Facility Location Information

AXIS HEALTH SYSTEM CARE LOCATIONS:

We have multiple locations available to serve you.

Integrated Care:
Archuleta Integrated Healthcare, 52 Village Drive, Pagosa Springs, CO 81147
(970) 246-2104

Cortez Integrated Healthcare, 691 East Empire St. Cortez, CO 81321
(970) 565-7946

Cortez Oral Health Clinic, 101 S. Maple Street, Cortez, Co 81321
(970) 565-1800

Dove Creek Integrated Healthcare, 495 4th St, Dove Creek, CO 81324
(970) 677-2291

LaPlata Integrated Healthcare, 1970 East 3rd Avenue, Durango, CO 81301
(970) 335-2288

Oral Health Clinic, 2530 Colorado Avenue, Suite A, Durango, CO 81301
(970) 335-2442

Behavioral Healthcare:
Crossroads at Grandview, 1125 Three Springs Blvd., Durango, CO 81301
(970) 403-0180

Columbine Behavioral Health, 281 Sawyer Drive, Suite 100, Durango, CO 81303
(970) 259-2162

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? ☐ Heterosexual ☐ 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				

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

I hereby consent to treatment, including tests, procedures and medications, as directed by Axis Health System staff. I understand my treatment will have a greater chance of success when I participate in its design and cooperate with any professional recommendations that are provided to me. I understand that I may refuse any services and/or treatment and this will not jeopardize my status as a patient of Axis Health System as long as I have a valid consent for treatment in place. I 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.

Patient or Legal Guardian Signature: _____ 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.

PROTECTED ACCESS AND ASSOCIATED DISCLOSURE LIMITATIONS:
There are limitations on access to patient information and disclosures that are based on the type of treatment and/or the age of the patient in question. Health information for the patient is protected differently in the following circumstances.

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: _____ Date: _____

Patient name (please print): _____

Legal Guardian name (please print): _____

Patient Email or Text Messaging
and Other Healthcare Communications Registration Form

Due to the changing world of healthcare and technology, AHS has the ability to provide patients with certain type of information via email and/or text messaging. If you wish to have the opportunity to receive information of this type, please complete this form.

AHS believes strongly in protecting the privacy of our patients. When you provide this information to us, it is only used as a way to communicate with you. In order to protect your privacy, no confidential or personal information will be sent from AHS via email or text messaging. AHS does not share the names, email addresses and/or telephone numbers of patients with any other company or agency or other patient.

I consent to receive emails or text messages from AHS to 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.

Choose ONE BOX ONLY BELOW

- ☐ Yes, please sign me up for email and text messaging
- ☐ I **do not** wish to be contacted by email (Text only)
- ☐ I **do not** wish to be contacted by text (Email only)
- ☐ I **do not** wish to be contacted for email and text messaging

Printed Name _____

Cell Phone number: _____

Email Address: _____

_____ _____
Signature Name (please print)

_____
Date

Telehealth Patient Informed Consent and Expectations

In order to participate in a telehealth service using an audio and/or visual software, as an AHS patient you must give your consent and understand AHS expectations.

Privacy

Telehealth is a service delivered by the use of electronic information and communication technologies (such as video conference, smart phone application or in this time of emergency a telephone conversation) by a healthcare provider to deliver services to an individual when he/she is located at a different site than the provider. Privacy laws that protect health information also apply to this type of visit. Axis Health System (AHS) complies with all federally required HIPAA and 42 CFR Part 2 regulations and Office of Civil Rights guidance related to these services offered through telehealth methods. AHS uses Lifesize software to facilitate telehealth services provided.

I understand the nature of a Telemedicine Consult:

1. Details of my medical history, including x-rays, test results, etc., will be discussed and a physical examination may take place.
2. Video, audio or pictures may be taken to assist in my diagnosis, treatment or referral.
3. I will have the opportunity to discuss with the provider any risks, consequences and benefits of using telehealth services as well as consult with any proposed treatment or procedure.

As a patient I understand that I have the right to:

1. Withhold my consent to the use of telehealth services in the course of my care at any time, without affecting my right to future care or treatment.
2. Revoke my consent orally or in writing at any time by contacting my provider. As long as this consent is in force and has not been revoked my AHS Provider may provide telehealth services to me.
3. Access any of my protected health information provided during these services

As a patient I understand that AHS expects:

1. That I am responsible for maintaining confidentiality for anything heard during this session and not share with any person other than my provider. I understand that it is my responsibility to ensure that the location in which I am receiving these services is secure to ensure others may not overhear what is being said during the provision of service.
2. That the space in which I am receiving these telehealth services must be in a private and confidential setting and whenever possible, in a room with only myself present.
3. That when connecting to the session I should be using headphones, if possible, to avoid any unintended disclosure of protected health information to others who may be present near me.
4. That I may not share the device screen with any other person and position it in a way that others cannot observe it.
5. That I may not take any screen shots or audio or video-record any sessions, however the provider may.
6. That if necessary, when I am not speaking it is best to mute my phone or computer audio to minimize background noise.
7. That if I fail to adhere to these expectations I understand the session may be discontinued.

I hereby consent to AHS providing telehealth services to me in the event I wish to receive them and they are available.

Patient: _____ Date: _____

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 Rocky Mountain Health Plan 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.

_____ _____
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.

_____ _____
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 PRIVACY 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: _____ Date: _____

Patient name (please print): _____

Legal Guardian name (please print): _____

IMMIGRATION AFFIDAVIT – 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: _____ 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 or the Assertive Community Treatment Program.*

PATIENT #: CareLogic _____ **Intergy _____**

_____ _____

Staff Signature Date