Value Care Health Clinic™

1050 S. Academy Blvd., Suite 140
Colorado Springs, CO 80910
P: (719) 574-7083
F: (719) 574-1226

NEW PATIENT PAPERWORK

PATIENT: _____ DOB: _____ SEX: MALE OR FEMALE

SSN: _____ PHONE: _____ EMAIL: _____

ADDRESS: _____ ZIP: _____ CITY: _____

RACE:
- ☐ CAUCASIAN
- ☐ AFRICAN AMERICAN
- ☐ AMERICAN INDIAN OR ALASKA NATIVE
- ☐ ASIAN
- ☐ CHINESE
- ☐ HISPANIC
- ☐ OTHER: _____

ETHNICITY:
- ☐ WHITE
- ☐ MEXICAN
- ☐ PUERTO RICAN
- ☐ CUBAN
- ☐ OTHER: _____

PRIMARY INSURANCE: _____ POLICY #: _____

POLICY SPONSOR: _____ DOB: _____ SSN: _____

RELATIONSHIP TO SPONSOR: _____

SECONDARY INSURANCE: _____ POLICY #: _____

POLICY SPONSOR: _____ DOB: _____ SSN: _____

RELATIONSHIP TO SPONSOR: _____

I CERTIFY THAT THE INFORMATION I HAVE PROVIDED IS ACCURATE AND CURRENT. I CONSENT TO TREATMENT FOR MYSELF OR MINOR CHILD AS THE PARENT/LEGAL GUARDIAN, UNDER VALUE CARE HEALTH CLINIC AS MY PHYSICIANS GROUP. I UNDERSTAND THAT UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABLILITY ACT OF 1996 (HIPPA), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION.

(INITIALS): _____

I AUTHORIZE VALUE CARE HEALTH CLINIC TO LEAVE VOICE MESSAGES ON MY HOME OR ALTERNATE PHONE FOR MY CARE INCLUDING FINANCIAL OBLIGATIONS, CLINICAL, PRESCRIPTION COMMUNICATION AND APPOINMENT REMINDERS.

(INITIALS): _____

PRINT NAME: _____ SIGNATURE: _____ DATE: _____

Value Care Health Clinic™

MEDICAL HISTORY

PATIENT: _____ DOB: _____ SEX: MALE OR FEMALE

☐Yes ☐No Do you have pain at this time? If so, on a scale of 1 (least pain) to 10 (most pain), how bad is your pain? _____

☐Yes ☐No Do you have and food or drug allergies? If Yes, allergic to: _____

Allergic reaction: _____

Medications

1. _____ Dose _____ 2. _____ Dose _____ 3. _____ Dose _____

4. _____ Dose _____ 5. _____ Dose _____ 6. _____ Dose _____

Preventative Care

*Please provide the date of the last time you had each of the listed below.

Dental Visit	Vision Screening	Cholesterol Check	Tetanus _____
A1C (Diabetics)	Colonoscopy	Mammogram	PAP _____
PSA	Bone Density	Flu Vaccine	Pneumonia Vaccine _____

Medical History

Asthma	☐Yes ☐No	Heart Disease	☐Yes ☐No	Gastrointestinal Problems	☐Yes ☐No
Cancer	☐Yes ☐No	Liver Disease	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Depression	☐Yes ☐No	Blood Pressure	☐Yes ☐No	Thyroid Disease	☐Yes ☐No
Epilepsy	☐Yes ☐No	Lung Disease	☐Yes ☐No	Thrombophlebitis	☐Yes ☐No
Ear/Nose/Throat	☐Yes ☐No	Breast Cancer	☐Yes ☐No	Mental Illness	☐Yes ☐No
Diabetes	☐Yes ☐No	Hyperlipidemia	☐Yes ☐No	Other:	☐Yes ☐No

