness Program, Longmont CPR, Hopelight Social Services, and Hopelight Education Services. Through these and other initiatives, Hopelight is able to serve our patients' needs in a holistic and collaborative environment. We care for the whole person!

In 2017, Hopelight took ownership of the Longmont Community Health Network. Established by the City of Longmont, LCHN exists to coordinate efforts among our city's various health providers for the good of individual patients.

Throughout our history, Hopelight has remained committed to providing high-quality care in a warm and friendly environment. We look forward to meeting you!

Please complete the enclosed paperwork so we may better serve you.

Sincerely,

Hopelight Medical Clinic Staff

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED, DISLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE READ IT CAREFULLY

As a Hopelight Medical Clinic (HMC) patient some of your health information is collected and maintained. The clinic is required by law to maintain your privacy and the security of your health information and to provide you with this Notice of Privacy Practices. This Notice describes how your health information may be used and shared, and explains your privacy rights. The clinic is required to follow the terms of this Notice. We may, however, change our privacy practices and the terms of this Notice in the future, and those changes may effect all health information maintained by the clinic. If our privacy practices change, you will be mailed a new Notice.

Each time you visit HMC, a record of your visit is created. This record is sometimes referred to as your "medical record" or "medical chart." This record allows:

- Doctors, nurse practitioners, physician's assistant, medical assistants, referral coordinators, nurses, and other health professionals to review your medical records and to plan your treatment;
- HMC to obtain payment for services we provide to you, such as from Medicaid, Medicare, or you; and

PERMITTED USES AND SHARING OF YOUR HEALTH INFORMATION:

- Treatment
- Payment
- Health Care Operations
- Future Communications
- Legal Requirements
- To Avoid Harm
- Research
- Public Health
- Health Oversight Activities
- Lawsuits and Disputes
- Workers Compensation
- Coroners, Medical Examiners, Funeral Directors
- National Security and Intelligence Activities
- Imprisonment

Other uses or sharing of your health information will be made only with your written authorization.

YOUR HEALTH INFORMATION RIGHTS:

- Receive a Copy of Your Information
- Request That We Correct Your Information
- Receive a List of Disclosures Made of Your Information
- Request That Your Information Be Communicated in a Confidential Manner
- Request That We Not Use or Share Your Information
- Receive a Copy of this Notice

FOR MORE INFORMATION OR TO REPORT A PROBLEM:

If you have questions or would like to file a complaint because you may contact HMC's medical director. All complaints must be submitted in writing. You may also contact the Secretary of the Department of Health and Human Services. We will not retaliate for the filing of a complaint. This Notice is effective as of May 29, 2018.

Patient Rights and Responsibilities

Hopelight Medical Clinic (HMC) is a non-profit clinic. Many of our staff members are volunteers contribute their own skills to the betterment of our community. We believe every person is made in the image of God. We are all equal in His eyes. Our time with you today is an expression of our love for Jesus. With His death on the cross, He paid the price so we all may enter into a relationship with Him and have life everlasting. It is our desire to address your healthcare needs to the best of our ability. We attempt to treat the complete person not simply physically, but emotionally, mentally, socially and spiritually. It is important for you, the patient, to understand that we can best help you with illness when we consider you as a complete person.

Patient Rights

Care and treatment will be based on your rights:

- To be treated with respect, courtesy, consideration, and in a safe environment.
- To be informed of your rights as a patient in advance of, or when discontinuing the provision of care. You may appoint a representative to receive this information should you so desire.
- To be offered prayer and/or spiritual counseling. The acceptance of the free medical care and services of HMC does not obligate any patient to accept prayer or spiritual counseling.
- To receive quality care regardless of age, sex, race, religion, disability, sexual orientation, diagnosis, economic or educational background.
- To actively participate in the development and implementation of your plan of care (physical, spiritual, emotional, mental and social aspects), and actively participate in the decision making process, including the right to refuse care.
- To have your personal privacy maintained at all times.
- To have confidential treatment of all communications and records pertaining to your care.
- To be free of all forms of abuse, harassment and coercion.
- To be free of seclusion or restraints not medically necessary.
- To be informed of outcomes of care, including potential outcomes.
- To receive information regarding your care (diagnosis, treatment plan, risks, benefits and alternative, and prognosis) in a manner that you can understand.

