BASIN CLINIC
PATIENT INFORMATION

Today's Date ______________________

Patient Name ______________ ______________ Date Of Birth ___/___/_____ Sex: M___ F___
First Mi Last

Mailing Address ________________ Physical Address ______________________ Marital Status _____

City ________________________ State _____________ Zip_______ **Email** ______________________

Telephone Home( )_____-_______ Cell ( )_____-______ Social Security Number_____-_____-______

Permission given to leave a phone message at this number, if necessary. **Circle (1)** YES NO Initial___

Place of Birth ____________________________ Mother's Maiden name ____________________
Primary Pharmacy ___________________________ Military Status _______________

Race: Caucasian ____ American Indian/ Alaska Native ____ Black/ African American ____
Asian ____ Pacific Islander/Native Hawaiian ___
Ethnicity: Hispanic/Latino _____ I wish to not supply this information____ **Please Check One**

Employer_____________________________ **Address**______________________________

Telephone ( ) ______-________ City/State/Zip _________________________________

GUARANTOR INFORMATION (person responsible for payment other than self)

Guarantor Name ________________ Address ________________ City/State/Zip ____________________

Date of Birth ___/___/___ Sex M__F__ Social Security Number _____-_____-_______

Married, Single, Divorced, Widowed Relationship to Patient ________________________

Telephone ( ) _____-________ Employer Name ____________________________________

Employer Address __________________________________ Employer Telephone ( ) _____-________

*******PLEASE PROVIDE YOUR INSURANCE CARD(S) TO THE RECEPTIONIST*******

Are you covered by another insurance which should pay your medical bills before Medicare? _______

If so, please provide this information to the receptionist.

Please check if applicable: Liability____ Worker's Compensation ____ Auto ____ Accident ____
Date _____________ Claim # ________________

In Case Of Emergency Notify____________________________ **Telephone ( )**_______-__________

Relationship to Patient _____________________________

Please Turn Over

Basin Clinic Admission Information

PERMISSION TO TREAT: I hereby authorize Basin Clinic to provide treatment to me or my minor child:____________________________________.
Print Patient's Name

EDUCATION:
For the purpose of advancing medical knowledge, I consent to the admittance of medical residents and other paramedical observers in accordance with ordinary practices of Basin Clinic and under the supervision of a staff provider. I also consent, for the purposes of education, to the occasional taking of photographs and the preparation of drawings and similar illustrative graphic materials and the use of such photographs and materials for scientific purposes.

PAYMENT OF SERVICES AGREEMENT:
I agree to pay for medical services provided by Basin Clinic. I also agree to pay for Radiology Services, provided by Montrose Medical Imaging, and/or pathology, and laboratory services provided by Montrose Hospital which are billed separately, should these services be deemed necessary in the opinion of the medical provider at Basin Clinic. Bills for all services shall be due and payable upon receipt. If charges are not paid within 30 days of receipt, I understand that I may be liable for collection agency expenses, including reasonable attorney fees, in the event action is brought against me for failure to pay charges as billed by Basin Clinic, Montrose Hospital and Montrose Medical Imaging.

MEDICARE, TITLE XVIII AND MEDICAID, TITLE XIX:
I certify that the information given by me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or it is intermediaries or carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf.

AUTHORIZATION FOR RELEASE OF INFORMATION:
I hereby authorize the release of medical records to any person or entity that is liable under a contract for payment of any charges incurred by me as part of medical treatment provided by Basin Clinic. I understand that following the release of any medical records, Basin Clinic, Montrose Hospital, and Montrose Medical Imaging will no longer be responsible for maintaining confidentiality.

AUTHORIZATION TO DOWNLOAD MEDICATION HISTORY:
I hereby authorize the download of my medication history into my medical record via Pharmacy Benefit Managers.

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize any third party responsible for any portion of the patient's covered medical services to make payment directly to Basin Clinic and/or Montrose Hospital or Montrose Medical Imaging. I acknowledge that this is assignment of benefits is irrevocable and assigns to the medical providers all rights under my insurance policies. I further understand that I am financially responsible to Basin Clinic and/or Montrose Hospital, or Montrose Medical Imaging for charges not covered by any insurance or third party payor.

THE UNDERSIGNED HEREBY CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS THE ABOVE STATED CONDITIONS.

________________________________ Date __________
Patient or Responsible Party Signature

____
(Print Name)

________________ Address ________________ Phone __________
Relationship to Patient

Basin Clinic Financial Policy

The Basin Clinic is committed to providing you with quality healthcare. Please read the following payment policy terms and check the section that pertains to you.

