PATIENT REGISTRATION (COMPLETE BOTH SIDES)

AXISHealth System

PATIENT INFORMATION (please fill out in blue or black pen). Parents: **Fill this out as if you are answering for your child.**							
Today's Date		Last Name		First		M.I.	
Date of Birth		Social Security No. (required)		-	-		
Gender Identity: ☐ M ☐ F ☐ Transgender Male / Female-to-Male ☐ Transgender Female / Male-to-Female ☐ Other ☐ Choose not to say							
Gender at birth: ☐ M ☐ F							
How do you identify in terms of sexual orientation? ☐ Straight ☐ Lesbian or Gay ☐ Bisexual ☐ Something else ☐ Don't know ☐ Choose not to disclose							
Street Address				Apartment/Unit#			
Mailing Address							
City		State		ZIP Code			
Home Phone		Work Phone		Cell Phone			
May we leave phone messages for you? ☐ Yes ☐ No *If Y -PLEASE CIRCLE THE BEST NUMBER ABOVE FOR US TO USE.*							
Do you live in the City Limits? ☐ Yes ☐ No			*Is it OK to e-mail information?* ☐ Yes ☐ No				
Is it OK to mail information to the address above? ☐ Yes ☐ No			Email:				
Parent or Guardian Name		Relationship?					
Custodial Responsibility	☐ Joint ☐ Sole ☐ Other *(please explain)* _____						
If patient is 18 years of age or younger, please provide mother's maiden name:							
Race (*Please check all that apply)*	☐ African American/Black ☐ Alaskan Native ☐ Native American: Tribal Affiliation_____ ☐ Asian ☐ Caucasian/White ☐ Pacific Islander ☐ Native Hawaiian ☐ *Refuse to provide*						
Ethnicity	☐ Latino ☐ Hispanic ☐ Not Latino/Hispanic ☐ *Refuse to provide*		Preferred Language:				
Marital Status	☐ Single ☐ Married ☐ Partner ☐ Separated ☐ Divorced ☐ Widowed						
Housing Status	☐ Not Homeless ☐ Homeless Shelter ☐ Doubling up ☐ Street ☐ Transitional Housing		Who do you live with?				
Number of individuals in the home		Number of Individuals under the age of 18 you (the Patient) are responsible for					
Military Status	Are you active duty? ☐ Yes ☐ No Are you a veteran? ☐ Yes ☐ No						
Employment Status	☐ Full Time ☐ Part Time ☐ Unemployed ☐ Disabled ☐ Retired ☐ Migrant/Seasonal ☐ Student, what school do you attend? _____						
Employer		Occupation					
Advanced Directives	Do you have any Advanced Directives? ☐ Yes ☐ No		If No, would you like information on this? ☐ Yes ☐ No				

AXISHealth System

EMERGENCY CONTACT					
Name			Relationship		
Home Number		Cell Number		City/State	

GUARANTOR	
Who is financially responsible for this patient?	
What is their address?	Same as patient? ☐ If not, what is it? Please provide below.

Mailing Address: _____ City_____ State_____ Zip_____

PRIMARY INSURANCE (*You will be asked to show your card at the appointment*)

Name of Policy Holder/Subscriber: _____

Insurance Co Name: _____ Policy Start Date:_____

Policy/ID Number: _____ Group/Plan Number: _____

Claims Address_____ City_____ State_____ Zip_____

Customer Service Phone#: (____) _____ Authorization # :(____) _____

SECONDARY INSURANCE – if appropriate (*You will be asked to show your card at the appointment*)

Name of Policy Holder/Subscriber: _____

Insurance Co Name: _____ Policy Start Date: _____

Policy/ID Number: _____ Group/Plan Number: _____

Claims Address_____ City_____ State_____ Zip_____

Customer Service Phone#: (____) _____ Authorization # :(____) _____

Axis Health System is dedicated to ensuring you have access to our services and our staff is available to assist you in determining if you are eligible for a variety of health benefit coverage options. These options may include ability to pay based on sliding fee discounts, special grant-provided services or public-funded health care coverage such as Medicaid. In many cases, our staff can assist qualifying patients with the enrollment or assessment process. Axis offers discounted fees for qualified patients who may be unable to pay the full fee for services. As a non-profit organization, we receive funding from local, state, federal and grant funding sources and we are required to collect financial information from our patients to continue to receive this funding. All information will remain confidential. *By declining to provide the requested financial information, you will be ineligible for financial assistance for your care.*

