AXISHealth System

PATIENT REGISTRATION (COMPLETE BOTH SIDES)

<table>
<tr><td colspan="8">PATIENT INFORMATION (please fill out in blue or black pen). Parents: Fill this out as if you are answering for your child.</td></tr>
<tr><td>Today's Date</td><td></td><td>Last Name</td><td></td><td>First</td><td></td><td>M.I.</td><td></td></tr>
<tr><td>Date of Birth</td><td colspan="2"></td><td colspan="2">Social Security No. (required)</td><td colspan="3">- -</td></tr>
<tr><td colspan="8">Gender Identity: ☐ Male ☐ Female
☐ Transgender Male ☐ Transgender Female ☐ Neither/Unknown ☐ Other ___________ ☐ Choose not to say</td></tr>
<tr><td colspan="4">Sex (assigned at birth or legal birth certificate): ☐ Male ☐ Female</td><td colspan="4">Preferred Pronouns: ☐ she/her ☐ he/him ☐ they/them ☐ neo/other</td></tr>
<tr><td colspan="8">How do you identify in terms of sexual orientation?
☐ Heterosexual ☐ Lesbian or Gay ☐ Bisexual ☐ Pansexual ☐ Asexual ☐ Other ___________ ☐ Unknown ☐ Choose not to disclose</td></tr>
<tr><td>Street Address</td><td colspan="4"></td><td>Apartment/Unit#</td><td colspan="2"></td></tr>
<tr><td>Mailing Address</td><td colspan="7"></td></tr>
<tr><td>City</td><td colspan="2"></td><td>State</td><td></td><td>ZIP Code</td><td colspan="2"></td></tr>
<tr><td>Home Phone</td><td></td><td>Work Phone</td><td colspan="2"></td><td>Cell Phone</td><td colspan="2"></td></tr>
<tr><td colspan="8">Communication may include appointment reminders, notices, feedback and health information. Please indicate your communication preferences below.</td></tr>
<tr><td colspan="8">May we leave phone messages? ☐ Yes ☐ No If Yes -<u>PLEASE CIRCLE THE BEST NUMBER ABOVE FOR US TO USE.</u></td></tr>
<tr><td colspan="3">May we mail the address above? ☐ Yes ☐ No</td><td colspan="5">Do you live in the City Limits? ☐ Yes ☐ No</td></tr>
<tr><td colspan="3">May we text you? ☐ Yes ☐ No</td><td colspan="5">Phone number to text:</td></tr>
<tr><td colspan="3">May we e-mail you? ☐ Yes ☐ No</td><td colspan="5">Email:</td></tr>
<tr><td>Parent or Guardian Name</td><td colspan="2"></td><td>Relationship?</td><td colspan="4"></td></tr>
<tr><td>Parent or Guardian Name</td><td colspan="2"></td><td>Relationship?</td><td colspan="4"></td></tr>
<tr><td>Custodial Responsibility</td><td colspan="7">☐ Joint ☐ Sole _______________ ☐ Other (please explain) ______________________________</td></tr>
<tr><td colspan="8">If patient is 18 years of age or younger, please provide mother's maiden name:</td></tr>
<tr><td>Race
(Please check all that apply)</td><td colspan="7">☐ African American/Black ☐ Alaskan Native ☐ Native American: Tribal Affiliation_______________
☐ Asian ☐ Caucasian/White ☐ Pacific Islander ☐ Native Hawaiian ☐ Refuse to provide</td></tr>
<tr><td>Ethnicity</td><td colspan="4">☐ Latino ☐ Hispanic ☐ Not Latino/Hispanic
☐ Refuse to provide</td><td>Preferred Language:</td><td colspan="2"></td></tr>
<tr><td>Marital Status</td><td colspan="7">☐ Single ☐ Married ☐ Partner ☐ Separated ☐ Divorced ☐ Widowed</td></tr>
<tr><td>Housing Status</td><td colspan="4">☐ Not Homeless ☐ Homeless Shelter ☐ Doubling up
☐ Street ☐ Transitional Housing</td><td>Who do you live with?</td><td colspan="2"></td></tr>
<tr><td>Military Status</td><td colspan="7">Are you active duty? ☐ Yes ☐ No Are you a veteran? ☐ Yes ☐ No</td></tr>
<tr><td>Employment Status</td><td colspan="7">☐ Full Time ☐ Part Time ☐ Unemployed ☐ Disabled ☐ Retired
☐ Migrant/Seasonal ☐ Student, what school do you attend? ______________________________</td></tr>
<tr><td>Employer</td><td colspan="2"></td><td>Occupation</td><td colspan="4"></td></tr>
<tr><td>Advanced Directives</td><td colspan="3">Do you have any Advanced Directives? ☐ Yes ☐ No</td><td colspan="4">If No, would you like information on this? ☐ Yes ☐ No</td></tr>
</table>

It is important that we receive a copy of both the front and back of your insurance card(s) to ensure correct billing. Please provide your cards to the front desk staff or copies can be emailed to billing@axishealthsystem.org.

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**___________					

INSURANCE COVERAGE			
Primary Insurance		**Secondary Insurance**	
Insurance Name:		Insurance Name:	
Subscriber Name:		Subscriber Name:	
Relationship to Patient:		Relationship to Patient:	
Member ID Number:		Member ID Number:	
Group Number:		Group Number:	
Effective Date:		Effective Date:	
Claims Address:		Claims Address:	

Axis Health System is dedicated to ensuring you have access to our 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.

