GUNNISON VALLEY FAMILY PHYSICIANS
CERTIFIED AMERICAN BOARD OF FAMILY PHYSICIANS

130 E. Virginia Avenue, Gunnison, CO 81230
Phone: (970) 641-0211 • Fax: (970) 641-1268

214 6th Street, Suite #1, Crested Butte, CO 81224
Phone: (970) 349-6749 • Fax: (888) 540-4013

Patient Information

Today's Date_____

Full Legal Name_____
Last Name First Name M. Nickname

Date of Birth_____ **Sex** ☐ Male ☐ Female **Soc. Sec. #**_____

Employer_____ **Occupation**_____

Marital Status ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widow

Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Decline **Language** ☐ English ☐ Spanish ☐ Other_____

Race ☐ White ☐ Black ☐ Asian ☐ Indian ☐ Alaskan ☐ Pacific Isle ☐ Decline ☐ Other_____

Permanent Mailing Address

_____
PO Box (if applicable) Street Apt/Lot# City State ZIP code

Local Mailing Address (if different)

_____
PO Box (if applicable) Street Apt/Lot# City State ZIP code

Email Address_____

Phone Home_____ Work_____ Cell_____

Emergency Contact Name_____
Last Name First Name M.

Mailing Address_____
PO Box (if applicable) Street Apt/Lot# City State ZIP code

Relationship_____ **Phone**_____

Responsible Party Information

The person signing this form will be noted in our records as the "Responsible Party" of the account, and will receive financial statements from our office.

Responsible Party's Full Legal Name_____
Last Name First Name M.

Date of Birth_____ **Patient's Relationship to Responsible Party**_____

Responsible Party's Mailing Address_____
PO Box (if applicable) Street Apt/Lot #

_____ **Phone**_____
City State ZIP code

See next page, please sign at bottom.

Financial Policy

I hereby authorize payment directly to Gunnison Valley Family Physicians (GVFP) for all insurance benefits otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges, paid by insurance or not, and for all services rendered on my behalf or my dependents.**

Co-pays are due at the time of service. If you have a deductible to meet, a minimum payment of $40.00 is due at the time of service. Once we have heard back from your insurance company you will receive a bill from our office if you have any balance due beyond what is paid at the time of service. We expect prompt payment from you. If we do not receive payment from you for three consecutive billings, we may turn your account over to a collection agency. If you need to make arrangements for payment, you must discuss this with the business office.

I understand that if my account becomes past due and is turned over for collection, I will be responsible for any collection fees required to secure this obligation.

Our policy is to charge for missed appointments not canceled within 2 hours unless extenuating circumstances are communicated directly to our office. If our office is not notified within this time frame, then you will be charged $50.00 for the missed appointment. These charges will be your responsibility and billed directly to you.

- The first two no-shows or last minute cancelled appointments will result in a written notification with a $50.00 charge.
- The third no-show or last minute cancellation may result in dismissal from our practice.
- Exceptional, unavoidable circumstances will be taken into consideration by our office staff.

I understand that GVFP has the right to discharge me or my family for consistently missed appointments, no show or late appointments, delayed or no payment to an account, an account in collections, noncompliance with treatment recommendations, and/or inappropriate behavior or mistreatment of any staff member of GVFP.

If a check is returned for insufficient funds, you will be notified and charged a $30.00 service fee.

I authorize you to release to my insurance company or third party payer information concerning health care, advice, treatment, or supplies provided to me.

It is our policy to verify patient identity, address, and insurance coverage at the time of patient registration/check-in. All patients must complete and sign this form before seeing the provider. We must obtain a copy of your current, valid insurance. Please present your insurance card at every visit. If you fail to provide us with the correct insurance information within 90 days, you may be responsible for the balance of a claim.

I consent to the performance of an examination and treatment which may be deemed necessary in the opinion of the attending provider.

By signing below, I certify that I have read and understand the above and agree that I am financially responsible for all charges paid by insurance or not.

Notice of Privacy Practices / Acknowledgment of Receipt

I have received the Gunnison Valley Family Physicians notice of privacy practices. By signing below, I acknowledge this information has been supplied to me and any questions I had about it have been answered.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Posting our fee schedule is a breach of our contracts with private insurers.

Thank you for understanding our policies. Please let us know if you have any questions or concerns.

I have read and understand all of the office policies and agree to abide by them:

_____ _____

Signature of patient or responsible party Date

_____

Print name of patient or responsible party