James Chappell, MD, PC

James Chappell, M.D.

6740 E. Hampden Ave., Suite 210

Denver, CO 80224

### Phone: 303-722-4683 • Fax: 303-778-0726

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Account #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Appointment Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Future Patient:

 We appreciate your interest in our office, and we would like to welcome you to our specialty practice in Endocrinology, Diabetes and Metabolism. Many patients come to us from significant distances at the referral of other physicians, friends and relatives. Our patients often have complex problems that need intensive time and effort to evaluate and treat comprehensively, without Managed Care short-cuts. Our philosophy is to either “do it right or not at all”.

 In a medical world gone awry … where every conceivable party, from the federal government to insurance company clerks, have invaded the physician-patient relationship, something very important has gotten lost in the rush of today’s health care shuffle. That something is **TRUST**. Some patients today have good reason to wonder … whether their physician has taken the time necessary to thoroughly evaluate their problem and educate them adequately about it, including a review of all available treatment options.

 We realize that there is something fundamentally wrong with our nation’s medical care system when many physicians feel trapped in the grasp of “corporatized” (HMO and Managed Care) medicine, but powerless to “change the system.” We have chosen another path. Understanding that we cannot “change the system,” we realize we can only change how we practice medicine. We have broken away from all managed care plans. Rather than handing over what little control we have left over the patient care environment to others, we have taken back complete control and designed treatment protocols with nothing but the patient’s interest in mind. It is our practice to recommend only what is best for you, not what is best for your insurance company or their company pocketbook.

 We offer our patients service that you simply will not find in other medical practices. Since there is still no adequate substitute for genuine “face-to-face” time between patient and physician for discussion of important issues, we reserve a full hour for your initial consultation sessions and 15 minutes for your follow-up visits. You will not be rushed, and all of your questions will be answered. Fees are stated in the Financial Policy.

 Your first visit will include a complete history and physical. If any laboratory tests are ordered, these will be done in the office

 prior to your departure, or at a convenient laboratory draw center. Any other diagnostic tests will be done at a later date and we will help you to arrange this appointment. After your visit, a letter will be sent to your other physicians and you will receive a copy of any laboratory results obtained during your office visit. Laboratories will be billed to your insurance by the laboratory and radiology procedures will be billed to your insurance by the radiology department where your procedure was done.

OUR MISSION, simply stated, is to maintain a medical practice environment in which we can treat you the way we ourselves would like to be treated if we were in your place. While most so-called “experts” say that this is simply not possible anymore, we do it every day! To these “experts” we say that the importance of a patient’s trust in their physician should never be underestimated.

 We invite you to experience the best that private medicine has to offer.

**James Chappell, MD, PC**

**PATIENT INFORMATION**

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name First Name Middle Initial

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip Code

Date of Birth: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_ Home Phone Number: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Month Day Year

Work Phone Number: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone Number: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SS#:\_\_\_\_\_-\_\_\_\_-\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Single □ Married □ Divorced □ Separated □ Widowed □

Female □ Male □

Primary Care Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_ Fax: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SPOUSE OR EMERGENCY CONTACT PERSON**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name First Name Initial

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip Code

Home Phone Number:(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone Number:(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SS#:\_\_\_\_\_-\_\_\_\_-\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**VOICE MESSAGE CONSENT**

I authorize you to leave a message(s) for me at the following number(s) listed below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT TO SHARE MEDICAL INFORMATION**

I give my permission to release or exchange information regarding my medical condition and treatment between my endocrinologist, his staff, other treating physicians and my family members/contact persons.

Yes □ No □

If yes, please provide the following:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing this form I understand all information shared is considered confidential. I authorize the release of any medical information necessary to process a claim and all future claims by the patient.

SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Financial Policy**

As a result of our sincere desire to base all medical decisions on what is best for the patient, not what is best for the insurance company, we are no longer contracted with any insurance carriers. For the purpose of transparency, the following is our financial policy.

