PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION (Please print)

Patient's Name: (Last) ______________________________ (First) ______________________________ (MI) ____________________

Address: ____

City, State, Zip: ____

Home: ______________________________ Cell: ______________________ Work: ______________________________________

E-Mail Address: ____ DOB: _____________________________

Sex: ☐ Female ☐ Male ☐ Transgender

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander
☐ Black/African American ☐ White ☐ Hispanic ☐ Other ☐ Declined

Language: ☐ English ☐ Spanish ☐ Indian: Hindi, etc. ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Social Security Number: ______ - ______- ______ PCP ______________________________

Pharmacy: ______________________ Address: ______________________________ Phone: (_____)_______-_____________

RESPONSIBLE PARTY INFORMATION (*If not self*) (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐

Responsible party name: (Last) ______________________________ (First) ______________________________ (MI) _______________

Date of birth: MM ______/DD ______/YYYY_______ Sex: ☐ Female ☐ Male

Social Security Number: _________-______-________ Phone number: _______________

Address: ____

City, State: ________________________________ ZIP: ____________________

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last) ____ (First) ____________________________

Phone number: ____ Do you have a living will? ☐ Yes ☐ No

Emergency contact relationship to patient: ____ ☐ Guardian

Address ____

City, State: ________________________________ ZIP: ____________________

Home phone: ________________________________ Work hone: ________________ Ext. _______

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative: ______________________________ Date: ______________________________

Printed name of patient or personal representative: ____________________________ Relationship to patient: ______________________

Patient name: ______________________________
Date of birth: _______________________________

Patient Consent for Financial Communications

Financial Agreement

- I acknowledge, that as a courtesy, AURORA DENVER CARDIOLOGY ASSOCIATES may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection. I acknowledge AURORA DENVER CARDIOLOGY ASSOCIATES may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to AURORA DENVER CARDIOLOGY ASSOCIATES any insurance or other third-party benefits available for health care services provided to me. I understand AURORA DENVER CARDIOLOGY ASSOCIATES has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to AURORA DENVER CARDIOLOGY ASSOCIATES, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to AURORA DENVER CARDIOLOGY ASSOCIATES by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for AURORA DENVER CARDIOLOGY ASSOCIATES, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that AURORA DENVER CARDIOLOGY ASSOCIATES or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or AURORA DENVER CARDIOLOGY ASSOCIATES or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/patient representative signature: ________________________________ **Date:** _________________

If you are not the patient, please identify your relationship to the patient. Circle or mark relationship(s) from list below:

Spouse	Guarantor
Parent	Healthcare Power of Attorney
Legal Guardian	Other (please specify) ________________________________

Medicare Secondary Payor Development Form

Facility Name	COID	Patient's Retirement Date	Spouse's Retirement Date	Spouse's Deceased Date

Patient's Name	Account No.	Medicare No.

You must ask the patient each question in sequence and comply with any instructions which follow an answer. Failure to obtain information regarding Medicare as a secondary payor is a violation of your Provider agreement with Medicare.

Does the patient have an HMO policy? ☐ No ☐ Yes

If Yes, name, address and phone of HMO:

____

____

Does the HMO replace Medicare? ☐ No ☐ Yes

If Yes, the HMO will be primary. If No, it will be secondary.

~~**Is this patient an inpatient?** ☐ No ☐ Yes~~

~~**Was the patient given Important Message?** ☐ No ☐ Yes~~

~~*If No, why not?*~~ ______________________________

Has patient been an Inpatient in a health care facility within the last 60 days? ☐ No ☐ Yes

If Yes, name, address and phone of facility:

____

____

Has the patient had any outpatient medical services in the last 72 hours? ☐ No ☐ Yes

If Yes, name, address and phone of facility:

____

____

1. Are you receiving Black Lung (BL) Benefits?
   ☐ No
   ☐ Yes; Date benefits began: ______________
   If Yes, BL is Primary only for claims related to BL.

