PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION (Please print)

Patient's Legal Name: (Last)_____(First)_____(MI) _____

Preferred Full Name (if different from above): _____

Address: _____

City, State, Zip: _____

Home Phone Number (landline):_____Cell:_____Work: _____

E-Mail Address:_____Date of Birth: _____

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer ☐ Choose not to disclose
☐ Additional Gender category not listed _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White
☐ Hispanic ☐ Chose not to disclose ☐ Other not listed _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Japanese ☐ Mandarin ☐ Korean ☐ French ☐ Indian: Hindi, Tamil, Gujarati etc
☐ Swahili ☐ Russian ☐ Arabic ☐ Vietnamese ☐ Haitian Creole ☐ Bosnian/Croatian/Serbian/Serbo-Croatian
☐ Albanian ☐ Burmese ☐ Tagalog ☐ Farsi-Iranian/Persian ☐ Portuguese ☐ Cambodian ☐ Other not listed_____

Patient Social Security Number:___-_____-_____

RESPONSIBLE PARTY INFORMATION (*If not self*) (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐
Responsible party name: (Last)_____(First)_____(MI) _____
Date of birth: MM_____/DD_____/YYYY_____ Sex: ☐ Female ☐ Male
Responsible Party Social Security Number: -_____-_____Phone number: _____
Address:_____
City, State:_____ZIP: _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last)_____ (First) _____
Phone number:_____ Do you have a living will? ☐ Yes ☐ No
Emergency contact relationship to patient:_____ ☐ Guardian
Address_____
City, State:_____ZIP: _____
Home phone:_____Work hone:_____Ext. _____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative:_____Date: _____

Printed name of patient or personal representative:_____Relationship to patient: _____

Patient Medical History

Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Referred By: Friend/Family: _____ Healthcare Provider: _____ Website: _____

Facility: _____ Insurance Company: _____ Advertisement: _____ Other:_____

Issue(s) you wish to discuss today: _____

Allergies: _____

List medications and dose you are on:(□See Attached List)

Have you had any of the following health problems? Check all that apply. □None apply

□ Heart attack	□ Asthma	□ Back problems	□ Bleeding/clotting	□ Arthritis
□ Heart disease	□ Emphysema	□ Diabetes	□ Anemia	□ Migraines
□ Chest pain	□ Stroke	□ Mental Illness	□ AIDS/HIV	□ Cancer. Type:_____
□ High blood pressure	□ Seizures	□ Thyroid problems	□ Reflux disease	□ Other: _____

Please list any surgeries you have had including dates: _____

Has anyone in your family had the following health problems? Check all that apply and list relationship. □None apply

□ High blood pressure_____	□ Diabetes_____	□ Bleeding Disorder_____
□ Heart disease_____	□ Asthma_____	□ Cancer, Type_____
□ Thyroid problems_____	□ Arthritis/Joint pain_____	□ Other:_____
□ Stroke_____	□ Mental Illness_____	□ _____

Have you ever smoked? No Yes **Do you smoke now?** No Yes - if yes, _____packs per day for the last _____years
Alcohol use? ____drinks per □day □week □month **Recreational drug use? (**circle) Yes No Type(s): _____
What is your occupation? _____ **Exercise Routine:**_____

Relationship Status: married single divorced widow(er) **Sexual Identity:**_____

Have you had any of the following in the last month: (Mark with an X)

General
□ No problems
□ Fever
□ Weight loss
□ Weight gain
□ Night sweats

Ears
□ No problems
□ Hearing loss
□ Ear pain

Nose
□ No problems
□ Congestion/Obstruction
□ Post nasal drip

Throat
□ No problems
□ Sore throat
□ Chronic cough
□ Difficulty swallowing

Pulmonary
□ No problems
□ Wheezing
□ Coughing
□ Shortness of breath

Gastrointestinal
□ No problems
□ Nausea/vomiting
□ Heartburn
□ Abdominal pain
□ Constipation/Diarrhea
□ Blood in stool

Musculoskeletal
□ No problems
□ Joint/Back pain
□ Muscle weakness
□ Balance issues

Genitourinary
□ No problems
□ Painful urination
□ Frequent urination
□ Blood in urine
□ Incontinence

Cardiovascular
□ No problems
□ Chest pain
□ Swollen ankles
□ Palpitations
□

Neurological
□ No problems
□ Numbness/weakness
□ Tingling
□ Dizziness
□ Memory loss

Psych
□ No problems
□ Depression/anxiety
□ Insomnia

Hematology/Endo
□ No problems
□ Anemia
□ Bleeding tendency
□ Heat/cold intolerance

Skin
□ No problems
□ Skin lesions
□ Pigmentation changes

Eyes
□ No problems
□ Change in vision

Women
□ Changing periods
□ Other concerns

Men
□ Erectile dysfunction

Please list any other medical providers you see: _____
Do you have an Advanced Directive Yes No
Advanced Care Planning Consent: I consent to discuss end-of-life planning issues with my healthcare provider (circle) Yes No
Please provide month and year you most recently had the following:
Mammogram:_____ Colonoscopy:_____ Bone Density:_____ Pap Smear:_____ Eye Exam:_____ Dental Exam:_____ Dermatology Exam:_____ Tetanus Booster (tdap) :_____

PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

1. _____(Patient or Guardian Initials)
Financial Agreement.

