Dr Monique Maly MD

Conifer Integrative Family Medicine

Cancellation policy

We do not double book any appointments and reserve a generous amount of time for each appointment to fully respect the time we spend with you. We ask that you respect our time also. It is especially important to us that you notify us in a timely manner if you are unable to make your scheduled appointment.

We ask that you give us 24 hours notice in the event cancellation is needed. If there is no communication, then we will proceed with billing you at a rate of 50% of the amount of the scheduled visit.

Name _____ Date _____

Signature: _____

Consent for SMS Text messaging

By signing below, I authorize Dr Monique Maly through her vendor texting service to contact me by SMS text message to serve me better. Text messages are not always secure. Messages travel over networks that Dr. Maly does not own or control. We cannot promise that any one else will see one of your text messages. For example, if you lose your cell phone or you let someone else use your phone, that person might see your communications between Dr. Maly and yourself.

It is not mandatory that we participate in text messaging. If it is your desire to allow text message communication please sign and date the form below.

I may opt out of receiving these communications at any time by notifying Dr. Maly.

Name:_____ Date: _____

Signature: _____

Payment policy

Dr. Maly's office works on a cash payment basis for office visits. She is not contracted with insurance companies. She may be considered an out of network provider.

We do take payment at the time of service with check or credit card.

We do not submit paperwork to your insurance company for you. We can, however, provide the necessary receipts for you to submit on your own. You may be eligible for some reimbursement towards your office visit expenses as long as you have out of network benefits. Since Dr. Maly does provide a medical service, you may also be able to use flex spending benefits and health savings account monies that you have set aside.

You may find that any lab work and testing may be covered by your insurance. We try to recommend in network labs for you as much as we can. Some of the testing Dr. Maly recommends is through out of network labs as well. You may have some coverage for this depending on your out of network benefits and deductible. It is up to you to call your insurance to check on your individual coverages for testing.

Due to Dr. Maly's comprehensive approach, fees are determined by the length of each visit.

I Understand and agree to the terms above:

Name: _____

Signed: _____ Date: _____

CONIFER INTEGRATIVE FAMILY MEDICINE
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

TREATMENT

We will use and disclose your protected health information to provide, coordinate, or mange your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situation without your authorization or providing you the opportunity to agree or object. These situations include:

1) **Required by Law**
2) **Public Health**
3) **Communicable Diseases**
4) **Health Oversight**
5) **Abuse or Neglect**
6) **Criminal Activity**
7) **Military Activity and National Security**

YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice may use for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

COMPLAINTS

You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective when patient signs it.

_____ _____

Signature Date

Conifer Integrative Family Medicine
Monique Maly, M.D.

Patient Registration

Name:_____ Date:____/____/___

Address:_____ City:_____State:____Zip:_____

Home Phone: (____)_____-_____ Cell Phone: (____)_____-_____

Work Phone: (____)_____-_____ Employer: _____
Is it OK to leave a message at any of these numbers? (Yes) (No) If so, please circle.

Email Address:_____
Is it OK to email you information at your email address? (Yes) (No)

Date of Birth:____/____/____ Age:_____Gender (M / F) Social Security #_____

Responsible Party: (Billing Responsibility)

Name:_____Relationship to Patient: __Self __Spouse __Parent __Other

Address:_____City:_____State:_____Zip_____

Home Phone: (___)_____-_____ Cell Phone: (___)_____-_____

Work Phone: (___)_____-_____ Employer:_____

Who To Notify in Case of Emergency:

Name:_____Relationship to Patient: __Self __ Spouse ___Parent__Other

Address:_____City:_____State:_____Zip:_____

Home Phone: (___)_____-_____ Cell Phone: (___)_____-_____

Work Phone: (___)_____-_____ Employer:_____

- **I understand that I am ultimately responsible for payment for services and or supplies.**
- **I understand that I am responsible for understanding my individual insurance coverage.**
- **I will make any disputes of charges at the time of service. All charges will remain as charged on the day of service.**
- **I understand that I Will be charged a fee for appointments that are not cancelled within 24 hours.**
- **I understand that I Will be charged a mimimum fee of $40.00 for each returned check.**

Signature:_____

Conifer Integrative Family Medicine
Monique Maly, M.D.

Patient Registration (Page 2)

Insurance Information:

Insurance Plan: (Name) _____

Insurance Plan: (Address) _____

Policy Number:_____ **Group Number:**_____

Responsible Party: _____
(Through whom the policy has been obtained)
Date of Birth:_____
Employer:_____
Work Phone:_____

Your relationship to the Responsible Party:_____
__Self ___Spouse ___Child ___Other

Is there a secondary insurance plan? _____Yes _____No

Please be sure to fill in the information above and give us your insurance card to copy if you would like us to generate a health insurance claim form for you.

Other information that is helpful to us in caring for you:

Your marital status: ___Single ___Married___ Divorced ___Widowed ___Other
Your Occupation: _____

Pharmacies that you prefer to use:

Name: _____ **Number:** _____
Name: _____ **Number:** _____

Laboratory that you prefer to use for routine lab work that is convered under your insurance plan:
____Quest Diagnostics Laboratory
____Boulder Community Reference Laboratory
____LabCorp
____Other: _____**Phone:** _____