Approximate Total Annual Household Income	$		
Number of individuals in the home		Number of individuals under the age of 18 the patient is responsible for	

Consent for Integrated Evaluation and Treatment

AXISHealth System

I hereby consent to treatment, including tests, procedures and medications, as directed by Axis Health System staff and have been given enough information to make an informed decision. Furthermore, I understand my treatment will have a greater chance of success when I participate in its design and fully cooperate with any professional recommendations that are provided to me. I also understand that I may revoke this consent at any time, in writing. However; if I choose to revoke my consent for treatment, Axis Health System will immediately discontinue providing services, dis-enroll me from the practice and close my medical record.

Patient or Legal Guardian Signature: *Please print & hand-sign here:* _____ Date: _____

Patient name (please print): _____

Legal Guardian name (please print): _____

Please note the following with regard to treatment:

AHS staff will depend on statements made by the patient, information provided in patient's medical history and other information as available to evaluate a patient's condition and decide on the best treatment.

Some services at AHS may be provided with telemedicine equipment and involve interaction with providers who are not physically in the clinic for your appointment. These sessions are transmitted via secure, dedicated high-speed lines and are not: videotaped, routed through the Internet, or saved in any way. However, relevant information from your visit will be documented in your medical records, just as it would be if the provider had been physically present.

Your healthcare providers will discuss with you the benefits and risks of treatment. If you are unclear about your treatment or the protection of your records, please feel free to ask questions at any time.

Please note the following with regard to your records and complaints:

We are required to inform you that in the event that you file a complaint, your records may not be maintained longer than seven years and therefore would be unavailable to review in respect to such complaints.

FINANCIAL AGREEMENT (*PLEASE COMPLETE BOTH PAGES*)

PATIENTS WITH INSURANCE:

As a patient, it is important that you understand the benefits and limitations of your insurance coverage. It is important to note that insurance coverage is not a guarantee of insurance payment. Insurance companies have a variety of plans and coverage that may affect what you are expected to pay. Before your appointment, we will verify your basic insurance coverage as the first step. There may be additional research you want to do to ensure you understand your financial responsibility under your plan. Please read the following for additional information regarding what you may be responsible for.

We require your benefits be *assigned* to AHS so we can be paid directly by the insurance company and *release records* solely for the purposes of payment. AHS participates in Medicare, Medicaid, CHP+ and other public or private insurance programs as deemed appropriate for the care offered at AHS. While we employ qualified professionals, the professional may not be contracted by your insurance company due to contractual requirements. When this occurs, your insurance company will not pay for these services.

Note: It is important for you to be aware you are responsible for full payment, regardless of insurance coverage. Your insurance may pay a portion of the claim, however, you are ultimately responsible for the balance not paid by insurance. AHS will mail a statement of your balance due and payment is due to us within 30 days of receiving your statement.

If you receive laboratory services as part of a visit that you have been billed for, your insurance may not cover the charge from our laboratory vendor; however, if you are eligible for our Sliding Fee Discount Program, the lab fees may be discounted.

To find out if you are eligible for the Sliding Fee Discount Program, or should you have any questions regarding your statement, please call our Billing Department at 970.335.2342.

INFORMATION SECURITY:

We recognize that many patients are concerned about the sensitive nature of the information we collect. Please be assured that we take every precaution to keep your personal information secure and use this information only to assist us in providing the services, filing claims and for identification/communication purposes as it relates to healthcare operations. We are required to obtain complete demographic information which includes your social security number to support billing for the services. Refusal to provide this information may constitute a refusal of service.

By signing this document, I hereby:

Authorize the Assignment of Benefits: Assign all medical benefits under my coverage to AHS for services provided to me. Furthermore, my signature authorizes and directs my insurance carrier(s), including Medicare, private insurance and any other health/medical plan to issue payment directly to AHS for services rendered.

Agree to my Financial Responsibility: Acknowledge and understand that my insurance co-payments are due at time of service and that I am responsible for any amounts that are not covered by my insurance, which may include co-insurances, deductibles or claims denied due to contracting.