1. All charges must be paid upon check-in at the time of service and our treatment fees are the same for all patients, regardless of insurance coverage or not, as is required by law. Fees for new patients with a diagnosis of diabetes, pre-diabetes, metabolic syndrome, PCOS or weight management will be $380.00 for commercially insured/uninsured patients and $350.00 for Medicare, Tricare and Medicaid patients. Fees for new patients with a diagnosis other than diabetes, pre-diabetes, metabolic syndrome, PCOS or weight management will be $350.00 for commercially insured/uninsured patients and $300.00 for Medicare, Tricare and Medicaid patients. The fee for follow up appointments will be $175.00 for commercially insured/uninsured patients and $150.00 for Medicare, Tricare and Medicaid patients.

2. The contract with your insurance company to pay for a portion of your medical care is between you and your insurance company. By eliminating costs associated with billing, coding diagnoses, procedures, referrals, authorizations, payment delays, EOB reviews, claim denials, re-submissions, collection risks, and other managed care costs, we can provide patients a fair price for services without the administrative hassles and bureaucracy.

3. For your benefit, we will provide you with copy of the super-bill, listing our fees and diagnostic codes at the end of the visit. This is for you to copy and submit to your insurance provider. We recommend you contact your insurance carrier to verify your benefits so you will have a basic understanding of how your insurance will reimburse you for services provided by our office. Your insurance policy may consider Dr. Chappell either “In-network” or “Out-of-Network” and your reimbursement may vary accordingly. Unfortunately, insurance carriers are not always willing to provide their allowable fees or disclose which billing codes they will cover. If this is the case, you may want to contact the Colorado Department of Insurance. www.dora.colorado.gov/insurance

4. It is your responsibility to obtain all referrals/authorizations required by your insurance plan, prior to your visit and to file your claim with your referral/authorization. Dr. Chappell will under no circumstance, contact or discuss any billing issues with your insurance.

5. You will be given a completed billing form with all the diagnostic codes and billing code necessary for you to file a claim with your insurance carrier. We recommend you contact your insurance carrier and request instructions for filing your claims. Note: Colorado State Law requires insurance carriers to process your health insurance claim within 30 days of receipt of a “clean” claim. (Colorado Revised Statutes 2013, Health Care Coverage, Title 10, Article 16, 10-16-106.5, Prompt Payment of Claims-Legislative Declaration-Rules)

6. Due to rising administrative costs and the numerous requests we receive, our office does not fill out “forms” from insurance companies. A copy of the patient’s medical records will be forwarded to the insurance company when a signed authorization to release medical records is received. Their medical review professionals can extract the information required from these records. A copying fee will be required prior to release of the copied records and is the responsibility of the insurance company. If you request a copy of your medical records, there will be a copy fee of $18.50 for the first 1-10 pages, an additional $0.85 per page from pages 11-40 and an additional $0.57 per page for additional pages copied after 40. If the records need certified, a $10.00 fee will be assessed. These fees are determined by the Colorado Medical Board. If you request that the physician fill out “**any forms**”, a $25.00 fee may be assessed for forms up to 2 pages and an extra $10.00 for each additional page after the first 2 pages. Most “forms” including FMLA forms should be filled out by your primary care physician.

**7. Please Note:** We do not charge interest, therefore, we are unable to offer in-house financing or payment plans. If you are unable to pay for your services upon check-in for your appointment in full with cash, check or money order, you may put the balance on your credit card and make monthly payments to your credit card company. Payment for services made after the office visit, if a bill is issued, will incur an additional $50.00 billing fee as a billing service will need to be hired in order to process the bill.

**8. Medicare:**

Dr. Chappell has chosen to “Opt Out” of Medicare. All patients who are on Medicare, or are eligible for Medicare, must sign the federally mandated “Private Contract” in order to receive services at our clinic. All services, must be paid in full at the time of service and neither Dr. Chappell, nor the patient may file a claim to Medicare for reimbursement. Some secondary insurers will cover part or all of the cost of the office visit if Medicare will not cover the office visit. However, it is your responsibility to obtain this information from your secondary insurer.

