

# Aspen Family Care Demographic & Billing Information Sheet

## Patient Information

Legal Name (First, MI, Last)		SS#	Date of Birth	
Address		Primary Phone#	Secondary Phone#	
City, State, Zip		Email		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Preferred Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Decline	
Race <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Other: _____ <input type="checkbox"/> Decline				

## New Patients

Who may we thank for your referral to our practice?  
 Family Member/Friend: \_\_\_\_\_  Dr. \_\_\_\_\_  Insurance Company  Other

## Please Complete the Following Parent Information if Patient is Age 17 or Under:

Mother's Name (First, MI, Last):	Employer
Mother's Address <input type="checkbox"/> Same as patient	Phone
Mother's City, State, Zip	
<hr/>	
Father's Name (First, MI, Last):	Employer
Father's Address <input type="checkbox"/> Same as patient	Phone
Father's City, State, Zip	

## Insurance Information:

	Primary Insurance	Secondary Insurance
Insurance Company		
Policy Holder Name		
Policy Holder SSN		
Policy ID Number		
Policy Group Number		
Policy Holder Employer		
Relationship to Policy Holder		



\_\_\_\_\_  
**Signature** (Must be a parent or guardian for children 17 and under)

\_\_\_\_\_  
**Date**

**NAME/DOB:** \_\_\_\_\_ / / **DATE:** \_\_\_\_\_

Please fill out the below review of medical symptoms and history. Place a check mark in the box if you have been experiencing any of the mentioned symptoms or if a diagnosis/condition applies to you. Thank you.

**Constitutional:**  **None of the below**

Weight loss or gain  Poor appetite  Fever  Chills  Weakness  Fatigue  Sleep problems

**Eyes:**  **None of the below**

Blurred vision  Double vision  Color blindness  Cataracts  Eye pain  Glaucoma  Last ophthalmologic exam: \_\_\_\_\_

**Ears, Nose, Mouth, Throat:**  **None of the below**

Decreased hearing  Ringing in ears  Frequent nose bleeds  Mouth/gum bleeding  Dentures  Hoarseness of voice  
 Pain/trouble swallowing  Chronic sore throat  Frequent strep throat  Mouth sores  Change in smell

**Cardiovascular:**  **None of the below**

Chest pain/angina  Heart attack  High blood pressure  Heart valve abnormality  Rheumatic fever  Leg pain with walking  
 Heart murmur  Low blood pressure  Heart skipping beats/palpitations  High cholesterol

**Respiratory:**  **None of the below**

Cough  Chronic bronchitis  Asthma/wheezing  Coughing up blood  Tuberculosis  Shortness of breath  History of smoking  
 COPD/Emphysema

**Gastrointestinal:**  **None of the below**

Nausea or vomiting  Vomit of blood  Chronic diarrhea  Constipation  Abdominal/stomach pain  Indigestion/"GERD"  Gallstones  
 Dark or black stools  Rectal bleeding  Jaundice(yellow skin)  Hepatitis  Gallbladder problems  Irritable bowel  Hemorrhoids  
 Ulcerative colitis/Crohn's Disease  Stomach ulcers  Frequent antacid use  Frequent laxative use  Stool changes (size/color)

**Musculoskeletal:**  **None of the below**

Muscle pain  Joint pain  Joint swelling  Joint stiffness  Serious injury/fracture

**Skin, Hair, Nails:**  **None of the below**

Rash  Changing moles  Skin infections  Itching  Hair loss/thinning  Nail changes  Nail fungal infections  Skin cancer  
 Severe sun burns

**Neurological:**  **None of the below**

Headaches  Dizziness  Seizures  Memory loss/forgetful  Strokes/TIA's  Tremor  Frequent falls or clumsiness  
 Passing out or fainting

**Mood, Thinking:**  **None of the below**

Nervousness/anxiety  Depression  Bipolar illness  Unusual fears  Suicidal thoughts  Homicidal thoughts  Anorexia/Bulimia  
 Lack of enjoyment  Prior psychiatric illness  ADD or ADHD  Concentration issues  Motivation issues  
 Prior treatment with psychiatric medication  Prior suicide attempt or hospitalization for mental illness