Family History

Heart Disease	☐Yes ☐No	Diabetes	☐Yes ☐No	High Blood Pressure	☐Yes ☐No
Colon Cancer	☐Yes ☐No	Breast Cancer	☐Yes ☐No	Thrombophlebitis	☐Yes ☐No
Uterine/Ovarian CA	☐Yes ☐No	Thyroid Disease	☐Yes ☐No	Depression	☐Yes ☐No

Surgical History

Date of Surgery: _____ Surgery for: _____

Date of Surgery: _____ Surgery for: _____

Social History

☐Yes ☐No Do you smoke? If so, how much? _____ For how long? _____

☐Yes ☐No Do you consume Alcohol? If so, how much? _____ For how long? _____

☐Yes ☐No Recreational drug use? What type? _____ How much? _____ For how long? _____

Value Care Health Clinic™

Review of Systems

*Please Circle if you have had any of the following in the last 7 days

Systemic Symptoms:	Fatigue	Fever	Chills	Night Sweats	Recent Weight loss	Recent Weight Gain		
Head Symptoms:	Sinus pain	Headache						
Eye Symptoms:	Worsening Vision	Floaters	Double Vision	Blurry Vision	Visual Flashes	Pain with Movement	Sensitivity to Light	Red Eyes
ENT Symptoms:	Hearing Loss	Earache	Ear Drainage	Ringing	Nose Bleeds	Sneezing	Nasal Itching	Sore Throat
	Mouth Soreness	Mouth Dryness						
Cardiovascular Symptoms:	Chest Pain	Palpitations	Leg Pain w/ Exercise	Slow Heart Rate	Fast Heart Rate			
Pulmonary Symptoms:	Difficulty Breathing	Shortness of Breath	Awakening Short of Breath	Sleeping Upright	Cough	Loose Cough	Dry Cough	
GI Symptoms:	Decreased Appetite	Anorexia	Difficulty Swallowing	Heartburn	Nausea	Vomiting	Vomiting Blood	
	Coughing up Sputum	Coughing up Blood	Wheezing					
GU Symptoms:	Blood in Urine	Abnormal Urine Odor	Decreased Urine Output	Change in Frequency	Frequent Emptying of Full Bladder	Urinating More than Once at Night		
	Urinary Frequency	Urinary Incontinence						
Endocrine Symptoms:	Excessive Thirst	Heat Intolerance	Cold Intolerance	Excessive Sweating	Feelings of Weakness			
Musculoskeletal Symptoms:	Back Pain	Muscle Aches	Arthralgia	Muscle Cramps	Joint pain	Joint Swelling	Joint Stiffness	
Psychological Symptoms:	Depression	Anxiety						
Skin Symptoms:	Dry Skin	Itching	Peeling	Skin Scaling	Skin Discoloration	Rash		

GAD -7 (Ages 11+ Only)

Over the last 2 weeks, how often have you been bothered by the following problems? (Use "✔" to indicate your answer)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total T_____ = _____ = _____ = _____)

Total Score: _____

Patient Health Questionnaire – (PHQ – 9) (Ages 11+ Only)

Over the last 2 weeks, how often have you been bothered by the following problems? (Use "✔" to indicate your answer)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down?	0	1	2	3
7. Trouble concentrating on things, like reading newspaper or watching TV?	0	1	2	3
8. Moving or speaking so slowly that other people notice? The opposite – being so fidgety or restless that you are more active than usual.	0	1	2	3
9. Thoughts that you would be better off dead or hurting yourself in some way.	0	1	2	3

(For office coding: Total T_____ = _____ = _____ = _____)

Total Score:_____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

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HIPAA ACKNOWLEDGEMENT AND CONSENT FORM

I understand that under the Health Insurance Portability and Accountability Act of 1996(HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessment or evaluations and physician's certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information (available in the office in print form). I have reviewed such Notice of Privacy Practices prior to signing this consent and acknowledge that I have studied it thoroughly. I understand that this organization at any time at the address above to obtain a current copy of the Notices or Privacy.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is abound to abide.

