GREEN MOUNTAIN
PARTNERS FOR HEALTH

Welcome to Green Mountain Partners for Health! Dr. Boyd and Dr. Francavilla created a small, independent practice because we believed it was the best way to care for patients. We pride ourselves in taking medicine back to the basics. We focus on partnering with our patients to provide personalized care, preventing health problems before they start, and being here when you need us. We believe your appointment time should be your appointment time, that you should have enough time with your provider, and that you should be able to get in for an appointment or reach your doctor when you need one. We love taking excellent care of our patients and building relationships. In order to be able to provide this level of care, we ask that you read over the following services and policies:

YOUR FIRST VISIT

Before your initial visit, please notify your health insurance company of your new primary care provider, if required. Please bring all your medications with you to the first appointment so we accurately prescribe them. Due to insurance limitations, we are not able to see you for BOTH a physical/wellness visit and managing medical issues at your first visit. We will try to help direct you towards what type of appointment is best for your first visit.

WELLNESS VISITS AND PHYSICALS

We recommend these yearly. The goal of a wellness visit or physical is to focus on wellness and preventive care, ideally when you are feeling well. Your provider will evaluate your need for vaccines, labs and screening tests based on age, gender, family history, your personal health and goals. We will then customize a plan to keep you healthy. If you have a specific concern, problem or need for medication refill you usually need a separate office visit to address these while your well exam or physical is usually included with insurance. If you do have a specific issue addressed as part of your physical or wellness visit, you will likely have additional charges as this will be considered an office visit in addition to your physical/wellness visit.

APPOINTMENTS

Here at Green Mountain Partners for Health, we believe your time is valuable and have created a process to limit wait times, usually eliminating them altogether. Your appointment time is almost always your actual visit time. In order to keep on schedule, please arrive 15 minutes prior to your first appointment to complete any necessary forms and obtain copies of your insurance card and government issued photo identification. Should you be delayed by more than 10 minutes please contact the office as we may need to re-schedule. Also, please cancel any appointments at least 24 hours in advance. Cancellations less than 24 hours in advance or arriving too late to be seen, will count as a “no-show”. If you “no-show” more than 2 times, you may be asked to find a new doctor’s office.

You may schedule appoints online at: www.DrFrancavilla.com or www.JamesBoydMD.com or by phone. If you need an urgent appointment, please call and we will do our very best to get you an appointment the same or next day, as appropriate.

Starting in 2017, we will be offering video consultations and phone consultations. Many of the main insurance providers will cover services for video consultations (with the exception of

Medicare). Phone consultations are generally not covered by insurance, but will be offered at $40.00. This can often save you a trip to the office. Not all issues can be treated over the phone or video visit and may necessitate an in person appointment.

PATIENT PORTAL

You will receive an invitation, by email, to access our Patient Fusion portal. This portal allows convenient communication with your provider and can be used to send and receive messages, make an appointment, view your medical history and get copies of your results. Our staff are happy to help if you have any difficulty accessing any information. Please do not use the patient portal for urgent communication.

YOUR INSURANCE PLAN

We do our best to send you to the correct lab, imaging center, or specialist for your insurance, but it is your responsibility to know if you have any special requirements from your insurance and to understand the cost of these services. The benefits included in your insurance, and the costs of your medical care are a contract between you and your insurance plan and it is your responsibility to know what is covered by your insurance plan.

PAYMENT

Please bring payment for any co-payments you will owe, according to your insurance benefits, to your office visit. If you have a high deductible plan, you may be asked to pay a percentage at your first visit. If you have a balance due, you may be asked to pay a portion of that balance before you can be seen.
If you are "self-pay" (without insurance), you will be asked to pay for your visit at the time of service. You will get a 30% discount for paying at the time of service.

AFTER HOURS CARE

Should you need urgent medical care after hours please contact the on call physician by calling the office at 303-566-7170, option 9. We can help you decide if you need to go to the emergency room, urgent care, can wait for a visit with us, or can have your problem solved by phone. If a medication is prescribed for a new problem you may be charged for a telephone visit. This can keep you from having to go to an urgent care or ER if it is an issue we can safely treat by phone.

SUPPLEMENTS

We know sometimes it is hard to find the right and best quality supplement that your doctor has recommended. Comparable versions of our supplements can be purchased at drug stores or online. We offer high quality versions of the supplements we often recommend, for purchase in our office, for your convenience. We also offer a meal replacement program as part of Dr. Francavilla's Colorado Weight Care program. These products are offered as part of one of many treatment options for weight loss.

Thank you for trusting Green Mountain Partners for Health with your care!

