



**Platte River Medical Clinic**  
**36 S. 18<sup>th</sup> Ste B**  
**Brighton, CO 80601**  
**303-659-7600**

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

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Marital Status \_\_\_\_\_ Social Security# \_\_\_\_\_

Circle One: Cell/Work/Other Phone \_\_\_\_\_ Email \_\_\_\_\_

- I would like to receive alerts via Text Messaging
- I would like to receive information via Email (See Attached Consent and Sign Below)

**Which category best describes your race?**

American Indian/Alaska Native	Asian	Asian Indian
Native Hawaiian/Other Pacific Islander	White	Black or African American
European	Filipino	Japanese
		Korean
		Other

**Which category best describes your ethnicity?**

Central American	Cuban	Dominican	Mexican
Hispanic or Latino/Spanish	Latin American/Latin	Spaniard	Puerto Rican
South American	Not Hispanic or Latino	Other	

Name of Person Who Carries Insurance \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security# \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_

Spouse or Other Responsible Party \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

- I agree to pay any and all court and attorney fees accrued if this account is assigned to a collection agency for non-payment.
- A \$5.00 re-billing fee will be assessed to the second statement sent out and any others there after.
- Returned checks may be subject to a \$20.00 charge plus allowable fees.
- If you are unable to cancel your scheduled appointment 24hrs prior - \$25.00 No Show Fee will be charged directly to you.

**Authorization to Release Information & Assignment of Benefits**

Authorization is hereby granted to release to my insurance company(ies) of record such information as may be necessary for the completion of my claims. I understand that I am financially responsible for charges not covered by insurance and assign any insurance benefits to the above said clinic.

\_\_\_\_\_/\_\_\_\_\_  
Signature / Date

If patient is a **minor**, at least one Parent/Guardian **must sign**, although both parents are financially responsible.

\_\_\_\_\_/\_\_\_\_\_  
Print Name of Parent or Guardian / Signature

I have **read** and **understand** the **HIPPA Policy** for Platte River Medical Clinic

\_\_\_\_\_/\_\_\_\_\_  
Signature / Date

I have **read** and **understand** the **Online Communications Consent** for Platte River Medical Clinic and give permission to contact me via electronic mail.

\_\_\_\_\_/\_\_\_\_\_  
Signature / Date