By providing your household income below, we may also be able to assist you in determining if you are eligible for a variety of additional health benefit options. In many cases, our staff can assist qualifying patients with the enrollment or assessment process. Some of these include:

- Discounted fees for qualified patients who may be unable to pay the full fee for services. Axis Health System offers a sliding scale discounted based solely on income and household size.
- Special grant provided services.
- Public funded health care coverage such as Medicaid or CHP+.

By declining to provide this financial information, you may be ineligible for financial assistance for your care. All information provided will remain confidential.

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

By signing below, I attest that the above registration information is true and accurate.

Patient or Legal Guardian Signature: ________________________________ Date: ____________

AXISHealth System

Acknowledgement of Information Received and Consent for Integrated Evaluation and Treatment

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. This information is also available to you in a Patient Handbook. I have read the following notices related to the use, disclosure, access and protections associated with my healthcare record. I understand that this practice participates in electronic Health Information Exchange (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.* This and the following information is available to me both electronically via email request, at AHS website www.axishealthsystem.org or by asking for a printed copy at any of our clinic locations:

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
Patient Handbook

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 if 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. Also, *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): ____

Please note the following regarding 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 telehealth 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 typically: videotaped, recorded, or saved in any way. However, with your consent where applicable, we may videotape or take pictures during the interaction to assist in your diagnosis, treatment, or referral, or for the purposes of supervision, training, or quality improvement. In addition, 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 regarding your records and complaints: We are required to inform you that if 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.

Minor Patients: AHS will not release a minor's protected health records to a parent/guardian if there is any legal action involving a determination of the best interests of the minor because the minor has a right to privileged and confidential communications in relation to that type of action, unless a valid waiver of the minor's privilege or court order is received by AHS. If a minor has consented to their own treatment, AHS, upon request from a parent or legal guardian, without the consent of the minor child, may advise the parent or legal guardian only of the services given or needed. Release of this information regarding services shall not be considered a waiver of the minor's right to privileged and confidential communications or AHS's duty of confidentiality. A parent or legal guardian may be notified without the minor's consent if, based on professional opinion, the minor is unable to manage his or her care or treatment and a parent or legal guardian will be notified any time a minor expresses safety concerns, including intent to harm self or others.

Telehealth Patient Informed Consent and Expectations

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 using 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 HIPAA compliant software for telehealth services.

I understand that during a Telehealth Service:

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 with my consent to assist in my diagnosis, treatment, or referral, or for purposes of supervision, training, or quality improvement.
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 during 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. If 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. 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, and that the session can be conducted free from distractions, or inappropriate activities.
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 for the purposes described above.
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 I come to the session with the same expectations as if the session occurred in person, including wearing appropriate attire.
8) 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 or Legal Guardian Signature: ________________________________ Date: _____________

Patient name (please print): ____

Legal Guardian name (please print): ____

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

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 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 Guardian Signature: _______________________________ Date: _____________

Patient name (please print): ______________________________________ Date of Birth: ___________

Legal Guardian name (please print): ____

(AHS Use Only) Patient # ____________________________

*Alternative Options:

☐ I do NOT authorize Axis Health System to disclose my SUD (Part 2 Program) information to my insurance.

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

Patient or Legal Guardian Signature: _______________________________ Date: _____________

Patient name (please print): _____________________________________ Date of Birth: ___________

Legal Guardian name (please print): ____

AXISHealth System

FINANCIAL AGREEMENT

PATIENTS WITH INSURANCE:
It is important that you understand the benefits and limitations of your insurance coverage. Insurance coverage is not a guarantee of insurance payment. Please contact your insurance company for more information about your financial responsibility under your plan.

AHS requires your benefits be *assigned* to AHS so AHS 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. We employ qualified professionals; some professionals may not be contracted by your insurance company due to contractual requirements. When this occurs, your insurance company may not pay for services. Your insurance may pay a portion of the claim; however, you are ultimately responsible for the payment of services received. AHS will mail a statement of your balance due each month; payment is due within 30 days. You may receive separate statements for different types of services rendered in our clinics. If you receive laboratory services as part of a visit, your insurance may not cover the charge from our laboratory vendor; however, you may be eligible for our Sliding Fee Discount Program, and lab fees may be discounted. If you have questions about our Sliding Fee Discount Program, eligibility or application please contact your clinic location front desk staff. If you have any questions regarding your statement, please call our Billing Department at 970.335.2342.

INFORMATION SECURITY:
Your personal information is secure with AHS. AHS uses this information for providing services, filing claims and identification/communication as it relates to healthcare operations. We are required to obtain demographic information which includes your social security number. Refusal to provide information may constitute a refusal of service.

FINANCIAL RESPONSIBILITY:
You are responsible for any balance due regardless of insurance coverage. If any account becomes past due, AHS reserves the right to collect on these balances prior to scheduling any future appointments. Past due amounts may involve a collection agency with the additional cost of attorney fees, court cost and any other miscellaneous fees that may be added to patient or guarantor's balance.

ACKNOWLEDGE AND AGREE 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, primary care and dental 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.

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 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 the time of service and 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.

I 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): ____

Final Step to Enrollment:
Please complete a Medical History and/or Dental History form, as appropriate for the services that you are enrolling for.