Patient Responsibilities

HMC expects all patients:

- To provide accurate and complete information concerning your present complaints, past illnesses, hospitalizations, medications and other matters relating to your health.
- To make it known whether you do or do not clearly understand the course of your medical/behavioral care and treatment plan and what is expected of you.
- To review and comprehend the clinic policies on patient's rights and responsibilities.
- To ask for clarification if you do not understand any policy, form, questions, procedure, diagnosis, treatment, prognosis or recommendation.
- To accept the consequences of deliberately refusing to follow the recommendation of the physician, or his designate.
- To be considerate and respectful of the HMC staff and property.
- To recognize the impact that your lifestyle may have on your personal health and accept the consequences for the outcomes if you do not follow the care, service or treatment plans.

Hopelight Medical Clinic General Information

Hopelight Medical Clinic General Information:

- **Hours of Operations**

Monday	9 AM to 3 PM
Tuesday	10 AM to 4 PM
Wednesday	8 AM to 7 PM
Thursday	9 AM to 4 PM
Friday	8 AM to 5 PM

- **Phone Number:** (303) 776-7117
- **Fax Number:** (888) 863-4354
- **Providers**
  - Lori Adams, NP
  - Jim Britton, MD
  - Anjoli Dixit, MD
  - Steve Haskew, MD
  - Julie Hubble, MD
  - Darlene Hughes, NP
  - Erin Keefer, PA
  - David McMarty, DO
  - David Podleck, MD
  - K. Lynn Walker, MD
- **Recommended After Hours Care**
  - Next Care Urgent Care, 2144 Main St, Longmont 80501
  - UCHealth Urgent Care, 1925 W Mountain Ave, Longmont 80501
  - U.S. HealthWorks Urgent Care, 1860 Industrial Circle, Longmont 80501

Medication Refill Policy

Welcome to the Hopelight Medical Clinic. We are pleased to have the opportunity to provide your medical care.

With regard to medication refills:

Please remember to contact your pharmacy while you still have 14 days remaining of your medications. This will allow the pharmacy adequate time to fax Hopelight a request for possible refills. Please note that an office visit and/or lab work may be required before a medication can be refilled.

If you call into the office for refills and leave A message after hours, it will be processed on the following business day.

The Hopelight staff will strive to provide refills in a timely manner - generally within three to five business days. However, sometimes refills may take longer to process depending on the circumstance.

Hopelight is unable to call out any antibiotic or narcotic prescriptions without first seeing the patient in the office. By a newly enacted Colorado state law, narcotic prescriptions can only be prescribed for 7 days. The Hopelight clinic is very adherent to this policy and prescriptions are only authorized on a limited case-by-case basis.

Thank you for your understanding.

Sincerely,

The Hopelight Medical Team

Pediatrics Information

Main Hospital Parent Advice Line

Please call this number with any after hours medical questions that cannot wait until the next business day. It is staffed by nurses from Children's Hospital and they provide excellent advice. Children's Hopspital also has an informational website at www.childrenscolorado.org.

- 24/7 Staffing
- (720) 777-0123

Children's After Hours Questions/Urgent Care

If your child has an emergency that cannot wait until the next office business day, we recommend that your child be seen at this Children's Hospital Outpatient Urgent Care.

- Children's Hospital North Campus
- (720) 777-1340
- 69 W State Highway 7 Broomfield, CO 80023

Tylenol Dosing

May be given every 6 hours if needed for fever above 100.5 °F. Dosing is preferably based on weight rather than age:

Weight [lb]	Milograms	Dropper	tsp
6-11	40	1/2 infant	1/4
12-17	80	1	1/2
18-23	120	1 1/2	3/4
24-35	160	2	1

NOTE:

1. Infant Drops = 80 mg/dropper; Children's Suspension = 160 mg/5 ml or tsp
2. 5 milliliters = 1 teaspoon; 1 kilogram = 2.2 lb