PATIENT INFORMATION

NAME (Last, First Middle)	SSN#	BIRTH DATE	SEX	GENDER IDENTITY

ADDRESS	CITY, STATE, ZIP	MRN

CELL PHONE	HOME PHONE	EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE

E-Mail Address	PRIMARY CARE PHYSICIAN	MARITAL STATUS	Preferred Language

RACE (Please Cicle)	ETHNICITY (Please Circle)
White Hispanic Asian Black/African American Other American Indian/Alaska Native Hawaiian/Pacific Islander Decline	Hispanic or Latino Not Hispanic or Latino Decline
EMPLOYER (If Workmen's Comp)	EMPLOYER ADDRESS & PHONE NUMBER (If Workmen's Comp)

RESPONSIBLE PARTY INFORMATION (If different from above)

NAME (Last, First Middle)	SSN#	BIRTH DATE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (If Applicable)
CITY, STATE ZIP	CITY, STATE ZIP
HOME PHONE	SECONDARY HOME PHONE
RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF THE INSURANCE COMPANY	POLICY#
NAME OF INSURED	GROUP#
ADDRESS OF INSURANCE COMPANY	CO-PAY AMOUNT
CITY, STATE ZIP	DEDUCTIBLE

RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE

NAME OF THE INSURANCE COMPANY			POLICY#
NAME OF INSURED	SSN#	BIRTH DATE	GROUP#
ADDRESS OF INSURANCE COMPANY			CO-PAY AMOUNT
CITY, STATE ZIP			DEDUCTIBLE

RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SIGNATURE OF PATIENT/GUARDIAN

DATE

Aspen Family Care/Aspen Medical Aesthetics Patient Consent

Patient Name: _____ **Date of Birth:** _____

- **Consent for Treatment:** I, the undersigned, voluntarily agree to the tests, procedures, and/or treatments which the physician has deemed necessary and which are administered to or performed on me under the direction of the physician or his/her designee.
- **Consent for Treatment of Minors:** I, the undersigned, understand that a minor child (17 and under) must have my consent to be treated. I understand that I must be present at each appointment for any child aged 14 and under. If the child is between the ages of 15 and 17, I understand that I must send a note with the child to the appointment consenting for the child to be treated. The notes must contain the date, a statement of consent, and my signature. Further, I understand that consent for treatment does not alter the legal requirements for confidentiality. I also understand that Colorado Law provides for minors to seek care without parental consent for certain issues.
- **Consent to receive one (1) monthly newsletter email from Aspen Family Care and Aspen Medical Aesthetics**
  - ❒ Yes ❒ No
  - ❒ Email Address:_____
- **Consent to Communicate Medical Results:** I, the undersigned, understand that medical results will be communicated directly to me unless I specifically identify individuals to whom information may be communicated (see box below to authorize other family members to receive results). Please indicate how we may inform you of test results (check all that apply):
  - ❒ Call my work number: _____Okay to leave voice mail at work? ❒ Yes ❒ No
    (The only message we will leave with a coworker is a note to call with our name and number.)
  - ❒ Call my cell phone: _____Okay to leave voice mail on cell? ❒ Yes ❒ No
  - ❒ Call my home number: _____Okay to leave voice mail at home? ❒ Yes ❒ No

    In the event that I am not available to receive medical results when called upon, I authorize Aspen Family Care to leave medical information with any of the names identified below. It is my responsibility to notify these persons that such information may be left with them and I agree not to hold Aspen Family Care responsible for information not conveyed to me through these persons.
- **I hereby acknowledge that I received Aspen Family Care/Aspen Medical Aesthetics' Notice of Privacy Practices.**

Family Information ***(Please list all other members of your household even if not authorized to receive results.)***