**9. Champus/Tricare:** We are not an active Champus/Tricare/Tricare for Life provider. We will NOT accept Champus/Tricare/Tricare for Life insurance, we will NOT file any claims to Champus/Tricare/Tricare for Life and we will NOT accept the Champus/Tricare/Tricare for Life fee schedule for reimbursement of our services.

10. **Workers Compensation:**

Dr. Chappell does not see workers compensation cases. If you are under workers compensation, he is willing to see you for your endocrinology issues, but will not do workers compensation, comment on work related injury or accept any workers compensation payments now or in the future. Any workers compensation form or paperwork must be done by your primary care physician or your workers compensation physician.

11. **No Shows or Late Cancelations:**

Dr. Chappell makes his living caring for patients. If an appointment is made, that time is reserved only for you. If you do not show for the appointment, Dr. Chappell cannot earn a living. If an appointment is canceled late, there is not enough time to fill that appointment slot. Dr. Chappell requires at least 24 hours notice for a cancelation. No shows and cancelations less than 24 hours prior to the appointment time will incur a fee equal to the cost of the appointment ($175.00 for insured/uninsured and $150.00 for Medicare, Tricare or Medicaid for follow up appointment an $300.00-$380.00 for new patients depending on the category noted in section 1 above). Extenuating circumstances will be taken into account.

By signing this document, you are agreeing to pay for our services in full and forego any insurance benefits/discounts.

I have read, understand and agree to the terms and conditions listed above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Parent if Patient is a Minor Date

|  |
| --- |
| **Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Account: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Dr. James Chappell M.D., P.C. Notice of Privacy Practices for Protected Health Information Effective Date: September 1, 2015  |
|  |

**Please answer one set of questions**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Have you had a flu shot last season? YES NO**
2. **Have you had pneumonia shot in the last 5 years? YES NO**

**If yes, when and where did you last have your injection? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Have you ever had a DXA Bone Density scan? YES NO**

**If yes, where and when did you have your last scan? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Do you use tobacco? YES NO**
2. **Do you drink alcohol? YES NO**
3. **Do you use illicit drugs? YES NO**

|  |
| --- |
| Dr. James Chappell M.D., P.C.Notice of Privacy Practices for Protected Health InformationEffective Date: September 1, 2015 |

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!

The office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, test results, diagnoses, treatment, and applying for future care of treatment. It also includes billing documents for those services.

Examples of Uses of Your Health Information for Treatment Purposes are:

During the course of your treatment, the physician determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input.

Example of Use of Your Health Information for Payment Purposes:

We honor requests for information from your health insurance company if the health insurance company (or other business associate, helping you to obtain reimbursement) requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:

We may obtain services from your insurance or other business associates such as quality assessments, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers of other business associates as necessary to obtain these services.

Your Health Information Rights

The health and billing records we maintain are the physical property of the office.

The information in it, however, belongs to you. You have the right to:

* Request a restriction on certain uses and disclosures of your health information by delivering the request to our office ---- we are not required to grant the request, but we will comply with any request granted;
* Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information (“Notice”) by making a request at our office;
* Request that you be allowed to inspect and copy your health records and billing records – you may exercise the rights by delivering the request to our office. Copies of your medical records will incur a fee outlined in the Financial Policy.
* Appeal a denial of access to your protected health information, except in certain circumstances;
* Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office. We may deny your request if you ask us to amend information that:
	+ - Was not create by us, unless the person or entity that created the information is no longer available to make the amendment;
		- Is not part of the health information kept by or for the office/hospital;
		- Is not part of the information that you would be permitted to inspect and copy; or,
		- Is accurate and complete

If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a “statement of disagreement” to be maintained with your records;

* Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our offices;
* Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses make to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant to that person’s involvement in your care or in payment for such care; or, uses or disclosures to notify family or other responsible for your care of your location, condition, or your death.
* Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office, except to the extent information or action has already been taken.

If you want to exercise any of the above rights, please contact Dr. Chappell, in person or in writing, during regular, business hours. She will inform you of the steps that need to be taken to exercise your rights.