2. Are the services to be paid by a government program such as a research grant?
   ☐ No
   ☐ Yes; *Government program will pay primary benefits for these services.*

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?
   ☐ No
   ☐ Yes; *DVA is primary for these services.*

4. Was the illness/injury due to work related accident or condition?
   ☐ No; **Go to Question 5.**
   ☐ Yes; Date of injury/illness: ______________
   Name, address and phone of Workers Compensation Plan:
   ____
   ____
   ____
   Policy or ID Number: ______________
   Name, address and phone number of your employer:
   ____
   ____
   If Yes, Workers Compensation is Primary Payor only for claims related to work related injury or illness. **Go to Question 8.**

5. Was the illness/injury due to a non-work related accident?
   ☐ No; **Go to Question 8.**
   ☐ Yes; Date of accident:

6. What type of accident caused the illness/injury?
   ☐ Automobile ☐ Non-Automobile
   Name, address and phone of no-fault or liability insurer:
   ____
   ____
   ____
   Insurance Claim Number: ______________
   No-Fault insurer is Primary payor only for those claims related to the accident. **Go to Question 8.**
   ☐ Other (explain) ______________

7. Was another party responsible for this accident?
   ☐ No; **Go to Question 8.**
   ☐ Yes; Provide name, address and phone of any liability insurer:
   ____
   ____
   ____
   Insurance claim number: ______________
   If yes, liability insurer is Primary only for those claims related to the accident. **Go to Question 8.**

8. Are you entitled to Medicare based on:
   ☐ Age**; Go to Questions 9 – 12.**
   ☐ Disability; **Go to Questions 13 – 16.**
   ☐ ESRD; **Go to Questions 17 – 23.**

9. Are you currently employed?
   ☐ No; Date of retirement: ______________
   ☐ Yes; Provide name, address and phone of your employer:
   ____
   ____

10. Is your spouse currently employed?
    ☐ No; Date of retirement: ______________
    ☐ Yes; Provide name, address and phone of spouse's employer:
    ____
    ____
    If the patient answered No to both questions 9 and 10, Medicare is primary. If the patient answered "Yes" to questions 1 – 4 or 5 – 7 then Medicare is NOT primary payer.
    Do not proceed any further.
    If yes to questions 9 or 10, go to questions 11 and 12.

11. Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment?
    ☐ No; **Stop.** *Medicare is primary payer unless the patient answered Yes to questions 1 – 4 or 5 – 7.*
    ☐ Yes

Medicare requires this form to be completed for every Medicare patient. The information is used to determine if other payors are primary to Medicare. Medicare requires the patient to sign the MSP form.

Medicare Secondary Payor Development Form

Patient's Name	Account No.	Medicare No.

12. Does the employer that sponsors your GHP employ 20 or more employees?
    - ☐ No; **Stop.** *Medicare is Primary payer unless the patient answered "Yes" to questions 1-4 or 5 – 7.*
    - ☐ Yes; **Stop.** *Group Health Plan is Primary. Obtain the following information.*

    Name, address and phone of GHP: ____________________

    Policy ID Number: ____________________

    Group ID Number: ____________________

    Name of Policy Holder __________ Relationship to Patient __________

13. Are you currently employed?
    - ☐ No; Date of Retirement ____________________
    - ☐ Yes; Provide name, address and phone of your employer: ____________________

14. Is a family member currently employed?
    - ☐ No
    - ☐ Yes; Provide name, address and phone of employer: ____________________

    If patient answers "No" to both questions 13 and 14, Medicare is Primary unless the patient answered "Yes" to questions 1–4 or 5–7. **Do not proceed any further.**
    If Yes to questions 13 or 14, go to question 15 and 16.

15. Do you have your group health plan (GHP) coverage based on your own, or a family member's current employment?
    - ☐ No; **Stop.** *Medicare is Primary unless the patient answered "Yes" to questions 1 – 4 or 5 – 7.*
    - ☐ Yes

16. Does the employer that sponsors your GHP, employ 100 or more employees?
    - ☐ No; **Stop.** *Medicare is Primary unless the patient answered "Yes" to questions 1 – 4 or 5 – 7.*
    - ☐ Yes; **Stop.** *Group Health Plan is Primary. Obtain the following information:*