Name (First MI Last)	Male ❒	Female ❒	Date of Birth	Relation	*OK to release results? NO ❒ YES ❒
Name (First MI Last)	Male ❒	Female ❒	Date of Birth	Relation	*OK to release results? NO ❒ YES ❒
Name (First MI Last)	Male ❒	Female ❒	Date of Birth	Relation	*OK to release results? NO ❒ YES ❒
Name (First MI Last)	Male ❒	Female ❒	Date of Birth	Relation	*OK to release results? NO ❒ YES ❒
Name (First MI Last)	Male ❒	Female ❒	Date of Birth	Relation	*OK to release results? NO ❒ YES ❒
Name (First MI Last)	Male ❒	Female ❒	Date of Birth	Relation	*OK to release results? NO ❒ YES ❒

Emergency Contact information

Name of nearest relative or close friend not living with the patient		
Name	Relation	Phone
Name of relative or friend to contact in case of an emergency		
Name	Relation	Phone

X _____

Signature (Must be a parent or guardian for children 17 and under) **Date**

****

For Future Use:

_____ Initials/Date	_____ Initials/Date	_____ Initials/Date	_____ Initials/Date
I have reviewed the above information contained on this form and have no additional changes.			

Aspen Family Care Financial Policy

Patient Name:_____D.O.B._____

Welcome to Aspen Family Care, PLLC. We are committed to providing you excellent medical care. We would like to take this opportunity to inform you of our office policy.

We will bill insurance claims as a courtesy to our patients provided we have your current insurance information, if not; you will be responsible for payment at the time of service. We accept payment from insurance companies, but require that you pay your portion, including co-pays, deductibles or coinsurance at the time of service. In accordance with our and your participation agreement with third-party payers, we cannot waive or discount co-payments. Payment is due upon receipt for any balance that is billed to you.

We follow all AMA coding/billing procedures, including procedure codes, preventive codes, visit codes and billing on time spent in the visit (including extended visit codes). Changing or re-coding claims once they have been submitted may constitute fraud and we **do not** do this unless a rare coding error has occurred.

Well exams are for preventive care, not evaluation of new conditions or significant changes in management of existing conditions. If new, multiple, or complex medical issues are discussed and managed at the time of a well exam, we will change your visit type to a problem-focused visit and ask you to reschedule your well exam. Under no circumstances can evaluation of new conditions be billed as a preventive visit.

The office bills only for services performed by our providers. Laboratory/Pathology companies are separate entities from us and will bill you or your insurance company separately. If you have any questions regarding your lab/pathology bill, please contact that laboratory/pathology company or your insurance company.

As a courtesy, we attempt to contact every patient to remind them of their appointment; however, it is the responsibility of the patient to arrive on time whether or not a reminder call was received. We ask that you notify us 24 hours in advance to cancel and/or reschedule your appointment. Please be aware that failure to do so may result in a missed appointment fee of $25.00 and $50.00 for a missed physical, well-child exam or procedure.

Returned checks will incur a $30 service charge.

It is your responsibility to notify our office if there is a change of name, insurance coverage, residence, and/or phone number.

We **do not** participate with Medicare or Medicaid; we attempt to notify every patient prior to their age of being eligible for Medicare; however it is the responsibility of the patient to seek a Medicare participating provider.

In the event that your account was paid late, placed on a payment plan, or your account is placed in collection status, any additional fees incurred due to this, will be added to your outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. If the account is sent to collections or if we receive a bankruptcy notification, we reserve the right to dismiss you as well as any family members from the practice.

Business hours are from 7:30am to 5:00pm Monday through Friday. Medical care received before or after these hours or on weekends, as well as emergent office visits without appointments, may have additional fees per standard billing procedures. Currently, these charges may be up to $50 per visit.

Please sign below so that we may confirm that you have read and understand our office policy regarding insurance and your responsibilities as a patient of Aspen Family Care.

_____	_____	_____
Patient Name	Patient/Guardian Signature	Date

Dear Patient:

Promoting health and treating illness are important to all of us. We understand this complicated process can be confusing, especially when multiple parties are involved (including lab services, radiology, referrals, etc). As partners in your health, Aspen Family Care providers recommend testing based on our extensive education and experience, always keeping your best health interests in mind. Because healthcare is our specialty, we stay up to date on the latest technology and testing to assist in such management.

