

## COLORADO PSYCHCARE, P.C. - PATIENT INFORMATION

Date \_\_\_\_\_

Name \_\_\_\_\_  
Last First MI SSN \_\_\_\_\_

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 \_\_\_\_\_  
Last First Relationship \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

### RESPONSIBLE PARENT INFORMATION (For Minors Only)

Name \_\_\_\_\_  
Last First SSN \_\_\_\_\_

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: ( )

3) Therapist Name \_\_\_\_\_

Clinic Name: \_\_\_\_\_

Street: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Office: ( ) Fax: ( )

2) \_\_\_\_\_

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.)



NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

**PATIENT HEALTH QUESTIONNAIRE (PHQ-9)**

Over the last two weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things.
2. Feeling down, depressed or hopeless
3. Feeling bad about yourself or that you are a failure
4. Thoughts that you would be better off dead or of hurting yourself
5. Trouble falling/staying asleep or sleeping too much
6. Feeling tired or having little energy
7. Poor appetite or overeating
8. Trouble concentrating on things such as reading or watching TV
9. Moving or speaking too slowly, or the opposite, being fidgety or restless

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3

(ADD COLUMNS) TOTALS:

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 at all    \_\_\_-Somewhat difficult    \_\_\_-Very difficult    \_\_\_-Extremely difficult

**GENERALIZED ANXIETY SCALE - GAD-7**

Over the last two weeks, how often have you been bothered by any of the following problems?

1. Feeling, nervous, anxious or on edge
2. Not being able to stop or control worrying
3. Worrying too much about different things
4. Trouble relaxing
5. Being so restless that it is hard to sit still
6. Becoming easily annoyed or irritable
7. Feeling afraid as if something awful might happen

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3

(ADD COLUMNS) TOTALS:

TOTAL SCORE: \_\_\_\_\_



## Mood Disorder Questionnaire

Patient Name \_\_\_\_\_ Date of Visit \_\_\_\_\_

Please answer each question to the best of your ability

**1. Has there ever been a period of time when you were not your usual self and...**

**YES NO**

...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	<input type="checkbox"/>	<input type="checkbox"/>
...you were so irritable that you shouted at people or started fights or arguments?	<input type="checkbox"/>	<input type="checkbox"/>
...you felt much more self-confident than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you got much less sleep than usual and found that you didn't really miss it?	<input type="checkbox"/>	<input type="checkbox"/>
...you were more talkative or spoke much faster than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...thoughts raced through your head or you couldn't slow your mind down?	<input type="checkbox"/>	<input type="checkbox"/>
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	<input type="checkbox"/>	<input type="checkbox"/>
...you had more energy than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you were much more active or did many more things than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	<input type="checkbox"/>	<input type="checkbox"/>
...you were much more interested in sex than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	<input type="checkbox"/>	<input type="checkbox"/>
...spending money got you or your family in trouble?	<input type="checkbox"/>	<input type="checkbox"/>

**2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?**

☐ ☐

**3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?**

☐ No problems    ☐ Minor problem    ☐ Moderate problem    ☐ Serious problem



NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

## **ALCOHOL SCREENING- MAST** (Michigan Alcohol Screening Test)

### **Questions - Circle Correct Answers**

- |  |                |
|--|----------------|
| 1. Do you feel you are a normal drinker?   | YES (0) NO (2) |
| 2. Do friends or relatives think you are a normal drinker?   | YES (0) NO (2) |
| 3. Have you ever attended a meeting of Alcoholics Anonymous (AA)?  | YES (5) NO (0) |
| 4. Have you ever lost friends because of drinking?   | YES (2) NO (0) |
| 5. Have you ever gotten into trouble at work/ home because of drinking?  | YES (2) NO (0) |
| 6. Have you ever neglected your obligations, your family or your work for two or more days in a row because you were drinking?     | YES (2) NO (0) |
| 7. Have you ever had delirium tremens (DTs), severe shaking, heard voices, or seen things that weren't there after heavy drinking? | YES (2) NO (0) |
| 8. Have you ever gone to anyone for help about your drinking?  | YES (5) NO (0) |
| 9. Have you ever been in a hospital because of drinking?   | YES (5) NO (0) |
| 10. Have you ever been arrested for drunk driving or driving after drinking?   | YES (2) NO (0) |

**TOTAL SCORE:** \_\_\_\_\_