Our Responsibilities

The office is required to:

* Maintain the privacy of your health information as required by law;
* Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
* Abide by the terms of this Notice;
* Notify you if we cannot accommodate a requested restriction or requests;
* Accommodate your reasonable request regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our “Notice” or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact our Office at (303)722-4683

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Dr, Chappell. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services, whose street address and e-mail address is: Office for Civil Rights – U.S. Department of Health and Human Services – 200 Independence Avenue S.W. – Room 509F, HHH Building – Washington, D.C. 20201.

* We cannot, and will not, require you to waive the rights to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office.
* We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Disclosures and Uses

Communication with Family

* Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person’s involvement in your care or in payment for such care if you do not object or in an emergency.

Notification

* Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Research

We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and establish protocols to ensure the privacy of your protected health information.

**Communication**

**As we do not have a HIPPA compliant e-mail, health care information including diagnosis and treatments will not be discussed via e-mail. Please call the office at 303-722-4682 to discuss health concerns or leave a message on the voice mail system. If prescription refills are needed contact your pharmacy or leave a message on the voice mail system.**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_\_

**Acknowledgment of Notice of Privacy Practices**

I hereby acknowledge that I received Dr. Chappell’s Notice of Privacy Practices.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**James Chappell, MD, PC**

**MEDICAL QUESTIONAIRE DATE:\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **Medication Allergies?** | Which Medications are you allergic to? | What does it do to you? |
| Yes or No |  |  |
|  |  |
|  |  |
| **Past Medical History:** Please check any of the following which you have had and give approximate date. |
|  | AnemiaArthritisAsthmaBleeding DisordersBlood ClotsBlood Pressure ProblemsBone FracturesCancerCholesterol ProblemsDiabetesEmphysemaHearing ProblemsHeart Disease or Murmers |  | Hepatitis or Liver ProblemsInfertilityIrritable BowelKidney StonesKidney DiseaseMalabsorptionMental IllnessMitral Valve ProlapseNeurological ProblemsOrgan TransplantOsteoporosisPancreatitisPneumonia |  | Prostate TroubleRheumatic FeverSexual DysfunctionSexually Transmitted DiseasesSkin DisordersStomach UlcersStrokesTumorsThyroid ProblemsTuberculosisUlcerative ColitisUrinary Tract InfectionsVision Problems |
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| Please list any additional medical illness you have if not included. |
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| **Past Surgical History:** Please list any surgeries you have had in the past.  |
|   |
| **Women Menstrual History:** Please complete the following with regard to your periods. |
| Age of onset: | Days between cycles: | Regular Y or N |
| Type: Heavy – Medium – Light | Duration: | Pain: |
| Birth Control: | Age of menopause: | Menopause: Natural or Surgical |
| **Habits:** |
| Smoking Now: Y or N | How Much? | How long? | Date you quit? |
| Alcohol: | How Much? | How long? | Date you quit? |
| Drug Use: | How Much? | How long? | What do you use? |
| Exercise: | How Much? | How long? | What do you do? |
| **Family History:** Please check any of the following which have occurred in your family, and indicate which family member it occurred; Mother, Father, Brother, Sister, Child, Grand Parent, Aunt, or Uncle. |
|  | AnemiaArthritisBleeding DisordersBlood Pressure ProblemsBone FracturesCancerCholesterol ProblemsDiabetes |  | EmphysemaHeart TroubleHepatitis or Liver ProblemsKidney DiseaseKidney StonesMalabsorptionMental IllnessNeurological Problems |  | ObesityOsteoporosisSkin DisordersStrokesStomach UlcersThyroid ProblemsTuberculosisTumors |
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| Please list any additional medical illness that has occurred in your family if not included above: |