As part of increasing complexity in payor systems, it is important that you, the patient, be aware of how your insurance plan works and to know which lab your plan is contracted with. With insurance plans constantly changing it is impossible for us to know your individual coverage of services with third parties, particularly lab services. There is a current trend to limit laboratory coverage with many insurances. Tests that may have been covered in the past may not be covered now. If this is a concern to you, we recommend you contact your insurance company FIRST with the specific ICD-10 and CPT codes to find out what they cover BEFORE getting your laboratory work done. We also recommend contacting your insurance company to find out how all types of office visits are covered by your plan.

ICD-10 codes are diagnosis codes used to communicate to your insurance company why labs are ordered. These codes are located on your laboratory requisition form.

CPT codes are used to communicate with your insurance company what specific labs are ordered. To obtain these codes, you will need to contact the lab and ask them to look up the codes for the various testing placed on your lab requisition.

Should you choose not to proceed with testing as recommended, it is important you know that this can result in undiagnosed illness, late diagnosis, or poor medical management of conditions. This can affect quality of life, as well as increase risk of death with certain conditions. In this situation, it is to be understood that not completing testing as recommended would be against medical advice and the responsibility for issues that could arise from not doing testing is yours.

Lab companies often offer discounted rates for labs not covered. However, to take advantage of this, they must know if you plan on paying prior to them billing your insurance. Once billed, if denied, the balance is typically billed at full price to you by the lab company.

Thank you very much.

Aspen Family Care

_____	_____	_____
Patient Name	Patient/Guardian Signature	Date

Child Health Questionnaire

Patient Name:_____**Date of Birth:**_____

Please fill out this form as best you can so we can provide you with better care. If you don't know the answer to any of the questions, please leave it blank. If your child was adopted, please still fill out the information as best you can. Thank you.

Mother information (husband/significant other may answer these questions if mother is not present and you know her medical history) :
How may many pregnancies have you had?_____
How many children have you given birth to?_____
Are you involved in raising any children that you have not given birth to?_____
Have you ever miscarried?_____
Have you ever had an abortion?_____
Do you have any medical problems?_____

Father Information (wife/significant other may answer these questions if father is not present and you know his medical history) :
Do you have any medical problems?_____

Child Information:
Was your child adopted?_____
Were there any problems during pregnancy or delivery?_____ If so, explain:_____
_____
_____
Was the birth vaginal?_____ If not, why?_____
_____
Were there any problems with your baby during the hospital stay after birth?_____
_____
Has your child ever been seriously ill?_____
Has your child ever been hospitalized?_____
Has your child ever had surgery (including tonsillectomy or ear tubes)?_____If yes, what?_____
Has you child ever had trouble with breathing, wheezing, or been diagnosed with "reactive airway disease" or "asthma"?_____
Are immunizations up to date?_____
Is your child in daycare?_____
Does anyone in your household smoke?_____
Does your child have frequent colds?_____
Has your child ever been diagnosed with strep throat?_____How often?_____
Does your child have frequent ear infections?_____If yes, how often?_____
Are both parents involved in child rearing?_____If not, why?_____
_____
If your child has siblings, do they get along?_____
If your child is school-age, are there any problems at school?_____
Are there any other health problems/concerns that your child has?_____

Provider Initials/Review Date:_____

Adult Physicals & New Patients

(Please complete this form if you are here for a physical exam or a new patient to our office).