Cancellation Policy/No Show Policy

We are a privately-owned clinic and our licensed providers are here to assist in your well- being. Please know that we have **zero tolerance** for **abusive behavior** towards our providers and staff. Your care will be terminated immediately if any rude or abusive behavior towards our staff occurs.

We understand that there are times when you must miss an appointment due to emergencies or obligations. However, when you do not call to cancel or reschedule an appointment you may be preventing another patient from getting treated vice versa. If your appointment is not cancelled at least (24) twenty-four hours prior to the appointed time it will be considered a no show. **If you have more than (3) three no shows including any practice we refer you to, you will be seen on a walk-in basis only; at the appointed walk-in clinic times.**

If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

_____ / _____

Patients Name Date of Birth

_____ / _____ _____

Sign (Patient or Legal Guardian) Date Relationship to Patient

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT: _____ DATE OF BIRTH: _____/_____/_____ DATE: _____ /_____/_____

I HEREBY AUTHORIZE THE MEDICAL RECORDS DEPARTMENT FROM:

_____

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number Fax Number

_____

Address (Street, City, State and ZIP)

TO RELEASE REQUESTED INFORMATION FROM MY MEDICAL RECORDS TO:

VALUE CARE HEALTH CLINIC 719-574-7083 719-574-1226

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number Fax Number

1050 S ACADEMY BLVD, SUITE 140, COLORADO SPRINGS, COLORADO 80910
Address (Street, City, State and ZIP)

_____ (INITIAL) PATIENT INFORMATION IS NEEDED FOR CONTINUING MEDICAL CARE.

INFORMATION TO BE RELEASED OR ACCESSED:

XX ☐ FULL MEDICAL RECORD ☐ CONSULTATION REPORT ☐ EMERGENCY ROOM RECORD

☐ OPERATIVE REPORTS ☐ LAB/PATH REPORTS ☐ X-RAY REPORTS/IMAGES

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information related to:

- ☐ Substance Abuse (including alcohol/drug abuse)
- ☐ Mental Health
- ☐ Psychotherapy Notes
- ☐ HIV related information (including AIDS related testing)

This material shall not be transmitted to anyone without written consent or authorization as provided.

_____ _____

Signature Date

THE ABOVE INFORMATION MAY BE RELEASED (SPECIFY NAME OR TITLE OF THE INDIVIDUAL OR THE NAME OF THE ORGANIZATION TO WHICH RECORDS ARE TO BE RELEASED AND THE APPROPRIATE ADDRESS):

I UNDERSTAND THAT MY RECORDS ARE CONFIDENTIAL AND CANNOT BE DISCLOSED WITHOUT MY WRITTEN AUTHORIZATION, EXCEPT WHEN OTHERWISE PERMITTED BY LAW. INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT AND NO LONGER PROTECTED. I UNDERSTAND THAT THE SPECIFIED INFORMATION TO BE RELEASED MAY INCLUDE BUT IS NOT LIMITED TO HISTORY, DIAGNOSES, AND/OR TREATMENT OF DRUG OR ALCOHOL ABUSE, MENTAL ILLNESS, OR COMMUNICABLE DISEASE, INCLUDING HIV AND AIDS.

I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION IN WRITING AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE UPON THE AUTHORIZATION.

THE AUTHORIZATION WILL EXPIRE SIX (6) MONTHS FROM THE DATE OF MY SIGNATURE, UNLESS I REVOKE THE AUTHORIZATION PRIOR TO THAT TIME.

PRINT NAME: _____ SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT: _____

Value Care Health Clinic™

RELEASE OF INFORMATION

Patient Name: _____ DOB:
Medicaid ID: _____
_____

I authorize Value Care Health Clinic to release verbal and/or written information concerning my current and/or prior medical treatment. The purpose of this release is to ensure continuity of care, to aid in effective treatment, and/or to allow for consultation between professionals to provide the best treatment possible. I release the persons, agencies, or institutions from any and all liability for providing such information. Any information I share is protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42, CFR Part 2, and cannot be disclosed without my written consent (except if necessary to protect my rights or welfare or if required by law).

