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 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

NAME: _____ **DOB:** ___/___/_____ **Date:** ___/___/_____

Please fill out the below review of medical symptoms and history. Place a check mark in the box if you have been experiencing any of the mentioned symptoms or if a diagnosis/condition applies to you. Thank you.

Constitutional	**Cardiovascular**	**Reproductive**	**Psychiatric**	**Hematologic/lymphatic**
o **ALL NEGATIVE** o Chills o Fatigue o Fever o Malaise(discomfort) o Night sweats o Weight gain o Weight loss	o **ALL NEGATIVE** o Chest Pain o Claudication (legs hurt during exercise) o Edema o Palpitations	o **ALL NEGATIVE** o Erectile dysfunction o Penile discharge o Sexual dysfunction (decreased drive/ejaculatory issues	o **ALL NEGATIVE** o Anxiety o Depression o Insomnia	o **ALL NEGATIVE** o Easy bleeding o Easy bruising o Lymphadenopathy (swollen lymph nodes)
HEENT	**Gastrointestinal**	**Metabolic/Endocrine**	**Integumentary**	**Immunologic**
o **ALL NEGATIVE** o Ear drainage o Ear pain o Eye discharge o Eye pain o Hearing loss o Nasal drainage o Sinus pressure o Sore throat o Visual changes	o **ALL NEGATIVE** o Abdominal pain o Blood in stools o Change in stools o Constipation o Diarrhea o Heartburn o Loss of appetite o Nausea o Vomiting	o **ALL NEGATIVE** o Cold intolerance o Heat intolerance o Polydipsia (excessive thirst) o Polyphagia (excessive hunger)	o **ALL NEGATIVE** o Brittle hair o Brittle nails o Hair loss o Hirsutism (Excessive facial hair) o Hives o Pruritis (Itchy skin) o Mole changes o Rash o Skin lesion	o **ALL NEGATIVE** o Contact allergy o Environmental allergy (dust, cat, etc) o Food allergy o Seasonal allergy (grass, trees, etc)
Respiratory	**Genitourinary**	**Neurological**	**Musculoskeletal**	
o **ALL NEGATIVE** o Chronic cough o Cough (new) o Know TB exposure o Shortness of breath o Wheezing	o **ALL NEGATIVE** o Dribbling o Dysuria (painful urination) o Hematuria (blood in urine) o Polyuria (excessive amounts of urine) o Slow stream o Urinary frequency (frequent urination) o Urinary incontinence o Urinary retention (unable to fully empty bladder)	o **ALL NEGATIVE** o Dizziness o Extremity numbness o Extremity weakness o Gait disturbance (unsteady on feet) o Headache o Memory impairment o Seizures o Tremors	o **ALL NEGATIVE** o Back pain o Joint pain o Join swelling o Muscle weakness o Neck pain	

For any items marked above, please provide more information about how long symptoms have occurring, severity, prior evaluations, specialists seen, and medications or therapies tried:

New Patient/ Adult Physicals

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: _____

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?	❒	❒
Have you ever been diagnosed with asthma or bronchitis?	❒	❒
Do you experience symptoms of allergies?	❒	❒
Are you interested in an Allergy Evaluation in our office?	❒	❒

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?** ❒ Yes ❒ No Date/Time:
Appointment Scheduled? ❒ Yes ❒ 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

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

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

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

   ❒ Foods (List foods/reaction):_____

   ❒ Other (List sources/reaction):_____

5. When are your symptoms worst? ❒ Year Round

❒ January	❒ April	❒ July	❒ October
❒ February	❒ May	❒ August	❒ November
❒ March	❒ June	❒ September	❒ December
			❒

	Yes	No
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?_____	❒	❒

11. What is your occupation (current or former)?

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