GREEN MOUNTAIN PARTNERS FOR HEALTH

PATIENT REGISTRATION HEALTH SUMMARY

Patient name (please PRINT):_____ DOB:_____

Mailing Address: _____City:_____State:___ Zip:_____ Male __Female__

Marital Status:_____ Education:_____ SSN_____

Email Address: _____ Employer Name _____

Cell Phone #: (_____) _____Home Phone #: (_____) _____Work Phone #: (_____) _____

Insurance Information (Please provide your insurance card at the time of registration or if you have a policy change).

Please complete this section if patient is a minor (if patient is under the age of 18)
Responsible Party Name:_____ _____DOB:_____

Relationship to Patient:_____ Primary Phone #: (_____) _____

Address:_____ City:_____State:_____Zip Code:_____

Emergency Contact
In case of an emergency, contact:_____ Phone #: (_____) _____

Relationship to patient: _____

Insurance Authorization and Assignment of Benefits:
I hereby authorize payment directly to Green Mountain Partners for Health(GMPH), PLLC and authorize the release of any medical information necessary to process insurance claims and for utilization review and quality assurance. I voluntarily consent to treatment for myself and/or dependents. I understand that I am financially responsible for all charges not covered or billed to any insurance or third party payor and/or not paid to GMPH. . Should the account be turned over to collections, I will pay all costs of collection including, but not limited to, agency fees, attorney fees and court costs. I further understand that a monthly finance charge of 1.5% (18.00% annually) will be assessed on any unpaid balance.

Patient/Guardian Signature:_____ **Date:** _____

(If patient is a minor, parent/legal guardian must sign on their behalf)
Relationship to patient: _____

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Patient name (please PRINT):_____ DOB:_____

ALLERGIES **(and reaction)** **NONE: _____**

MEDICATIONS **NONE: _____**

What medications are you taking (including birth control pills, herbals, vitamins, dietary supplements, and over-the counter)?

PRESENT HEALTH CONDITIONS

YES	NO	DISEASE		YES	NO	DISEASE
		Irregular Heart Beat				Prostate Problems
		Congestive Heart Failure				Gout
		Heart Attack				Arthritis
		Heart Murmur				Skin Disease, Type:
		Rheumatic Fever				Stroke
		High Cholesterol				Epilepsy/Seizures
		High Blood Pressure				Diabetes/High Blood Sugar
		Asthma				Thyroid Problems – too high or too low
		Emphysema/Chronic Bronchitis				Anemia/Low Blood
		Blood Clot in Lung				Bleeding Problems, Type:
		Blood Clot in Leg				Blood Transfusion
		Tuberculosis				Cancer, Type:
		Gallstones				Anxiety
		Liver Disease, Type:				Depression
		Ulcers in Bowel/Stomach				Glaucoma
		Bleeding from Bowels				Other:
		Kidney Disease, Type:				Other:
		Kidney Stones				Other:

SURGERIES

YES	NO	DISEASE		YES	NO	DISEASE
		Cataract Surgery, Left Right				Joint Replacement of Knee / Hip
		Tonsils Removed				Back Disc Surgery
		Neck Artery Surgery				Prostate Surgery
		Open Heart Surgery/Catheterization				Hernia Surgery
		Appendectomy				Vasectomy
		Gallbladder Removal				Hysterectomy
		Abdominal Surgery				Other:
		Broken Bone Repair				Other:
		Joint Scope Surgery				Other:

Patient name (please PRINT):_____ DOB:_____

FAMILY HISTORY

YES	NO	DISEASE	RELATION TO YOU	YES	NO	DISEASE	RELATION TO YOU
		Heart Attack				Bleeding Problems	
		High Blood Pressure				Sickle Cell Anemia	
		High Cholesterol				Diabetes/High Blood Sugar	
		Asthma				Thyroid Problems	
		Tuberculosis				Cancer, Type:	
		Liver Disease				Cancer, Type:	
		Kidney Disease				Alcohol Abuse	
		Gout / Arthritis				Anxiety	
		Osteoporosis				Depression	
		Stroke				Glaucoma	
		Epilepsy / Seizures				Other:	

OTHER HISTORY

Exercise: ____ Days per week Type of exercise:_____

When was your last: Tetanus _____ Hepatitis B _____ Pneumovax _____ HPV _____ MMR_____
Shingles Vaccine_____

Smoking:
Have you ever smoked: ___ Yes ___ No How many years did you smoke? _____ When did you quit? _____
How many packs per day do you smoke now? _____ Do you use smokeless tobacco: ___ Yes ___No

The following questions are very important and strictly confidential. Please answer them accurately.