Agencies/Personal Value Care Health Clinic can contact are:_____

_____

By signing below, I certify that this request has been made voluntarily, and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this Authorization in writing, at any time, except to the extent that action has already been taken to comply with this.

A legible copy of this signed Authorization (e.g., transmitted via facsimile) may be used with the same effectiveness as an original. I understand that the information that is disclosed may be subject to disclosure by the recipient, and is no longer protected under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

Value Care Health Clinic is a team based clinic. Your health care team includes your provider, a medical assistant, a care coordinator and potentially a behavioral health provider. We are proud partners of AspenPointe for behavioral health services. This means we work together on your care. Please initial here to acknowledge that we may share your clinical information with your health care team.

(INITIALS):_____

If you receive services from AspenPointe, the following link provides access to your rights, your consent and acknowledgement to treatment, agreement to a Release of Information for Treatment, Payment, and Operations purposes under HIPAA and CO State law, and information regarding your provider;
http://www.aspenpointe.org/Health+Care+Services/How+Do+I+Get+Started-4-641.html

_____ _____
Signature of Client Date Signature of parent/guardian Date

Revocation (if applicable): I hereby revoke the above Authorization.

_____
Signature Date

Value Care Health Clinic™

FINANCIAL POLICY

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1. INSURANCE – We participate in most insurance plans, including Medicare and Medicaid. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. If you are not insured by a plan we do business with, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim or not.

2. CO-PAYMENTS and DEDUCTIBLES –
   a. Co-pays must be paid at the time of service in the form of cash, check or credit card.
      i. A $5.00 minimum applies to credit card payments.
      ii. A $10.00 minimum applies to check, subject to a $25.00 Return Check Fee if bank does not honor check
   b. In the event a patient has a deductible that has not been met we will collect $50.00 payment towards that deductible and submit the claim to your insurance company.

3. MISSED APPOINTMENTS / TARDY ARRIVALS
   a. We ask for a 24-hour notice to cancel or reschedule an appointment. Failure to do so, after documented warning, could result in dismissal from our practice, a fee of $30.00, and or be placed on a walk-in status only.
   b. When a patient arrives more than 10 minutes after the start time of their scheduled appointment, we reserve the right to re-schedule the appointment.

4. NON-PAYMENT – If your account is over 120 days past due, Value Care Health Clinic has the right to disclose to an outside collection agency or attorney all relevant personal and account information necessary to collect payment for services rendered. You are responsible for all costs of collection. Once an account is sent to a collections agency you and your immediate family members may be discharged from this practice.

5. INSURANCE BENEFITS AND INFORMATION RELEASE FORM
   I hereby authorize the Doctor to release all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the Doctor for any services rendered that are not paid for directly by me.

6. MEDICARE AUTHORIZATION
   I request that payment of authorized Medicare benefits be made either to me or on my behalf to Value Care Health Clinic *for any services furnished me. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.*

_____ _____
Patient Signature Date

_____ _____
VCHC Staff Witness Date

AspenPointe Health Services: Disclosure Statement

The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of licensed psychologists, licensed social workers, licensed professional counselors, licensed marriage and family therapists, certified or licensed addictions counselors, and unlicensed individuals who practice psychotherapy. The agency within the Department that has responsibility specifically for licensed and unregistered psychotherapists for mental health is the Mental Health Section of the Division of Registrations. The Board of Examiners for each license or registration listed below can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800. Additionally, AspenPointe as an agency is also licensed by the Office of Behavioral Health (OBH) to provide substance use disorder treatment services. OBH may be reached at 3824 West Princeton Circle, Denver, CO 80236-3111, (303) 866-7400.

A licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a master's degree in their profession and have two years of post-masters supervision. A licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. A licensed Social Worker must hold a master's degree in social work. A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure. A Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1000 hours of supervised experience. A CAC II must complete the additional required training hours and 2000 hours of supervised experience. A CAC III must have a bachelor's degree in behavioral health, and complete additional required training hours and 2000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical masters degree and meet the CAC III requirements. A Registered Psychotherapist is registered with the State Board of Registered Psychotherapists, is not licensed or certified, and no degree, training or experience is required.

