

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 Circle) White Hispanic Asian Black/African American Other American Indian/Alaska Native Hawaiian/Pacific Islander Decline			ETHNICITY (Please Circle) 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 <input type="checkbox"/>	Female <input type="checkbox"/>	Date of Birth	Relation	*OK to release results? NO <input type="checkbox"/> YES <input type="checkbox"/>

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 giving you the best care possible. 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 participation agreements with third-party payers, we cannot waive or discount co-payments. Payment is due upon receipt for any balance that is billed to you.

Changing or re-coding claims once they have been submitted constitutes fraud and we **do not** do this under any circumstances.

If multiple or complex medical issues are discussed and managed at a routine physical exam, an additional office visit may be billed and any subsequent charges will be your responsibility.

The office bills only for services performed by our providers. The laboratory companies are a separate entity, and will bill you or your insurance company for labs that are performed. If you have any questions regarding your lab bill, please contact that laboratory 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.

Name (Please Print)

Date

Signature of Patient or Responsible Party



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 the not doing testing is yours.

Labs often offer discounted rates for labs not covered. However to take advantage of this, they must know you plan on paying prior to billing of insurances. Once billed, if denied, the balance is typically billed at full price.

Thank you very much.

Aspen Family Care

Patient Name

Patient/Guardian Signature

Date

Aspen Family Care Adolescent Patient Review

Patient Name: _____

DOB: _____

Date: _____

Please take the time to fill out this form as best you can. Your answers to these questions are confidential (between you and your doctor). It is very important that you answer them honestly so that your doctor can provide you the best care. Learning how to discuss your health with your doctor is an important part of growing up. If you need help answering any of the questions, please leave it blank.

Are you concerned about your weight?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a poor appetite or do you throw up after eating?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have fever, chills or wake up sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel tired or weak?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had a blood transfusion?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have headaches?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever passed out or fainted?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any changes in your skin or have rashes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have decreased hearing or ringing in your ears?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have blurred or double vision or color blindness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you wear glasses or contacts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have hay fever or seasonal allergies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you exercise regularly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you ever short of breath or do you frequently cough or wheeze (at rest or exercising)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have frequent sore throats or strep throat?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had rheumatic fever?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you ever have abdominal or stomach pain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you ever have indigestion or regularly use antacids?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble with chronic diarrhea or constipation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any trouble with urinating or urine infections?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have any of your friends told you that they have had sex?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had sex?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you know about sexually transmitted diseases (S.T.D.'s)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you attracted to females, males, both or neither? (Circle any that apply)		
Do you feel comfortable talking to your parents about growing up and the changes your body is going through?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If female, have you started your menstrual periods yet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If female, do you know about self breast exams?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If male, do you know about self testicular exams?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any questions or concerns about your body?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been hospitalized or very sick?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had a broken bone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever hit your head and had a concussion or passed out?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had a seizure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble getting along with your parents or siblings?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble making friends?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have difficulty at school?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you sad or do you cry often?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has anyone ever threatened to hurt you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has anyone ever hit you or touched you in a way that made you feel bad or uncomfortable?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you or have your tried smoking cigarettes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever tried drinking alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever tried drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are any of your friends drinking, smoking or trying drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you wear a seat belt?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you wear a helmet when biking, rollerblading, snowboarding or skateboarding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No



Aspen Family Care
Allergy Questionnaire
Intake Form

Date:	
Patient Name:	D.O.B.:
Phone Number:	

Questions:	Yes	No
Do you experience any of these symptoms more than twice a year?: Cough, cold, congestion, difficulty breathing, headaches, runny nose, sore throat, itchy/irritated eyes, sinus pain, ear pain, unexpected fatigue, skin irritation, snoring?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been diagnosed with asthma or bronchitis?	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience symptoms of allergies?	<input type="checkbox"/>	<input type="checkbox"/>
Are you interested in an Allergy Evaluation in our office?	<input type="checkbox"/>	<input type="checkbox"/>

**If you answered "Yes" to any of the above questions,
 please continue to the backside of
 this form.**

For Office Use:	
Reviewed By:	Patient Contacted? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Date/Time:
Appointment Scheduled? <input type="checkbox"/> Yes <input type="checkbox"/> No Date/Time:	