**Endocrine:**  **None of the below**

Diabetes/Insulin resistance  Thyroid disorder  Heat/cold intolerance  Pituitary disorder  Adrenal gland disorder  Parathyroid disorder

**Hematologic, Lymphatic, Cancers:**  **None of the below**

Anemia  Bleeding disorders  History of blood clots  Blood transfusions  Coagulation disorder  Hemochromatosis  Thalassemia  
 B12 or other vitamin deficiency  Any prior diagnosis of cancer of any type (please list): \_\_\_\_\_

**Allergic, Immunologic:**  **None of the below**

Hives/Urticaria  Frequent illnesses/infections  Seasonal/chronic allergies  Other (please list): \_\_\_\_\_

**Genitourinary:**  **None of the below**

Pain/burning urination  Urinary urgency  Urinary hesitation  Kidney infections  More nighttime urination  Urine stream changes  
 Blood in urine  Leaking of urine  Kidney stones  Bladder infections  More frequent urination

**Sexual History:**  **None of the below**

Are you or have you been sexually active?  Pain with sexual activity  Changes in sexual desire  Total # of sexual partners: \_\_\_\_\_  
 Are you sexually attracted to men, women or both? (please circle)  
 Chlamydia  Gonorrhea  Genital herpes  Genital warts/"HPV"  Syphilis  HIV/AIDS  Other STD(please list): \_\_\_\_\_

**Male only:**  **None of the below**

Prostate problems  Erectile dysfunction  Testicular lumps/pain  Testosterone Deficiency

**Female only:**  **None of the below**

Total # of pregnancies: \_\_\_\_\_  Age when you had your first period: \_\_\_\_\_  Menstrual cramps  Pain with ovulation  
 # of delivered children: \_\_\_\_\_  # of days on average between periods: \_\_\_\_\_  Vaginal discharge/itching/odor  
 # of miscarriages: \_\_\_\_\_  How long does your period last: \_\_\_\_\_  PMS  Hot flashes  Hormone use  
 # of abortions: \_\_\_\_\_  Light/moderate/heavy flow (please circle)  Biopsies of uterine lining  Breast biopsies  
 # of fetal or child deaths: \_\_\_\_\_  Day last menstrual period started: \_\_\_\_\_  Breast lumps  Nipple discharge  
 Your age at first live birth: \_\_\_\_\_  Last pap smear: \_\_\_\_\_  History of breast feeding  
 Birth control use (please list type): \_\_\_\_\_  History of abnormal pap smear: \_\_\_\_\_  Last mammogram: \_\_\_\_\_



**Aspen Family Care**  
**Allergy Questionnaire**  
**Intake Form**

<b>Date:</b>	
<b>Patient Name:</b>	<b>D.O.B.:</b>
<b>Phone Number:</b>	

Questions:	Yes	No
Do you experience any of these symptoms more than twice a year?: Cough, cold, congestion, difficulty breathing, headaches, runny nose, sore throat, itchy/irritated eyes, sinus pain, ear pain, unexpected fatigue, skin irritation, snoring?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been diagnosed with asthma or bronchitis?	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience symptoms of allergies?	<input type="checkbox"/>	<input type="checkbox"/>
Are you interested in an Allergy Evaluation in our office?	<input type="checkbox"/>	<input type="checkbox"/>

**If you answered "Yes" to any of the above questions,  
 please continue to the backside of  
 this form.**

For Office Use:	
<b>Reviewed By:</b>	<b>Patient Contacted?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
	Date/Time:
<b>Appointment Scheduled?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Date/Time:</b>	