- I acknowledge, that as a courtesy, **Aspen Medical Group** may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. _____(Patient or Guardian Initials)
Third Party Collection. I acknowledge that **Aspen Medical Group** may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. _____(Patient or Guardian Initials)
Assignment of Benefits. I hereby assign to **Aspen Medical Group** any insurance or other third-party benefits available for health care services provided to me. I understand **Aspen Medical Group** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **Aspen Medical Group,** I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. _____(Patient or Guardian Initials)
Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to **Aspen Medical Group** by the Medicare or Medicaid program.

5. _____(Patient or Guardian Initials)
Consent to Telephone Calls for Financial Communications. I agree that, in order for Aspen Medical Group, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that Aspen Medical Group or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or Aspen Medical Group or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. _____(Patient or Guardian Initials)
A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X_____Date_____

If you are not the Patient, please identify your Relationship to the Patient.
(Circle or mark relationship(s) from list below):

Spouse	Guarantor
Parent	Healthcare Power of Attorney
Legal Guardian	Other (please specify)_____

Late Arrival Policy

We realize emergencies and illnesses occur, however, a courtesy phone call allows us to use our time for another patient. Your cooperation will help us continue to provide quality services and maintain accurate scheduling.

I,_____, understand that I must arrive to my scheduled appointment **NO MORE THAN 10 minutes** after the appointment time.

If I arrive more than 10 minutes after my appointment time, I may be asked to re-schedule the appointment for another date and/or time.

_____
Patient Printed Name

_____
Patient or Guardian Signature

_____
Today's Date

HOW CAN WE REACH YOU?

From time to time, your provider will need to contact you. By filling out the information below, we are better able to serve you.

I,_____ by filling in the spaces below give HealthONE my permission to speak with and/or leave a phone message regarding my medical care and/or billing information with the following individuals.

PLEASE CONSIDER CAREFULLY WHOM YOU AUTHORIZE TO HAVE ACCESS TO PROTECTED INFORMATION REGARDING YOUR CARE.
I fully understand that this consent will remain valid until revoked in writing.

My Home answering machine#_____ Initials_____
My Cell or Cell voice mail: #_____ Initials_____

My Office/Work voice mail: #_____ Initials_____

My Spouse/Guardian Name: _____
#_____ Initials_____

If other, please name: _____
Relationship to patient: _____
#_____ Initials_____

In an effort to protect your privacy, we have developed a policy on leaving medical care message information.

- We will NOT leave messages with anyone except the patient or legal guardian unless stated above.
- We will NOT leave any confidential information on an answering machine unless stated above.
- We will NOT leave any messages on a voice mail unless stated above.

Signature _____Date_____

Aspen Medical Group
4500 E. 9th Ave. Suite 450
Denver, CO 80220
(p) 303.394.9355
(f) 303.394.1932

Authorization/Release For Use And Disclosure For Protected Health Information (PHI)

Patient Name: _____ **DOB:**_____

Address:_____ **Phone:**_____

City:_____ **State:**_____ **Zip:** _____

For Disclosure Only: I hereby authorize the disclosure of the following Protected Health Information (PHI) of the patient listed above for the purpose of primary follow-up care.

To □ **From □**

Aspen Medical Group
4500 E.9th Ave. Suite 450
Denver, CO 80220
Phone: 303-394.9355 Fax: 303-394.1932

To □ / From □ _____

_____

PH:_____ **Fax:**_____

For Treatment Dates:_____

How would you like to receive your records? _____Will Pick up _____Mail to address above _____ Fax (Please list number above)

Are you transferring care to another provider? □ Yes □ No

Type of Access Required: Copies of the Record □ Inspection of the Record □

Selected Portions of Protected Health Information (PHI):

□ Entire Record □ Lab □ Progress Notes □ Emergency Room □ Imaging/Radiology □ Physicians Orders

□ History/Physical □ Cardiac Studies □ Billing Records □ Consult Report □ Demographics

□ Internal Marketing □ Operative Reports □ Nursing Notes □ Verbal Communications

□ Rehabilitation/ PT □ Medication Logs □ Other: _____

Expiration: This Authorization Will Expire: □ Fulfillment of this Request OR □ Date: _____

1. **I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing/results, or AIDS information._____ (Initial)**
2. **I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).**
3. **I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.**
4. **If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and be re-disclosed.**
5. **I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.**
6. **I will receive a copy of this form after I sign it.**

I have read the above and authorize the disclosure of the Protected Health Information (PHI) as stated.

Signature of Patient/Guardian:_____

Relation to Patient:_____**Date:**_____