Colorado PHYSICIAN PARTNERS
ColoradoPhysicianPartners.com

Patient Information

Patient Name:	Today's Date:
Address:	Patient DOB: Sex:
City:	Preferred Name:
State: Zip:	SSN:
Home Phone:	Provider:
Cell Phone:	Race:
Work Phone:	Ethnicity:
Email:	Language:

Consent for Methods of Contact

Colorado Physician Partners has my permission to share medical information and advice with me in the following ways (please check all that apply):

☐Voicemail ☐Text Message ☐Email
☐Home ☐Cell ☐Work
☐Other_____

Telephone Consumer Protection Act Consent

To increase efficiency, Colorado Physician Partners and its practices may contact you using an automated telephone dialing system. Please indicate below whether you consent to this type of contact.

☐ I hereby authorize Colorado Physician Partners and its employees, agents, and assignees to contact me via email, text messaging, and to my cellular devices using automated telephone dialing systems or an artificial or prerecorded voice.

☐ I do not authorize Colorado Physician Partners to contact me using an automated telephone dialing system or an artificial or prerecorded voice.

Emergency Contact

Name:	Phone:	Relationship to patient:

Contacting Others

Colorado Physician Partners has my permission to share a limited amount of my information with the following people only when it is directly relevant to their involvement in my healthcare or payment for my healthcare:

Name:	Phone:	Relationship to patient:
Name:	Phone:	Relationship to patient:
Name:	Phone:	Relationship to patient:

Guarantor Information

Guarantor Name: ☐Same as patient	Guarantor DOB:
Guarantor Address:	Guarantor Phone:
City:	Guarantor Relationship to Patient:
State: Zip:	

Insurance Information

Primary Insurance:	Secondary Insurance:
ID Number:	ID Number:
Group Number:	Group Number:
Group Name:	Group Name:
Subscriber Name: ☐Same as patient	Subscriber Name: ☐Same as patient
Subscriber DOB:	Subscriber DOB:

Authorization to Pay Benefits to Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my provider, Colorado Physician Partners, when they accept assignment.

Authorization to Release Medical Information: I hereby authorize Colorado Physician Partners to release any information necessary for my course of treatment to my insurance provider.

_____ _____

Patient (or personal representative) Signature Date