## Allergy Questionnaire – Part II

1. What symptoms are you experiencing (From #1 on front page)?

2. How often do you experience these symptoms? \_\_\_\_\_

3. Do you have any of these symptoms

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Cough               | <input type="checkbox"/> Runny Nose        | <input type="checkbox"/> Nasal Polyps        | <input type="checkbox"/> Eczema         |
| <input type="checkbox"/> Wheezing            | <input type="checkbox"/> Nasal Congestion  | <input type="checkbox"/> Poor Sense of Smell | <input type="checkbox"/> Hives/Swelling |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Itchy Nose        | <input type="checkbox"/> Ear Infection       | <input type="checkbox"/> Headaches      |
| <input type="checkbox"/> Chest Tightness     | <input type="checkbox"/> Itchy/Watery Eyes | <input type="checkbox"/> Sinus Infection     | <input type="checkbox"/> Snoring        |
| <input type="checkbox"/> Sneezing            | <input type="checkbox"/> Postnasal Drip    | <input type="checkbox"/> Blocked Ears        | <input type="checkbox"/> Fatigue        |
| <input type="checkbox"/> Phlegm/sputum       |  | <input type="checkbox"/> Other: _____        |   |
- Color: \_\_\_\_\_

4. Which of the following seems to bother you or trigger/cause the above symptoms?

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Grass          | <input type="checkbox"/> Cats                | <input type="checkbox"/> Cosmetics     | <input type="checkbox"/> Drafts          |
| <input type="checkbox"/> Nervousness    | <input type="checkbox"/> Hay                 | <input type="checkbox"/> Dogs          | <input type="checkbox"/> Aerosol Sprays  |
| <input type="checkbox"/> House Dust     | <input type="checkbox"/> Cold Air            | <input type="checkbox"/> Mold & Mildew | <input type="checkbox"/> Horses          |
| <input type="checkbox"/> Perfumes       | <input type="checkbox"/> Smoke               | <input type="checkbox"/> Humidity      | <input type="checkbox"/> Basements       |
| <input type="checkbox"/> Other Animals  | <input type="checkbox"/> Insecticides        | <input type="checkbox"/> Pollution     | <input type="checkbox"/> Weather Changes |
| <input type="checkbox"/> Leaves         | <input type="checkbox"/> Alcoholic Beverages | <input type="checkbox"/> Odors         | <input type="checkbox"/> Exercise        |
| <input type="checkbox"/> Latex (rubber) | <input type="checkbox"/> Insect Bits/stings  | <input type="checkbox"/> Insect Bites  |  |
- Foods (List foods/reaction): \_\_\_\_\_
- Other (List sources/reaction): \_\_\_\_\_

5. When are your symptoms worst?  Year Round

- |                                   |                                |                                    |                                   |
|-----------------------------------|--------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> January  | <input type="checkbox"/> April | <input type="checkbox"/> July      | <input type="checkbox"/> October  |
| <input type="checkbox"/> February | <input type="checkbox"/> May   | <input type="checkbox"/> August    | <input type="checkbox"/> November |
| <input type="checkbox"/> March    | <input type="checkbox"/> June  | <input type="checkbox"/> September | <input type="checkbox"/> December |

Yes                      No

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 6. Are your symptoms better away from home?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had an allergy skin test or blood test?                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had allergy injections?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you received cortisone (prednisone, methylprednisone, etc.) drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Are you on allergy medications?<br>What meds? _____ How long? _____    | <input type="checkbox"/> | <input type="checkbox"/> |

11. What is your occupation (current or former)?

For Office Use		
Is Patient:	Yes	No
Using beta blocker?	<input type="checkbox"/>	<input type="checkbox"/>
Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Significantly immunocompromised?	<input type="checkbox"/>	<input type="checkbox"/>
Malignancy?	<input type="checkbox"/>	<input type="checkbox"/>
Severe chronic illness?	<input type="checkbox"/>	<input type="checkbox"/>
<b>If yes to above, select blood test</b>		
Wheezing or difficulty breathing?	<input type="checkbox"/>	<input type="checkbox"/>
Experiencing active hives or extensive dermatitis?	<input type="checkbox"/>	<input type="checkbox"/>
<b>If yes to above, treat symptoms and schedule for another day</b>		
Having symptoms consistent with food allergies?	<input type="checkbox"/>	<input type="checkbox"/>
<b>If yes, to above, consider skin panel and food panel</b>		
<b>Indications:</b>		
Inhalant Panels <input type="checkbox"/> Skin Test <input type="checkbox"/> Blood Test		
Food Panels <input type="checkbox"/> Skin Test <input type="checkbox"/> Blood Test		
<b>Schedule skin test for:</b>		
<b>Reviewed By:</b>		