| Please list age of the following. If deaths have occurred, please list at what age and the cause. |
| Father: | Sisters: |
| Mother: | Children: |
| Brothers: |  |
| **Review of Systems:** Please check if you are currently or recently experienced any of the following: |
| **Constitutional Symptoms** | **Respiratory** | **Genitourinary** |
|  | FatigueWeaknessWeight Loss or Weight GainFevers / Chills / Night Sweats |  | Coughing or WheezingCoughing up BloodCoughing up PhlegmShortness of BreathPain with Breathing |  | Pain or Burning on UrinationChange in Color/Odor of UrineBlood in UrineFrequency of UrinationUrgency of UrinationStop and Start UrinatingIncontinenceImpotenceDecreased Libido |
|  |  |  |
|  |  |  |
|  |  |  |
| **Eyes** |  |  |
|  | Eye PainGlasses / ContactsBlurred VisionLoss of VisionItchy or Watery EyesRed EyesHeadaches | **Cardiovascular** |  |
|  |  | Shortness of Breath while Lying FlatNumber of Pillows you Sleep OnDecreased Ability to ExerciseChest PainRapid Heart Rate or PoundingSkipped Heart BeatsSwelling in your Feet or Ankles |  |
|  |  |  |
|  |  |  |
|  |  | **Musculoskeletal** |
|  |  |  | BackacheMuscle or Joint AchesMuscle Weakness or StiffnessMuscle or Bone Pain |
|  |  |  |
| **Ears, Nose, Mouth, Throat** |  |  |
|  | Pain in the EarsDecreased HearingRinging in your EarsDizzinessInfection (ENT continued)Frequent ColdsSinus Congestion or PainNasal DrainageItching or Hay feverNosebleedsFacial PainTooth or Gum PainHoarsenessSore Throat | **Gastrointestinal** |  |
|  |  | Abdominal PainDifficulty SwallowingAppetiteBloating or Belching (GI continued)Nausea / VomitingVomiting BloodConstipation or DiarrheaChange in Bowel HabitsBlood in the StoolChange in Stool Color or SizeFood Intolerance | **Neurological** |
|  |  |  | Fainting or BlackoutsPain / Burning in Legs or FeetNumbness or Tingling (neuro continued)Shakes or TremorsSeizures |
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|  |  |  |
|  |  | **Psychiatric** |
|  |  |  | DepressionThoughts of SuicideNervousnessHallucinationsTensionInsomnia |
|  |  |  |
|  |  |  |
|  |  |  |
|  | **Hematologic/Lymphatic** |  |
|  |  | Easy BruisingPast TransfusionsSwollen GlandsNeck Pain or Stiffness |  |
| **Breasts** |  | **Skin** |
|  | LumpsDischargePainSelf Exams |  |  | Rashes, Sores, LumpsItching, DrynessChange in ColorChanges in your NailsChanges in your Hair |
|  |  |  |
|  | **Allergic/Immunologic** |  |
|  |  | Frequent InfectionsHay FeverTetanus Shot in Last 5 YearsFlu Shot in Last YearPneumonia ShotExposure to Tuberculosis |  |
| **Endocrine** |  |  |
|  | Heat or Cold IntoleranceExcessive SweatingExcessive Hunger or ThirstFrequent UrinationHot Flashes |  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| Please add anything which is not listed above. |

**James Chappell, MD, PC**

**6740 East Hampden Ave. Suite 210 Denver, CO 80224**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Due to the volume of prescriptions on a daily basis, you may choose 1 local and 1 mail order pharmacy ONLY.
2. If your prescription has already been sent and you want or need to switch pharmacies, your prescriptions can be transferred between pharmacies. You will need to contact your pharmacy to do so.
3. If you fail to provide pharmacy information or incorrect information is provided, then the prescription cannot be issued.
4. If you require refills or new prescriptions, please contact your pharmacy first. If after 3 attempts you encounter a problem contact our office.
5. If you have a mail order and local pharmacy listed, please specify the main pharmacy you wish to use. If you do not specify, your prescription will be sent to mail order.
6. Any local pharmacy changes will require a new pharmacy sheet. All subsequent visits will require an initial by the date if there is no change.

Please provide the following information:

**Local Pharmacy:** **Mail Order Pharmacy (Name Only):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Address **(NOT CROSS STREETS)**

Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax# (If available) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Diabetic Testing Supply Company (If Applicable):**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications **FROM THIS OFFICE ONLY**  **CIRCLE ONE FOR EACH MEDICATION**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mail order or Local

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**By signing below I acknowledge and agree to all of the above.**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_