Patient Name:_____D.O.B._____Date:_____

Social History-

□ Married □ Single □ Divorced; # of children_____, Occupation_____

Tobacco use-

□ Never □ Social Packs per day-_____for # years_____, Quit- year_____

Alcohol use- # of drinks_____per □ Day □ Week □ Month **Marijuana/ Illicit Drug Use-**_____

Do you have any allergies to medication? Please list □ N/A

_____

_____

Have you had any previous surgeries? Please list □ N/A

_____

_____

Medical Problems/ History:

_____

_____

_____

_____

Family History: Please include the AGE it began—Heart issues, cancer (and type if known), stroke, hypertension, cholesterol, diabetes

□ Father _____ □ Mother _____

□ Paternal Grandmother_____ □ Maternal Grandmother _____

□ Paternal Grandfather _____ □ Maternal Grandfather _____

□ Paternal Aunt _____ □ Maternal Aunt _____

□ Paternal Uncle _____ □ Maternal Uncle _____

□ Siblings _____

Health Maintenance

Females Only:

Last Mammogram:_____

Last Pap:_____

Last Menstrual Period:_____

Birth Control: Y / N _____

Postmenopausal: Y / N When? _____

Bone Density: Y / N When? _____

Hysterectomy: Y / N When? _____

Patients over 50:

Colonoscopy: Y / N When?_____

Shingles Vaccine: Y / N When?_____

All Patients:

Last Tetanus Shot:_____

Last Flu Shot: _____

Patient Allergy Symptom Survey

PATIENT NAME:_____D.O.B._____PHONE:_____DATE:_____

COMMON SYMPTOMS: Check number according to severity: 0=None, 1=Mild, 5=Very Severe

	0	1	2	3	4	5			0	1	2	3	4	5
Abdominal Gas or Cramping								Hives						
Arthritis or Muscle Pain								Hyperactivity						
Asthma								Itching						
Cough								Nasal Congestion						
Eczema								Poor Memory or Concentration						
Fatigue								Sneezing						
Frequent Colds or Sore Throats								Trouble Breathing While Sleeping						
Frequent Sinus or Ear Infection								Wheezing						
Headache								Watery, Red, Itchy Eyes						
Dry Eyes								Burning Eyes						

SYMPTOM SCORE:_____ List any other current symptoms:_____

History: Are there any foods which cause you problems?_____Symptoms:_____

Do you have a history of allergies? ( ) Yes ( ) No If yes, how long have you had allergies? _____

What season(s) do your allergies usually flare up? ( ) Spring ( ) Summer ( ) Fall ( ) Winter ( ) All Year

Have you been allergy tested before? ( ) Yes ( ) No If yes, when _____
Does any medication give you relief of your allergy symptoms? ( ) Yes ( ) No Comment_____
Do you have pets at home? ( )Yes ( ) No Type_____
Are you exposed to fumes or dust? ( ) Yes ( ) No Comments_____
Do you smoke? ( ) Yes ( ) No How much?_____ Exposed to second hand smoke? ( ) Yes ( ) No
Do you have a basement? ( ) Yes ( ) No Water in basement? ( ) Yes ( ) No Mold present in house/insulation? ( ) Yes ( ) No
Bedroom flooring, ( ) Carpet ( ) Hardwood ( ) Tile.
Cockroach problem? ( ) Yes ( ) No
Who else in your family has allergies/asthma? ( ) Mother ( ) Father ( ) Sibling ( ) Children
Have you ever been diagnosed with asthma? ( ) Yes ( ) No If so when? _____ Severity: ( ) Mild ( ) Moderate ( ) High
Do you think your asthma is under control? ( ) Yes ( ) No
How often do you use your inhaler? _____ Last date used? _____
Are you taking any sleep aids? (include OTC) _____

Contraindications:

Do you suffer from uncontrolled asthma or reduced lung function? ( ) Yes ( ) No
Have you ever had a severe allergic reaction? ( ) Yes ( ) No Hospitalization due to allergies? ( ) Yes ( ) No
Do you take medication for your blood pressure? ( ) Yes ( ) No Medication: _____
Have you taken any allergy, antihistamine, cold medicine or sleep aids in the past 72 hours? ( ) Yes ( ) No
Are you pregnant? ( ) Yes ( ) No ( ) N/A
Are you interested in allergy testing? ( ) Yes ( ) No