SLIDING FEE DISCOUNT PROGRAM:

AHS offers a Sliding Fee Discount Program to patients that qualify. Proof of income is required, such as:

- Two most recent paystubs (must be consecutive)
- Previous year's W-2
- Previous year's tax return

FINANCIAL AGREEMENT (PAGE 2)

STATEMENTS:
As a courtesy, AHS will send statements each month for any outstanding balance you owe for services. Due to the separate billing systems required for the variety of services we provide, you may receive separate statements for different types of services rendered in our clinics.

FINANCIAL RESPONSIBILITY:
You are responsible for any balance due regardless of insurance coverage. In the event that any account becomes past due AHS reserves the right to collect on these balances prior to scheduling any future appointments. Collection of amounts due may involve a collection agency.

AGREEMENT TO PAY:
By signing below you acknowledge your responsibility to pay for any services rendered by AHS. You also acknowledge your understanding that you may be billed for multiple services on the same day if you received both behavioral health and primary care services. AHS reserves the right to limit, reschedule or refuse treatment to anyone who cannot pay at the time of service.

For your convenience we accept cash, check, or credit card as payment.

ACKNOWLDGEMENT:

I have received, understand and agree to abide by the above as it relates to my financial obligations as a patient.

Patient or Legal Guardian Signature: *Please print & hand-sign here:* _____ Date: _____

Patient name (please print): _____

Legal Guardian name (please print): _____

Consent to Email, Call, or Text for Appointment Reminders and Other Healthcare Communications

ELECTRONIC HEALTH INFORMATION EXCHANGE NOTICE

AHS endorses, supports, and participates in electronic Health Information Exchange (HIE) through CORHIO (Colorado Regional Health Information Organization) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share (when appropriate) clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps all of your health care providers more effectively share information and provide you with better care. The HIE network also enables emergency medical personnel and other providers who are treating you to have immediate access to the available medical data about you that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the Axis Health System's HIE, or cancel an opt-out choice at any time.

I authorize and acknowledge that AHS will securely transmit my Health Information over the HIE.
_____ (Patient initials).

Patients in our practice may be contacted via email, phone, and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).If at any time I provide an email, phone # or text # at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email, phone # or text address from the Practice. _____ (Patient initials). I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails, phone calls, and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing.

I authorize and acknowledge I will receive text messages for appointment reminders, feedback, and general health reminders/information to the following cell phone number:

Cell Phone number: _____

I authorize to receive phone calls and voicemails for appointment reminders and general health reminders/feedback/information to the following phone number:

Phone number:_____

I authorize to receive email messages for appointment reminders, information regarding our Patient Portal, and general health reminders/feedback/information to the following email address:

Email Address: _____

My Preference for Appointment Reminders is (choose one): ☐ Text Message ☐ Phone call ☐ Do Not Remind me

Please print & hand-sign here:

_____ _____

Signature Name (please print)

_____

Date

AXISHealth System

Patient Consent for Axis Health System
Use and Disclosure of Protected Health Information to Payor(s)

Patient Name	Date of Birth	Last 4 SS#

Patient Consent for Axis Health System (AHS) Use and Disclosure of Protected Health Information (PHI), Including Substance Use Disorder (SUD) Information, to Payor(s): Federal Law protects patient health information with specific (42 CFR Part 2) protections for substance use disorder information, even when disclosing this information to organizations that pay for these services. The purpose of this written consent is to allow AHS to disclose health information including SUD information to these Payors in order to bill and report services.

Authorization: I understand that this information may not be disclosed without my written authorization. I hereby authorize, for myself or as a legal representative, the use and disclosure of all protected health information (PHI), including substance use disorder information, by AHS for the purpose of payment.

Further Disclosure: I understand that information disclosed by AHS for payment and reporting may be further disclosed through the behavioral health organization, Colorado Health Partnerships (CHP) to the Colorado Department of Healthcare Policy and Financing and the Colorado Department of Health and Human Services, who are also Payors.

Other Information About This Authorization: I understand the terms of this consent and that, upon request, may obtain information on any disclosures made. I understand that I may refuse to sign this authorization and refusal will not affect my ability to obtain treatment unless treatment is required by court order. I understand I have the right to revoke this authorization at any time and it must be submitted in writing. If I revoke this authorization, it will not have any effect on information disclosed prior to AHS receiving the revocation. I may request a copy of this signed authorization at any time.