# Aspen Family Care/Aspen Medical Aesthetics Patient Consent

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

- **Consent for Treatment:** I, the undersigned, voluntarily agree to the tests, procedures, and/or treatments which the physician has deemed necessary and which are administered to or performed on me under the direction of the physician or his/her designee.
- **Consent for Treatment of Minors:** I, the undersigned, understand that a minor child (17 and under) must have my consent to be treated. I understand that I must be present at each appointment for any child aged 14 and under. If the child is between the ages of 15 and 17, I understand that I must send a note with the child to the appointment consenting for the child to be treated. The notes must contain the date, a statement of consent, and my signature. Further, I understand that consent for treatment does not alter the legal requirements for confidentiality. I also understand that Colorado Law provides for minors to seek care without parental consent for certain issues.
- **Consent to receive one (1) monthly newsletter email from Aspen Family Care and Aspen Medical Aesthetics**  
 Yes  No  
 Email Address: \_\_\_\_\_
- **Consent to Communicate Medical Results:** I, the undersigned, understand that medical results will be communicated directly to me unless I specifically identify individuals to whom information may be communicated (see box below to authorize other family members to receive results). Please indicate how we may inform you of test results (check all that apply):  
 Call my work number: \_\_\_\_\_ Okay to leave voice mail at work?  Yes  No  
 (The only message we will leave with a coworker is a note to call with our name and number.)  
  
 Call my cell phone: \_\_\_\_\_ Okay to leave voice mail on cell?  Yes  No  
  
 Call my home number: \_\_\_\_\_ Okay to leave voice mail at home?  Yes  No  
*In the event that I am not available to receive medical results when called upon, I authorize Aspen Family Care to leave medical information with any of the names identified below. It is my responsibility to notify these persons that such information may be left with them and I agree not to hold Aspen Family Care responsible for information not conveyed to me through these persons.*
- I hereby acknowledge that I received Aspen Family Care/Aspen Medical Aesthetics' Notice of Privacy Practices.

**Family Information (Please list all other members of your household even if not authorized to receive results.)**

Name (First MI Last)	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of Birth	Relation	*OK to release results? NO <input type="checkbox"/> YES <input type="checkbox"/>
Name (First MI Last)	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of Birth	Relation	*OK to release results? NO <input type="checkbox"/> YES <input type="checkbox"/>
Name (First MI Last)	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of Birth	Relation	*OK to release results? NO <input type="checkbox"/> YES <input type="checkbox"/>
Name (First MI Last)	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of Birth	Relation	*OK to release results? NO <input type="checkbox"/> YES <input type="checkbox"/>
Name (First MI Last)	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of Birth	Relation	*OK to release results? NO <input type="checkbox"/> YES <input type="checkbox"/>
Name (First MI Last)	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of Birth	Relation	*OK to release results? NO <input type="checkbox"/> YES <input type="checkbox"/>

**Emergency Contact information**

<b>Name of nearest relative or close friend not living with the patient</b>		
Name	Relation	Phone
<b>Name of relative or friend to contact in case of an emergency</b>		
Name	Relation	Phone

X \_\_\_\_\_  
 Signature (Must be a parent or guardian for children 17 and under) Date

\*\*\*\*\*

**For Future Use:**

_____ Initials/Date	_____ Initials/Date	_____ Initials/Date	_____ Initials/Date
<i>I have reviewed the above information contained on this form and have no additional changes.</i>			

## Aspen Family Care Financial Policy

**Patient Name:** \_\_\_\_\_ **D.O.B.** \_\_\_\_\_

Welcome to Aspen Family Care, PLLC. We are committed to giving you the best care possible. We would like to take this opportunity to inform you of our office policy.

