GUNNISON VALLEY FAMILY PHYSICIANS
CERTIFIED AMERICAN BOARD OF FAMILY PHYSICIANS

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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:_____
First Name M. Last Name Preferred Name

Date of Birth:_____ **Sex:** ☐ Male ☐ Female ☐ Other **Soc. Sec. #**_____

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: Phone 1 (Cell)_____ Phone 2 (Home/Work)_____

Employer:_____ **Occupation:**_____

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed

Race: ☐ White ☐ Black/African Am ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Decline

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Decline **Language:** ☐ English ☐ Spanish ☐ Other_____

Preferred Pharmacy: ☐ City Market ☐ Clark's ☐ Walmart ☐ Other:_____

Emergency Contact Name:_____
First Name M. Last Name

Relationship:_____ **Phone:**_____

Information for who is paying the bill

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. They are responsible for paying the bill.

Responsible Party's Full Legal Name:_____
First Name M. Last Name

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.**

Payment is due at the time of service. Copays 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 may receive a bill from our office. We expect prompt payment from you. Delinquent accounts are subject to service fees if not resolved and 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 (877.622.5074).

If you need to cancel an appointment, you must notify us at least 2 hours before your appointment time. If our office is not notified within this time frame or you do not come to your appointment, then you will be charged $100.00 for the missed appointment. These charges will be your responsibility and billed directly to you.

- All no-shows or last-minute cancelled appointments will result in a $100.00 charge.
- 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, you will be notified and charged a $30.00 service fee.

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 and photo identification. Please present your insurance card at every visit. If you fail to provide us with the correct insurance information within 90 days, you will be responsible for the balance.

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

I consent to electronic communication with the office, which may include email, use of the portal, text, phone call, and telehealth appointments for my care.

I authorize you to release to my insurance company or third-party payer information concerning health care, advice, treatment, or supplies/products provided to me. (e.g., QHN, VaxCare, CIIS, pharmacy, insurance, specialists, etc.)

Please contact our billing company with all billing questions at 877.622.5074.

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, including service charges for delinquent accounts.

Notice of Privacy Practices / Acknowledgment of Receipt

I have received the GVFP 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 full 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.

Responsible Party Name (print):_____ Date:_____

Responsible Party Signature:_____