Expiration: Without my written revocation, this authorization will automatically expire on the date that I am no longer a patient of AHS and upon receipt of final payment to AHS for any services rendered by AHS to me.

Please print & hand-sign here:

_____ _____

Patient or Legal Representative Signature — Date

_____ _____

Print Name of Legal Representative (if applicable) — Relationship to Patient

Revocation: I revoke my authorization for disclosure of protected health information including SUD information to Payors.

Please print & hand-sign here:

_____ _____

Signature of Member or Legal Representative — Date

(AHS) Use Only) Patient # _____

ACKNOWLEDGEMENT OF INFORMATION RECEIVED

AXIS HEALTH SYSTEM WRITTEN ACKNOWLEDGMENT OF AVAILABILTY OF NOTICE PRIVACY PRACTICES

NOTICE OF PRIVCACY PRACTICE

AHS adheres to all state and federal regulations as they apply to the access, protection, disclosure and use of your healthcare information contained in our records. The AHS Notice of Privacy Practices provides you with the details associated with how AHS will manage this protected information about you and is available on our website at www.axishealthsystem.org or by asking for a printed copy at any of our clinic locations.

I _____have read the above two notices related to the use, disclosure, access and protections associated with my healthcare record. I understand that this practice participates in electronic HIE and I hereby authorize the release of medical records to the HIE in support of my care and as necessary to process claims related to my care. Currently my lab results are routinely exchanged in the HIE.

I also understand that details regarding the privacy protections for my record are contained in AHS's *Notice of Privacy Practice* is available to me both electronically and in paper copy

The following information is also available to you in a Patient Handbook. It can be requested at any of the clinic locations and is also available on our website (www.axishealthsystem.org). It contains information on our:

Appointment Policy
Behavioral Health Grievance Policy
Notice of Privacy Practices
How to Choose a Medical Healthcare Provider
Medical Grievance Policy
Patient Rights & Responsibilities
Advance Directives

Our staff is available to assist you in this process if needed. Please note, by signing, you are confirming that you have read or have access to the documents above.

Patient or Legal Guardian Signature: *Please print & hand-sign here:* _____ Date: _____

Patient name (please print): _____

Legal Guardian name (please print): _____

PATIENT HISTORY (*PLEASE COMPLETE ALL PAGES*)

Patient Name:_____

Your answers on this form will help your healthcare team obtain an accurate history of you or your child's medical concerns and conditions. Please do your best to complete all three pages. If you cannot remember specific details or if you have questions/concerns about the information we are requesting, please speak with your healthcare team.

Current Healthcare Provider		
Do you have a previous Primary Care Provider?	☐ Yes ☐ No (check one)	*If Yes – please list:*
Do you have a Dentist?	☐ Yes ☐ No (check one)	*If Yes – please list:*

Allergies:

Source: (medications, pollens, food, animals, other)	Type of reaction:

Current Medications: (include prescriptions, over the counter, supplements, vitamins, and herbs)

Name of Drug	Dose	Times Per Day	Reason	Prescribed By

Preferred Pharmacy:_____

Health Maintenance:	**Yes**	**No**
Are all immunizations up to date?		
Dental visit in the past year?		
Vision check in the past year?		
Well Child check in the past year?		

Hospitalization and Surgical History (include psychiatric):

Child was in the hospital or had surgery because:	Date	Location	Overnight Stay?

Patient Name: _____

Past and Current Medical Conditions: Please indicate with an **X** if you have had the following:

	Skin Condition		**Neurology**
	Eczema/Psoriasis		Migraine or headaches
	Eyes/Ears		Seizures
	Blindness		Traumatic brain injury / concussion
	Hearing Loss		Developmental Delay
	Respiratory		**Gastrointestinal**
	Asthma		Irritable bowel / Ulcerative colitis / Crohn's
	Pneumonia		**Musculoskeletal**
	Cardiovascular		Back/neck injury
	Hypertension		Arthritis
	High cholesterol		**Urological/Renal**
	Heart disease		Kidney Stones
			Chronic kidney disease
	Endocrinology		Frequent Urinary Tract Infection
	Diabetes Type 1		**Emotional / Behavioral**
	Diabetes Type 2		ADHD
	Thyroid Problems		Learning Disability
	Blood Conditions		Depression
	Anemia		Alcohol or Drug Abuse
	Bleeding / clotting problems		Anxiety
	Other:		

Birth History: Please complete for all patients up to age 12	**Yes**	**No**
Did birth mother have Gestational Diabetes?		
Did birth mother have Preeclampsia?		
Did birth mother have an infection/STD/Group B Strep		
Did birth mother have child preterm and steroids were given?		
Vaginal Delivery?		
C-Section?		
Admitted to NICU?		