Alcohol/Drugs:

__ Yes __ No Do you drink? How much? _____ How often? _____

__ Yes __No Do you use drugs? How much? _____ How often? _____ What kind? _____

What drugs have you used in the past?_____

FEMALE PATIENTS ONLY

# of Pregnancies: _____ # of Deliveries: _____ # of Elective Abortions: _____ # of Miscarriages: _____

When was your last menstruation? _____ How old were you when you went through Menopause? _____

When was your last Pap smear? _____ Have you ever had an abnormal Pap smear? __ Yes __No

If "Yes," when was the abnormal Pap smear? _____

What was the abnormality? _____

What kind of treatment did you have?_____

When was your last Mammogram? _____ Have you ever had an abnormal Mammogram? __ Yes __No

If "Yes," when was the Mammogram? _____

The above information is current and correct to the best of my knowledge.

_____ _____
Patient/Guardian Signature **Date**

I have reviewed the above history.

_____ _____
Physician's Initial **Date**

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Name of Patient: _____ Patient Date of Birth: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices with the effective date of 6/30/2016.

- We are required by law to maintain privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and have a copy of it available for you.
- We will not use or share your information other than as prescribed here unless you tell we can in writing. You may change your mind at any time. Let us know in writing if you change your mind.

_____ _____
Signature of Patient/Patient Representative Date

_____
Relationship to Patient

Consent to Leave Messages

Green Mountain Partners for Health at times, we may need to contact you about test results, appointments, referrals or billing/insurance information. By filling out the information below, we will be better able to serve you. In an effort to protect your privacy and follow federal guidelines, we have developed on leaving medical care messages. Unless we have written permission to do so:

- We will NOT leave messages with anyone except the patient or legal guardian
- We will NOT leave messages on voice mail or answering machines
- We will NOT send emails

Please read below and carefully consider who, if anyone, you want to have access to your medical/account information.

I, _____ give my permission for Green Mountain Partners for Health to leave **phone** messages regarding my medical care/account information. I fully understand that this consent will remain valid until revoked in writing by me.

I, _____ give my permission for Green Mountain Partners for Health to send **email** messages regarding my medical care/account information. I fully understand that this consent will remain valid until revoked in writing by me.

Who else may we share your test results with on your behalf? Circle: Spouse/Partner/Mother/Father/Child
If yes, name: _____

Signature: _____ Date: _____

GREEN MOUNTAIN PARTNERS FOR HEALTH
Patient Responsibilities

Name of Patient: _____ Patient Date of Birth: _____

___ Notify your health insurance company of your new primary care provider, if required.

___ Specific concerns or medication refills may require an office visit separate of a wellness exam of physical.

___ If you have specific issues addressed during your wellness exam or physical you will likely have additional charges.

___ Bring government issued photo identification and insurance cards to every visit.

___ Contact the office if you're delayed more than 10 minutes as we may need to reschedule.

___ Cancel any appointments at 24 hours in advance. Cancellations with less than 24 hours notice will count as a “no show”.

___ If you “no show” more than twice you may be asked to find a new doctor's office.

___ It is your responsibility to know if you have any special requirements from your insurance in regards to referrals or other care and to understand the cost of all services provided.

___ Co-payments you will owe, according to your insurance, are due at your appointment.

___ If you have a balance due you may be asked to pay a portion of that balance before you can be seen.

___ If you are “self pay” (without insurance) you will be asked to pay for your visit at the time of service. You will receive a 30% discount for paying at the time of service.

___ Refills must be requested through your pharmacy and if you are out of medication it probably means you are due for another appointment.

___ You must be seen to get refills of controlled substances. These cannot be filled more than 90 days at a time.

___ Payment for service with large deductible plans is due at the time of the appointment.

___ Insurance Authorization and Assignment of Benefits
I hereby authorize payment directly to Green Mountain Partners for Health, PLLC and authorize release of any medical information necessary to process insurance claims and for utilization review and quality assurance. I voluntarily consent to treatment for myself and/or dependents. I understand that I am financially responsible for all charges not covered or billed to any insurance or third party payor and/or not paid to Green Mountain Partners for Health. Should the account be turned over to collections, I will pay all costs of collection including, but not limited to, agency fees, attorney fees and court costs. I further understand that a monthly finance charge of 1.5% (18.00% annually) will be assessed on any unpaid balance.

PATIENT/GUARDIAN SIGNATURE: _____ Date: _____
(If patient is a minor, parent/legal guardian must sign on their behalf)