____1. Patient With Insurance_ MUST PRESENT INSURANCE CARD EACH VISIT. Any co-payments, co-insurance, or non covered services are due on the day of your visit. In the event payment in full cannot be made, notify the front desk and you will be required to sign a mutually satisfactory payment arrangement form. Any balance due remaining after your insurance has completed your claim is due within (30) thirty days.

____2. Patient Without Insurance- Payment in full is expected at time of your visit. We accept Cash, Checks, Credit/Debit cards. In the event payment in full cannot be made notify the front desk and you will be required to sign a mutually satisfactory payment arrangement. A 10% discount will be applied for all services paid at time for service.

____3. Patient with Worker's Compensation- It is your responsibility to report your injury to your employer. The front desk will verify with your employer, prior to being seen, that the report is on file.

If you are insured by a plan that we are not contracted with, we will kindly submit your claim but payment in full is expected at each visit.

If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

If your account is over 90 days past due and you have failed to pay any balance due or fail to honor your payment arrangement, your account will be referred to an outside collection agency. If this happens you will be responsible for all amounts due plus costs associated with collection, courts, and attorney fees.

I authorize Basin Clinic to release to my insurance carrier (s) and/or CMS an it's agents and/or my secondary insurer any information needed to determine benefits or benefits payable for related services.

I have read and agree to this Financial Policy and Release of Information stated above that applies to me.

________________________________ ________________
Patient or Responsible Party Date

________________________________ ________________
Print Person Signing on behalf of patient Reason Patient Can NOT sign

____
Relationship to patient Home Address Telephone

Basin Clinic Inc.

421 W. Adams St · PO Box 340 Naturita, CO 81422
970-865-2665 ph 970-865-2674 fx

Providing Quality Health Care

THE INFORMATION YOU PROVIDE ON THIS FORM IS ONLY USED TO HELP FUND THE CLINIC THROUGH GRANTS FROM FOUNDATIONS.
Please ask the receptionist if you have any questions.

NAME:______________________________DATE____________________

FROM SCALE BELOW FOLLOW YOUR FAMILY SIZE OVER TO ANNUAL INCOME AND CIRCLE THE CORRESPONDING LETTER

Family Size	Z	N	A	B	C	D
1	$0 - $4,824	$0 - $4,824	$4,825 - $7,477	$7,478 - $9,769	$9,770 - $12,060	$12,061 - $14,110
2	$0 - $6,496	$0 - $6,496	$6,497 - $10,069	$10,070 - $13,154	$13,155 - $16,240	$16,241 - $19,001
3	$0 - $8,168	$0 - $8,168	$8,169 - $12,660	$12,661 - $16,540	$16,541 - $20,420	$20,421 - $23,891
4	$0 - $9,840	$0 - $9,840	$9,841 - $15,252	$15,253 - $19,926	$19,927 - $24,600	$24,601 - $28,782
5	$0 - $11,512	$0 - $11,512	$11,513 - $17,844	$17,845 - $23,312	$23,313 - $28,780	$28,781 - $33,673
6	$0 - $13,184	$0 - $13,184	$13,185 - $20,435	$20,436 - $26,698	$26,699 - $32,960	$32,961 - $38,563
7	$0 - $14,856	$0 - $14,856	$14,857 - $23,027	$23,028 - $30,083	$30,084 - $37,140	$37,141 - $43,454
8	$0 - $16,528	$0 - $16,528	$16,529 - $25,618	$25,619 - $33,469	$33,470 - $41,320	$41,321 - $48,344
9	$0 - $18,200	$0 - $18,200	$18,201 - $28,210	$28,211 - $36,855	$36,856 - $45,500	$45,501 - $53,235
10	$0 - $19,872	$0 - $19,872	$19,873 - $30,802	$30,803 - $40,241	$40,242 - $49,680	$49,681 - $58,126
11	$0 - $21,544	$0 - $21,544	$21,545 - $33,393	$33,394 - $43,627	$43,628 - $53,860	$53,861 - $63,016
12	$0 - $23,216	$0 - $23,216	$23,217 - $35,985	$35,986 - $47,012	$47,013 - $58,040	$58,041 - $67,907
13	$0 - $24,888	$0 - $24,888	$24,889 - $38,576	$38,577 - $50,398	$50,399 - $62,220	$62,221 - $72,797
14	$0 - $26,560	$0 - $26,560	$26,561 - $41,168	$41,169 - $53,784	$53,785 - $66,400	$66,401 - $77,688
15	$0 - $28,232	$0 - $28,232	$28,233 - $43,760	$43,761 - $57,170	$57,171 - $70,580	$70,581 - $82,579
16	$0 - $29,904	$0 - $29,904	$29,905 - $46,351	$46,352 - $60,556	$60,557 - $74,760	$74,761 - $87,469
Poverty Level	40% & Homeless	40%	62%	81%	100%	117%