We will bill insurance claims as a courtesy to our patients provided we have your current insurance information, if not; you will be responsible for payment at the time of service. We accept payment from insurance companies, but require that you pay your portion, including co-pays, deductibles or coinsurance at the time of service. In accordance with our participation agreements with third-party payers, we cannot waive or discount co-payments. Payment is due upon receipt for any balance that is billed to you.

Changing or re-coding claims once they have been submitted constitutes fraud and we **do not** do this under any circumstances.

If multiple or complex medical issues are discussed and managed at a routine physical exam, an additional office visit may be billed and any subsequent charges will be your responsibility.

The office bills only for services performed by our providers. The laboratory companies are a separate entity, and will bill you or your insurance company for labs that are performed. If you have any questions regarding your lab bill, please contact that laboratory or your insurance company.

As a courtesy, we attempt to contact every patient to remind them of their appointment; however, it is the responsibility of the patient to arrive on time whether or not a reminder call was received. We ask that you notify us 48 business hours in advance to cancel and/or reschedule your appointment. Please be aware that failure to do so may result in a missed appointment fee of \$25.00 and \$50.00 for a missed physical, well-child exam or procedure.

Returned checks will incur a \$30 service charge.

It is your responsibility to notify our office if there is a change of name, insurance coverage, residence, and/or phone number.

We **do not** participate with Medicare or Medicaid; we attempt to notify every patient prior to their age of being eligible for Medicare; however it is the responsibility of the patient to seek a Medicare participating provider.

In the event that your account was paid late, placed on a payment plan, or your account is placed in collection status, any additional fees incurred due to this, will be added to your outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. If the account is sent to collections or if we receive a bankruptcy notification we reserve the right to dismiss you as well as any family members from the practice.

Business hours are from 7:30am to 5:00pm Monday through Friday. Medical care received before or after these hours or on weekends, as well as emergent office visits without appointments, may have additional fees per standard billing procedures. Currently, these charges may be up to \$50 per visit.

Please sign below so that we may confirm that you have read and understand our office policy regarding insurance and your responsibilities as a patient of Aspen Family Care.

\_\_\_\_\_  
Name (Please Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Responsible Party



Dear Patient:

Promoting health and treating illness are important to all of us. We understand this complicated process can be confusing, especially when multiple parties are involved (including lab services, radiology, referrals, etc). As partners in your health, Aspen Family Care providers recommend testing based on our extensive education and experience, always keeping your best health interests in mind. Because healthcare is our specialty, we stay up to date on the latest technology and testing to assist in such management.

As part of increasing complexity in payor systems, it is important that you, the patient, be aware of how your insurance plan works and to know which lab your plan is contracted with. With insurance plans constantly changing it is impossible for us to know your individual coverage of services with third parties, particularly lab services. There is a current trend to limit laboratory coverage with many insurances. Tests that may have been covered in the past may not be covered now. If this is a concern to you, we recommend you contact your insurance company FIRST with the specific ICD-10 and CPT codes to find out what they cover BEFORE getting your laboratory work done. We also recommend contacting your insurance company to find out how all types of office visits are covered by your plan.

ICD-10 codes are diagnosis codes used to communicate to your insurance company why labs are ordered. These codes are located on your laboratory requisition form.

CPT codes are used to communicate with your insurance company what specific labs are ordered. To obtain these codes, you will need to contact the lab and ask them to look up the codes for the various testing placed on your lab requisition.

Should you choose not to proceed with testing as recommended, it is important you know that this can result in undiagnosed illness, late diagnosis, or poor medical management of conditions. This can affect quality of life, as well as increase risk of death with certain conditions. In this situation, it is to be understood that not completing testing as recommended would be against medical advice and the responsibility for issues that could arise from the not doing testing is yours.

Labs often offer discounted rates for labs not covered. However to take advantage of this, they must know you plan on paying prior to billing of insurances. Once billed, if denied, the balance is typically billed at full price.

Thank you very much.

Aspen Family Care

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Patient Name

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Patient/Guardian Signature

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Date