501 Anglers Drive Suite 201
Steamboat Springs, CO 80487
970.871.1323 (p) 970.871.9177 (f)
www.steamboatfamilydoc.com

Family Medicine
personalized care

PATIENT NAME_____

FINANCIAL OBLIGATIONS

I have been given the opportunity to read and review Steamboat Springs Family Medicine's financial policy. I understand that I am responsible for payment in full of all charges incurred. This includes costs not covered by my insurance company. I further understand that I am responsible for contacting and/or following up with my insurance company should they not pay in a timely manner.
I understand I am responsible for contacting Steamboat Springs Family Medicine to update any address and/or phone number changes.

_____ _____
Printed name of patient (or guardian if minor) Date

_____
Signature of responsible party

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been provided the opportunity to read and review a copy of Steamboat Springs Family Medicine's Notice of Practices (HIPAA) policy. I authorize SSFM to release my health and/or billing information to to the following:

Name of Person:_____Relationship_____

Name of Person:_____Relationship_____

_____ _____
Printed name of patient (or guardian if minor) Date

_____
Signature of responsible party

Electronic (online) Communication (E-mail/Portal/Text) Agreement

I acknowledge that I have been given the opportunity to read and review Steamboat Springs Family Medicine's Electronic Communication Agreement. I understand that electronic (online) communication has risks, including possible risks not mentioned in the agreement. I agree to and will abide by the policies described in the agreement. I agree to use reasonable judgment with regard to any messages I send or receive. I further understand and agree that I am responsible for contacting Steamboat Springs Family Medicine to update and changes to my email address(s) and/or if I decide I no longer wish to participate in electronic communication. You agree, by providing us with your landline or cell phone number(s) you give express authorization, for medical and non medical reasons, to be contacted at those numbers, as well as authorize such contact by our agents and assigns. This express authorization also applies to any landline or cell phone numbers(s) you may acquire in the future. We may also contact you by sending text messages or emails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dealing device, as applicable. Providing your phone number(s) is not a condition of receiving our services. I/we have read this disclosure and agree that we may be contacted as described above. I do not have any unanswered questions about what this Agreement requires.

_____ _____
Printed name of patient (or guardian if minor) Date

_____
Signature of responsible party