

David I. Greenberg, MD, FACC  
Ronald D. Blonder, DO, FACC  
Ted E. Eastburn, MD, FACC  
David J. Schwartz, MD, FACC  
James M. Glass, MD, FACC, PhD  
Joseph R. Lee, MD, FACC  
David A. Rosenbaum, MD, FACC  
Nita G. Harris, MD, FACC

Mary R. Olsovsky, MD, FACC  
Jonathan A. Sherman, MD, FACC  
Chris Y. Kim, MD, FACC  
Kimberly L. Dulaney, MD, FACC  
Russell A. Linsky, MD  
Nancy Lundy, MSN, ANP-C  
Brandon Smith, PA-C  
Mary Kuwana, ACNP-BC



1400 E. Boulder, Suite 700, Colo Spgs, CO 80909  
MAILING ADDRESS PO Box 9809, Colo Spgs, CO 80932  
MAIN OFFICE PHONE 719-635-7172 FAX 719-444-3747

## Confidential Communication Request (HIPAA Form)

From time to time in caring for our patients, it may become necessary to contact you by telephone. Often our patients are not available when we call them and we would like to be able to leave detailed telephone messages (i.e. lab results) when possible. In order to protect your privacy we need your written permission to leave detailed telephone messages on your answering machine or voice mail system. However, it should be noted that our current notice of privacy practices does allow us to call you with a courtesy reminder regarding any upcoming appointment(s).

Please read the following choices and tell us whether or not we can leave voice mail regarding your medical information, such as lab & test results, and with whom we may leave it with.

Choose one of the following:

I DO CONSENT to leave detailed messages as follows:

I, \_\_\_\_\_, give PIKES PEAK CARDIOLOGY and their staff my permission to leave telephone messages regarding my medical care with the following options: (Initial each one that you want us to be able to use for leaving you telephone messages). This will remain in effect until you rescind it in writing.

My home phone answering machine Initials \_\_\_\_\_

My spouse (name) \_\_\_\_\_ Initials \_\_\_\_\_

Other (name) \_\_\_\_\_ Phone number \_\_\_\_\_ Initials \_\_\_\_\_

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

I DO NOT CONSENT to leave detailed messages:

I, \_\_\_\_\_, wish to be contacted personally and I DO NOT AUTHORIZE detailed messages regarding my medical care be left on an answering machine, voice mail or with others.

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

Revocation of prior consent:

I, \_\_\_\_\_, wish to rescind or stop the above authorizations.

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

If not signed by patient, please indicate your relationship to the patient \_\_\_\_\_

# Patient Contact Information

## PATIENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_

Male  Female      Marital Status  Married  Single  Other

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

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

## EMPLOYER INFORMATION

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer Address \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION

Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to Patient  Spouse  Sibling  Other \_\_\_\_\_

## HEALTH INSURANCE

Do you currently have Health Insurance?  Yes  No

Company Name \_\_\_\_\_ Phone \_\_\_\_\_

Company Address \_\_\_\_\_

ID Card Number \_\_\_\_\_ Group Number \_\_\_\_\_

**Please present card at time of service. If you do not have your card with you, we may ask you to pay for services in full.**

Do you currently have a Secondary Health Insurance?  Yes  No

Company Name \_\_\_\_\_ Phone \_\_\_\_\_

Company Address \_\_\_\_\_

ID Card Number \_\_\_\_\_ Group Number \_\_\_\_\_

If Medicare is your secondary plan, please check the reason why

- Working Age Beneficiary or Spouse with Group Health Plan
- Disabled Beneficiary under age 65 with a Group Health Plan
- Auto Insurance or Workers Comp is primary