COLORADO PSYCHCARE, P.C. - PATIENT INFORMATION

Date_____

Name_____SSN_____
Last First MI

Address_____
Street City State Zip

Phone: Home_____ Work_____ Cell_____

Date of Birth_____ Age_____ Sex_____ Marital Status: M S D W

Referred By_____ Occupation_____ Employer _____

****

EMERGENCY CONTACT INFORMATION

Name_____ Relationship _____
Last First

Address_____
Street City State Zip

Phone: Home_____ Work_____ Cell_____

RESPONSIBLE PARENT INFORMATION (For Minors Only)

Name_____ SSN _____
Last First

Address_____
Street City State Zip

Phone: Home_____ Work_____ Cell_____

********** **Please complete the following (if applicable)** **********

1) **PCP Name:** _____
Clinic Name: _____
Street: _____
City, State, Zip: _____
Office: (____)_____ Fax: (____)_____

2)_____
Clinic Name: _____
Street: _____
City, State, Zip: _____
Office: (____)_____ Fax: (____)_____

3) **Therapist Name** _____
Clinic Name: _____
Street: _____
City, State, Zip: _____
Office: (____)_____ Fax: (____)_____

4) **Attorney** _____
Firm Name: _____
Street: _____
City, State, Zip: _____
Office: (____)_____ Fax: (____)_____

Billing and Financial Agreement

Please carefully read through this agreement and initial where indicated

GENERAL MEDICAL CONSENT - I, the undersigned, consent to and authorize medical care, which may include routine diagnostic procedures, laboratory services, medical treatments and medications deemed necessary or advisable by the treating physician. I understand that the practice of medicine is not an exact science and acknowledge that no promises or guarantees have been made regarding treatment outcomes. **Initial**_____

BILLING PROCEDURES - All billing for Colorado PsychCare providers (**with the exception of Dr. Langer – please see below**) will be under the name and practice of ***Howard J. Entin, MD, PC***. Dr. Entin is the clinical Medical Director and maintains all necessary insurance affiliations and participation contracts under his name. If your insurance requires pre-certification and you need to request additional clinical sessions from your insurance company, or if you inquire about insurance payments with your insurance company, please refer to Dr. Howard Entin as the participating/treating provider of services. If you refer to a clinician other than Dr. Entin, you may be denied insurance benefits. **Dr. Langer's patients are billed under her name. If you are a patient of Dr. Langer, please use her name for all inquiries you may make with your insurance company.** **Initial**_____

PREAUTHORIZATION REQUIREMENTS – I understand it is my sole responsibility to obtain all necessary authorizations, verifications, and to comply with all insurance company requirements for processing my claims. I understand information Colorado PsychCare may obtain is not a guarantee of benefits or payments. **Initial**_____

ASSIGNMENT FOR DIRECT PAYMENT - I authorize the release of any medical information necessary to process all necessary claims related to treatment. I also authorize payment of medical benefits to the provider for services rendered. **Initial**_____

HIPAA - (Health Insurance Portability & Accountability) rules regarding release of healthcare information and Notice of Privacy Practices have been made available to me. PATIENT RIGHTS AND RESPONSIBILITIES have been made available to me and are understood. **Initial**_____

FINANCIAL AGREEMENT:

I understand payment of my copay/coinsurance/deductible (if not met) is due and payable at the time of service. I understand there is no guarantee of reimbursement from any insurance company. I acknowledge full responsibility for, and agree to pay all charges and costs incurred by me and not paid by my health insurance or other payor. **Initial**_____

I understand all charges including co-pays/coinsurance and deductible are due and payable at the time my appointment. I have provided credit card information to be kept on file for payment of charges. **If full payment is not received within 30 days of invoicing, I understand a $20 service fee will be added per month until the balance is paid in full.** **Initial**_____

In addition, I understand in the event of nonpayment, the outstanding balance on my account will be subject to interest charges not to exceed 1.5% monthly and my account may be turned over to a collections agency. I agree to pay an additional 35% of the unpaid balance as the reasonable cost of collection from such agency. **Initial**_____

I understand that that CPS has a $35 return check fee. If my financial institution declines payment for any reason, $35 return check fee will be added to my balance. **Initial**_____

I understand that any lawsuit over the terms of this agreement shall be brought within the courts of Colorado and governed by the laws of that state. Accordingly, the parties hereby subject themselves to the jurisdiction of those courts. Should such a dispute result in any term being declared contrary to those laws, the remaining terms shall still be binding. I will pay all reasonable and necessary costs (including attorney fees) of any lawsuit to enforce this agreement. Further medical services may not be provided until the balance is paid or until alternative arrangements have been made. **Initial**_____

