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: _____
PRIMARY 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 physicians 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 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.**

_____/_____

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: _____

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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

Medicaid Accountable Care Collaborative Program
Primary Care Medical Provider (PCMP) Choice Form

What is this form for?

As a member of Medicaid's Accountable Care Collaborative (ACC) Program, you must choose a Primary Care Medical Provider (PCMP). This form allows you to tell Medicaid what your choice is. You may choose any PCMP who is participating in the ACC Program. If you have already called **Health***Colorado* to choose a PCMP, you don't need to fill out this form.

What if I am not ready to choose a PCMP?

You do not have to choose a PCMP today. You can still go to today's appointment even if you do not fill out this form, and your doctor cannot tum you away from today's appointment.

What if I change my mind and want to choose a different PCMP later?

If you select a PCMP using this form and later decide you want to switch, call **Health***Colorado* at 303-839-2120 in the Denver metro area, or 1-888-367-6557 outside metro Denver. The call is free.

If you are not sure if you want to be in the ACC Program or if you want to know if other health plans are available to you, call **Health***Colorado.* Whichever Medicaid health plan you choose, you are allowed to disenroll from the plan for any reason in the first 90 days.

Date: _____

I choose Value Care Health Clinic **to be the Primary Care Medical Provider (PCMP) for the**
(Practice Name)

Medicaid ACC Program members listed below.

PCMP phone number: 719-641-9416 **PCMP #or Practice Name:** 79206816

Medicaid ID# (from your Medicaid ID card) *(Include all 7 digits)*							Social Security Number or Date of Birth	Print Full Name	Signature of Medicaid Member / Parent / Legal Guardian *(By signing this I confirm that I am the Parent/LegalGuardian)*

Provider: Please see instructions on back.

Fax this form to **Health***Colorado* at 303-832-8352 or Community Care of Central Colorado Service Center 719-314-4268.