You are entitled to receive information about the credentials of staff, methods of therapy, the techniques used, the duration of your therapy (if it can be determined), and fee structure. Please ask if you would like to receive this information. You may seek a second opinion from another therapist which may or may not be covered by your benefit plan. Please consult with us to see if your benefit plan covers this service. You may terminate therapy at any time, unless otherwise prevented by law. You should know that AspenPointe clinicians are supervised by qualified staff who review their clinical work on a regular basis. You are entitled to the name of the individual who supervises your clinician and you may request his/her name at any time. The therapist listed below is your current primary therapist. When multiple providers are involved in your care, you are entitled to receive information about those providers' degrees, credentials and licenses upon request. In a professional relationship, sexual intimacy between a therapist and a client is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.

Generally speaking, the information provided by and to a client during therapy sessions is legally confidential. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent. In addition, information disclosed to a therapist is privileged communication and cannot be disclosed in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates. However, there are exceptions to the general rule of legal confidentiality and privilege. For example, therapists are required to report child abuse. Some of these exceptions are listed in Colorado Revised Statute 12-43-218 and in the Notice of Privacy Rights you were provided. There are other exceptions that will be identified, if feasible, should any such situation arise during therapy.

In addition, the information provided by and to a substance abuse client is legally confidential (Alcohol and Drug Abuse Client Records, 42 CFR, Part 2) and may not be released without the client's written consent. The confidentiality of

alcohol and drug abuse client records maintained by this program is protected by federal law and regulations. Generally, the program may not say to a person outside the program that a client attends the program, or disclose any information identifying a client as an alcohol and drug abuser, unless: The client consents in writing; OR the disclosure is allowed by a court order; OR the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation; OR the client commits or threatens to commit a crime either at the program or against any person who works for the program. Violation of the federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs. Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

PRIMARY THERAPIST

Brian L Koch *Graduated from* *University of Colorado in Colorado Springs* *in* *2010*

(Name) *(College or University)* *(Year Grad)*

with a *Masters* *in* *Community Counseling*.

(Degree Type) *(Field of Study)*

Check all that apply: In the. State of Colorado, I am a

- ☐ *Licensed Psychologist*
- ☐ *Licensed Clinical Social Worker*
- ☐ *Licensed Social Worker*
- ☐ *Licensed Marriage and Family Therapist*
- *XX* *Licensed Professional Counselor*
- ☐ *Certified Addictions Counselor I*
- ☐ *Certified Addictions Counselor II*
- ☐ *Certified Addictions Counselor III*
- ☐ *Licensed Addictions Counselor*
- ☐ *Registered Psychotherapist*
- ☐ *Other:*

Your therapist/case manager's clinical supervisor is *Roberta Renfro, NCC, LPC*
Phone number *719-572-6153*

I have read the preceding information, it has also been provided verbally, and I understand my rights as a client.

Client Signature Date

Legal Guardian Signature (if applicable) Date

Witness Signature (if applicable) Date

CONSENT FOR SERVICES/TREATMENT AND PATIENT ACKNOWLEDGEMENT

1. CONSENT FOR TREATMENT. I voluntarily consent to behavioral health services and treatment performed by staff and providers at AspenPointe. This may also include treatment by a medical professional who can prescribe medication. I understand that the practice of behavioral health is not an exact science and no guarantees have been made to me as to the result of treatment. I understand that I have a right to consent to proposed treatment as well as a right to refuse proposed treatment. I also have a right to stop services and/or treatment at any time. I have a right to a second opinion regarding my diagnosis and my individual course of treatment.