Family Size	E	F	G	H	I
1	$14,111 - $16,040	$16,041 - $19,175	$19,176 - $22,311	$22,312 - $24,120	$24,121 - $30,150
2	$19,002 - $21,599	$21,600 - $25,822	$25,823 - $30,044	$30,045 - $32,480	$32,481 - $40,600
3	$23,892 - $27,159	$27,160 - $32,468	$32,469 - $37,777	$37,778 - $40,840	$40,841 - $51,050
4	$28,783 - $32,718	$32,719 - $39,114	$39,115 - $45,510	$45,511 - $49,200	$49,201 - $61,500
5	$33,674 - $38,277	$38,278 - $45,760	$45,761 - $53,243	$53,244 - $57,560	$57,561 - $71,950
6	$38,564 - $43,837	$43,838 - $52,406	$52,407 - $60,976	$60,977 - $65,920	$65,921 - $82,400
7	$43,455 - $49,396	$49,397 - $59,053	$59,054 - $68,709	$68,710 - $74,280	$74,281 - $92,850
8	$48,345 - $54,956	$54,957 - $65,699	$65,700 - $76,442	$76,443 - $82,640	$82,641 - $103,300
9	$53,236 - $60,515	$60,516 - $72,345	$72,346 - $84,175	$84,176 - $91,000	$91,001 - $113,750
10	$58,127 - $66,074	$66,075 - $78,991	$78,992 - $91,908	$91,909 - $99,360	$99,361 - $124,200
11	$63,017 - $71,634	$71,635 - $85,637	$85,638 - $99,641	$99,642 - $107,720	$107,721 - $134,650
12	$67,908 - $77,193	$77,194 - $92,284	$92,285 - $107,374	$107,375 - $116,080	$116,081 - $145,100
13	$72,798 - $82,753	$82,754 - $98,930	$98,931 - $115,107	$115,108 - $124,440	$124,441 - $155,550
14	$77,689 - $88,312	$88,313 - $105,576	$105,577 - $122,840	$122,841 - $132,800	$132,801 - $166,000
15	$82,580 - $93,871	$93,872 - $112,222	$112,223 - $130,573	$130,574 - $141,160	$141,161 - $176,450
16	$87,470 - $99,431	$99,432 - $118,868	$118,869 - $138,306	$138,307 - $149,520	$149,521 - $186,900
Poverty Level	133%	159%	185%	200%	250%

Poverty Level refers to the percent of Federal Poverty Level which corresponds to the upper limit of income in each rating level.
Rev. 3/2017

Basin Clinic Inc.

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970-865-2665 ph 970-865-2674 fx

Providing Quality Health Care

We are honored that you have chosen us as your healthcare provider. Today we have exciting news regarding your health management!

As we continue in our efforts to provide our patients with the highest quality of care, we are constantly looking for methods of working together with you to ensure that you are not only aware of, but also involved in the management and improvement of your health.

We are proud to inform you that our practice now offers the opportunity to use the power of the web to track the most important aspects of your healthcare through our office.

Participating patients are given secure User IDs and passwords, enabling them to access the Portal to view their personal health record, whenever it is convenient for them.

For the patients that have an e-mail address: We can set up your portal account and an e-mail will be sent to you with your User name and password.

Please write your e-mail address here: ______________________________

If you don't have an email address, we can still set up a portal account for you. You can access it at any computer that you know is a secure location by using the following Portal address: https://basinclinic.myupdox.com. We will provide you with a username and password.

If you have any questions or concerns, please call Pamela Stamm at Basin Clinic 865-2665 #3. If she is not available, please leave a message and she will return your call.

Please complete and return this form to the receptionist

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Providing Quality Health Ca

PRIVACY PRACTICE ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practice and have been provided the opportunity to review it.

Date______________________

Patient Name__________________________ Birthdate________

Signature____

Please complete this section if you would like Basin Clinic to share your medical information with the person/people listed below, such as, a spouse, family, friends, or caregivers.

I_______________________________________authorize Basin Clinic to release and or share my medical information with the following person/people.

Name_____________________________ Relation___________

Name_____________________________ Relation___________

Name_____________________________ Relation___________

Name_____________________________ Relation___________

Patient Signature_________________________ Date_________