OFFICE APPOINTMENT CANCELLATION POLICY

In order to function efficiently for the benefit of patients and providers, our office has an appointment cancellation policy in place. **WE MUST BE INFORMED OF A CANCELLATION OR CHANGE AT LEAST 24 BUSINESS HOURS PRIOR TO THE SCHEDULED APPOINTMENT IN ORDER TO AVOID A LATE CANCEL CHARGE.** (For example, for a Monday appointment at 1 pm you must cancel the prior Thursday by 1 pm.) **If a cancellation is made with less than the required notice, you may be billed for the full amount of the scheduled session.** **Initial**_____

I understand that I will be billed for missed appointments. I understand that health insurance policies do not cover the cost of missed appointments *or late cancellations*, and I am therefore responsible for payment of the full charge (not the copay amount) for any missed session. **Initial**_____

X Signature of Patient/ Responsible Party _____ **Date**_____

Patient Name : _____

COLORADO PSYCHCARE, P.C. **PATIENT INTAKE INFORMATION**

Name_____ Date _____

Presenting Problem _____

_____

_____

Current Medications (include name, dose, how often used, how long taken)

1. _____ 5._____
2. _____ 6._____
3. _____ 7._____
4. _____ 8._____

Height_____ Weight _____Drug Allergies_____

Current Healthcare Providers

1. _____ 3._____
2. _____ 4._____

Chronic Medical Conditions _____

_____

_____

Past Surgeries/ Hospitalizations _____

_____

_____

Past Psychiatric/ Chemical Dependency History - (Hospitalizations, Prior Out-Patient Therapy)

_____

_____

Family History of Mental Health/ Chemical Dependency Problems _____

_____

_____

MEDICAL REVIEW OF SYSTEMS / ACTIVE MEDICAL PROBLEMS -

(*Please indicate yes or no - circle all that apply* – give details below)

1. General -	yes___ no ___	fatigue, weight change, skin problems
2. Eyes/ears-	yes___ no ___	vision problems, hearing problems
3. Nose/ throat -	yes___ no ___	nose bleeds, colds, sinus, allergies, swallowing problems
4. Cardiovascular -	yes___ no ___	chest pain, fainting, palpitations, high blood pressure
5. Respiratory -	yes___ no ___	shortness of breath, asthma, cough, wheezing
6. Gastrointestinal -	yes___ no ___	nausea, vomiting, constipation, diarrhea, pain, bloating
7. Genitourinary -	yes___ no ___	urgency, frequency, incontinence, UTIs, sexual problems
8. Muscular -	yes___ no ___	pain, weakness, stiffness, joint problems
9. Neurological -	yes___ no ___	seizures, tremors, headaches, memory, speech problems
10. Endocrine -	yes___ no ___	diabetes, hormonal issues, thyroid problems
11. Blood/ Lymph -	yes___ no ___	anemia, bleeding/ bruising tendency

DETAILS _____

_____

_____

_____

_____

_____

Colorado PsychCare, P.C.

Howard J. Entin, MD, PC
6081 S. Quebec Street - Suite 200 - Centennial, CO 80111
(Phone) 303-721-7330 (Fax) 720-488-6566

AUTHORIZATION TO RELEASE AND/OR OBTAIN MEDICAL RECORDS AND HEALTH INFORMATION

Patient Name _____ **Date of Birth**_____

I hereby authorize Colorado PsychCare and the following provider, person or entity to release and obtain my medical records and health information as follows:

1) _____

2) _____

3) _____

Address: _____ City: _____ St: _____ Zip: _____

Phone: _____ Fax: _____

---

1) I authorize the following information to be released:

☐ Health records ☐ Billing records ☐ Other: _____

I understand that the information to be released may include the following: Diagnoses and/or treatment for alcohol and/or drug abuse; Behavioral health services/psychiatric care; AIDS/AIDS Related Complex (ARC) diagnoses and/or treatment; HIV test results. Limited as follows _____

2) This authorization will remain effective for 365 days unless lesser time noted here:

_____

3) At this time please:

☐ Send records to party listed above ☐ Request records from party listed above ☐ Keep on file

4) By signing below I agree to the following:

I understand that I have the right to revoke/withdraw this authorization, in writing, at any time, and that the revocation/withdrawal will be effective except to the extent that the above provider or entity releasing my information has already taken action in reliance on my authorization. My written statement that I want to revoke/withdraw my authorization should be delivered to Colorado PsychCare PC, or to the provider or entity listed above. The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and would no longer be protected. I understand there may be a fee involved with fulfillment of this request.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, etc.)