2. CONTACT. I authorize AspenPointe to contact me regarding my services and/or treatment, appointment reminders, insurance items, or any call pertaining to my care. I authorize AspenPointe staff to contact me or my designated representative after discharge from services and/or treatment to obtain information for follow-up purposes only. I understand that these communications may occur in writing, secured email, phone, or text message. Should I choose not to receive text message reminders from AspenPointe, I will opt out of these services by contacting AspenPointe in writing.

3. TELEPSYCHIATRY SERVICES. I authorize AspenPointe to use secured telepsychiatry services, if necessary, to provide services and/or treatment. I understand that all laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry. I have the right to withdraw my consent to telepsychiatry services at any time and it will not impact my right to care.

4. AUTHORIZATION FOR RELEASE OF INFORMATION. I authorize AspenPointe to utilize confidential medical information or other information contained in my medical records as necessary for claims payments, medical management, or quality of care review purposes. I further authorize the release of such confidential information to my insurance company or other health coverage plan, including government payers, as necessary for claims payment, medical management, and quality review activities as conducted by such company or plan or its subsidiaries or designees. This authorization includes the release of AIDS diagnosis or a positive HIV antibody result, alcohol and/or drug use/abuse information, genetic testing, congenital disorders, and mental health information. I understand this authorization for release of information can be revoked by me in writing at any time, but only with respect to the proposed treatment and not with respect to care and treatment that has already been provided to me.

5. WAIVER OF RESPONSIBILITY FOR PERSONAL VALUABLES. I understand that AspenPointe does not assume any liability for the loss or damage to my personal property while on AspenPointe premises. I understand all valuables should not be brought or left at AspenPointe.

6. PAYMENT AGREEMENT AND ASSIGNMENT. Except as prohibited by an agreement between my insurance company and AspenPointe or by state or federal law, I agree to be responsible for my co-payments, deductibles, or other charges for services not covered or paid by insurance or other third party payers. I authorize AspenPointe to file any claims for payment of any portion of the patient bills and assign all rights and benefits to AspenPointe, as appropriate. I further agree, subject to state or federal law, to pay all costs, attorney fees, expenses, and interest in the event that AspenPointe takes action to collect same because of my failure to pay in full any and all incurred charges.

7. CANCELLATIONS. I will give a minimum of 24 hours' notice for all appointments I need to cancel or reschedule. I understand that if I arrive late for a scheduled appointment I may not be seen and agree that unattended or late appointments may result in AspenPointe discontinuing services and/or treatment.

8. Pikes Peak Community Health Partnership (PPCHP). AspenPointe Health Services clients are part of the PPCHP, which is a Colorado Regional Care Collaborative Organization (RCCO). Through PPCHP, you can receive healthcare services as needed. PPCHP utilizes data for: 1) individual client care coordination among providers in order to better assess client overall needs and design treatment plans that serve the whole person needs or clients common to both organizations and 2) population health management through analysis of healthcare data with the goal to improve healthcare outcomes for identified populations with efficiencies of operations and cost savings. I acknowledge that I have been provided this information regarding how my information may be used.

9. Colorado Regional Health Information Organization (CORHIO). Clients who receive services at AspenPointe are automatically enrolled in CORHIO. CORHIO is the state-designated entity to lead efforts to expand the use of health information across Colorado. CORHIO facilitates the exchange of health information in the behavioral health community with the physical health care community to improve coordination of care so that important information about your healthcare is available to providers who render services for you. You do have the right to opt out of participation in CORHIO or revoke a previous opt out request you may have made. You can do so by selecting the relevant check box below:

☐ I choose to OPT OUT of Participation in CORHIO

10. ACKNOWLEDGEMENTS. I acknowledge that I have been given/offered a copy of the following and/or that I am able to access this information on AspenPointe website (www.aspenpointe.org).

- **Client Rights and Responsibilities**
- **Notice of Privacy Rights,** including Confidentiality of Alcohol and Drug Abuse Patient Records
- **Health First Colorado Member Handbook**
- **Client Agreements for Treatment**

☐ Client/Legal Guardian refused/unable to sign (identify reason):

Staff Signature Date

Client Signature Date