Gestational age at birth (weeks):		Maternal age:
Apgar Scores:	1 min	5 min
Birth weight:		
Hearing test?		
Newborn Screening?		

Family History: Please indicate with an X if a family member has one of the following conditions:

Condition	**Mother**	**Father**	**Siblings**	**Grandparents**
Heart Disease				
High Blood Pressure				
Cancer				
Diabetes				
Asthma				
Mental Illness				
Migraine				
Eczema/Atopic Dermatitis				
Sudden death at age less than 50				

Patient Name: _____

Behavioral/Social History: Please complete for all patients age 2-17	Yes	No
Do you exercise on a regular basis?		
Do you feel satisfied with your current weight?		
Do you like school?		
Do you have problems coming or staying in school?		
Do you have any learning problems?		
Do you have any suspensions, expulsions, and or behavior/attendance contracts from school this year or last year?		
Do you have close friends you can talk to when stressed?		
Do you have a job after school?		
Do you always wear a seatbelt?		
Have you ever had problems at home?		
Has anyone ever hurt you emotionally, physically, or sexually?		
Do you have concerns about your family's income?		
Do you worry about getting enough to eat?		
Have you ever had guns or weapons in the home?		
Have you ever had trouble sleeping, depression, or suicidal thoughts?		
Have you ever experienced/witnessed a traumatic event?		
Have you ever been involved with social services or been in/out of home/foster care placement?		
Have you ever had individual, group, or family counseling/therapy?		

Complete if patient is 12 or older:	Yes	No
Do you drink alcohol?		
Do you use Meth or other street drugs?		
Do you use recreational marijuana?		
Are you experiencing issues related to your sexual orientation?		
Are you sexually active?		
Are you using condoms or birth control?		
Do you use tobacco products? (smoking, chew, snuff, other)		
Do you use any holistic or alternative treatments? (acupuncture, massage, naturopathic remedies, medical marijuana, other)		

Complete for all patients:

Within the past 12 months, we worried whether our food would run out before we got money to buy more:
☐ Often true ☐ Sometimes true ☐ Rarely true ☐ Never true

Within the past 12 months, the food we bought didn't last and we didn't have money to get more:
☐ Often true ☐ Sometimes true ☐ Rarely true ☐ Never true

IMMIGRATION AFFADAVIT – PUBLIC BENEFITS

I, _____, swear or affirm under penalty of perjury under laws of the State of Colorado that (check one):

☐ 1. I am a United States citizen or;

☐ 2. I am not a United States citizen but am a Permanent Resident of the United States; or

☐ 3. I am not a United States citizen, but I am lawfully present in the United States pursuant to Federal Law. (*This status requires verification under the Federal SAVE Program. Additional information may be required)*.

I understand that this sworn statement is required by law because I have applied for a public benefit or may receive services covered by public monies. I understand that state law requires me to provide proof of lawful presence in the United States prior to the receipt of this publicly supported benefit or programming. I further acknowledge that making a false, fictitious, or fraudulent statement or representation in this sworn affidavit is punishable under criminal laws of Colorado as perjury in the second degree under Colorado Revised Statute 18-8-503 and it shall constitute a separate criminal offense each time a public benefit is fraudulently received.

Patient or Legal Guardian Signature: *Please print & hand-sign here:* _____ Date: _____

Patient name (please print): _____

Legal Guardian name (please print): _____

FOR AHS STAFF USE ONLY:

Please check one of the following if documentation is not provided:

☐ Individual cannot provide required documentation; or

☐ Individual refuses to provide required documentation.

PLEASE Note: If identification documentation is not provided or refused the patient is not eligible for any of the following programs: *Ft. Lyon SUD Residential Tx, LPIH's Colorectal Screening, or the Assertive Community Treatment Program.*

PATIENT #: CareLogic _____ **Intergy _____**

_____ _____

Staff Signature Date