Allergy Questionnaire – Part II

1. What symptoms are you experiencing (From #1 on front page)?

2. How often do you experience these symptoms? _____
3. Do you have any of these symptoms

<input type="checkbox"/> Cough	<input type="checkbox"/> Runny Nose	<input type="checkbox"/> Nasal Polyps	<input type="checkbox"/> Eczema
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Nasal Congestion	<input type="checkbox"/> Poor Sense of Smell	<input type="checkbox"/> Hives/Swelling
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Itchy Nose	<input type="checkbox"/> Ear Infection	<input type="checkbox"/> Headaches
<input type="checkbox"/> Chest Tightness	<input type="checkbox"/> Itchy/Watery Eyes	<input type="checkbox"/> Sinus Infection	<input type="checkbox"/> Snoring
<input type="checkbox"/> Sneezing	<input type="checkbox"/> Postnasal Drip	<input type="checkbox"/> Blocked Ears	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Phlegm/sputum		<input type="checkbox"/> Other: _____	

 Color: _____
4. Which of the following seems to bother you or trigger/cause the above symptoms?

<input type="checkbox"/> Grass	<input type="checkbox"/> Cats	<input type="checkbox"/> Cosmetics	<input type="checkbox"/> Drafts
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Hay	<input type="checkbox"/> Dogs	<input type="checkbox"/> Aerosol Sprays
<input type="checkbox"/> House Dust	<input type="checkbox"/> Cold Air	<input type="checkbox"/> Mold & Mildew	<input type="checkbox"/> Horses
<input type="checkbox"/> Perfumes	<input type="checkbox"/> Smoke	<input type="checkbox"/> Humidity	<input type="checkbox"/> Basements
<input type="checkbox"/> Other Animals	<input type="checkbox"/> Insecticides	<input type="checkbox"/> Pollution	<input type="checkbox"/> Weather Changes
<input type="checkbox"/> Leaves	<input type="checkbox"/> Alcoholic Beverages	<input type="checkbox"/> Odors	<input type="checkbox"/> Exercise
<input type="checkbox"/> Latex (rubber)	<input type="checkbox"/> Insect Bits/stings	<input type="checkbox"/> Insect Bites	

 Foods (List foods/reaction): _____
 Other (List sources/reaction): _____
5. When are your symptoms worst? Year Round

<input type="checkbox"/> January	<input type="checkbox"/> April	<input type="checkbox"/> July	<input type="checkbox"/> October
<input type="checkbox"/> February	<input type="checkbox"/> May	<input type="checkbox"/> August	<input type="checkbox"/> November
<input type="checkbox"/> March	<input type="checkbox"/> June	<input type="checkbox"/> September	<input type="checkbox"/> December

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

6. Are your symptoms better away from home?
7. Have you ever had an allergy skin test or blood test?
8. Have you ever had allergy injections?
9. Have you received cortisone (prednisone, methylprednisone, etc.) drugs?
10. Are you on allergy medications?

What meds? _____	How long? _____
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11. What is your occupation (current or former)?

For Office Use		
Is Patient:	Yes	No
Using beta blocker?	<input type="checkbox"/>	<input type="checkbox"/>
Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Significantly immunocompromised?	<input type="checkbox"/>	<input type="checkbox"/>
Malignancy?	<input type="checkbox"/>	<input type="checkbox"/>
Severe chronic illness?	<input type="checkbox"/>	<input type="checkbox"/>
If yes to above, select blood test		
Wheezing or difficulty breathing?	<input type="checkbox"/>	<input type="checkbox"/>
Experiencing active hives or extensive dermatitis?	<input type="checkbox"/>	<input type="checkbox"/>
If yes to above, treat symptoms and schedule for another day		
Having symptoms consistent with food allergies?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, to above, consider skin panel and food panel		
Indications:		
Inhalant Panels <input type="checkbox"/> Skin Test <input type="checkbox"/> Blood Test		
Food Panels <input type="checkbox"/> Skin Test <input type="checkbox"/> Blood Test		
Schedule skin test for:		
Reviewed By:		