    Name, address and phone of GHP: ____________________

    Policy ID Number: ____________________

    Group ID Number: ____________________

    Name of Policy Holder __________ Relationship to Patient __________

17. Do you have group health plan (GHP) coverage?
    - ☐ No: Stop. *Medicare is Primary.*
    - ☐ Yes; Provide name, address and phone of GHP: ____________________

    Policy ID Number ____________________

    Group ID Number: ____________________

    Name of Policy Holder __________ Relationship to Patient __________

    Name, address and phone of employer, if any from which you received GHP coverage: ____________________

18. Have you received a kidney transplant?
    - ☐ No
    - ☐ Yes; Date of Transplant: ____________________

19. Have you received maintenance dialysis treatments?
    - ☐ No
    - ☐ Yes; Date dialysis began: ____________________

    If you participated in self dialysis training program, provide date training started: ____________________

20. Are you within the 30 month coordination period?
    - ☐ No; **Stop.** *Medicare is Primary.*
    - ☐ Yes

21. Are you entitled to Medicare on the basis of either ESRD and age, or ESRD and disability?
    - ☐ No; **Stop.** *GHP is Primary during the 30 month coordination period.*
    - ☐ Yes

22. Was your initial entitlement to Medicare (including simultaneous Entitlement) based on ESRD?
    - ☐ No; *Initial entitlement based on age or disability.*
    - ☐ Yes; **Stop.** *GHP continues to pay Primary during the 30th month coordination period.*

23. Does the working aged or disability MSP provision apply (i.e., is the GHP primary based on age or disability entitlement)?
    - ☐ No; *Medicare continues to pay Primary.*
    - ☐ Yes; *GHP continues to pay Primary during the 30 month coordination period.*

I understand that I am responsible for charges not covered by the Medicare program, and that such services include, but are not limited to the following: Cosmetic surgery, dental care, take-home drugs, private duty nurses, custodial care, television, telephone, private room (unless medically necessary), personal convenience items, non-FDA approved medical devices.

X ____________________ Patient or Representative / Relationship

X ____________________ Witness Date

Patient Name________________________________ DOS____________________

Review of Systems-New Patient

(*Please circle any problems you have been having*)

Cardiovascular: ____No Problems

chest pain , arm pain with exertion , chest fluttering or palpitations , sleeping with more than one pillow , syncope , edema

Respiratory: ____No Problems

shortness of breath , shortness of breath with activity , shortness of breath when lying flat , cough , wheezing

Constitutional: ____No Problems

fever , night sweats , weight gain (___lbs) , weight loss (___ lbs) , fatigue

Gastrointestinal: ____No Problems

abdominal pain , vomiting , change in appetite , frequent diarrhea , vomiting blood , heartburn , nausea , constipation

ENMT: ____No Problems

Ears: difficulty hearing , ear pain Nose: frequent nosebleeds , nose/sinus problems

Mouth/Throat: sore throat , mouth ulcer , teeth abnormalities , snoring

Neurologic: ____No Problems

loss of consciousness , weakness , numbness , seizures , dizziness , frequent or severe headaches

Musculoskeletal: ____No Problems

muscle aches, muscle weakness , **arthralgia's** /joint pain , back pain , swelling in the extremities

Integumentary: ____No Problems

Skin: Jaundice , rash , itching , dry skin , growths/lesions

Hematologic/Lymphatic: ____No Problems

easy bruising , excessive bleeding , swollen glands

Psychiatric: ____No Problems

depression , sleep disturbances

Eyes: ____No Problems

dry eyes , vision change , irritation

Genitourinary: ____No Problems

difficulty urinating , blood in urine , increased urinary frequency

Reviewed All Systems With Patient

Patient Name____

Primary Care Physician ____

Pharmacy Name____Location____

Allergies/Adverse Reactions____

Social History

Smoking Status : NEVER / CURRENT/ PAST SMOKER	**Notes**	
Smoking – If so how much?	**Notes**	
Has smoked since age:___________	**Notes**	
Date Quit Smoking? ______________	**Notes**	
Alcohol intake: NONE / OCCASIONAL / MODERATE / SEVERE	**Notes**	
Caffeine intake: YES OR NO	**Notes**	
Illicit drugs : ____	**Notes**	
Marital status : SINGLE / MARRIED/ DIVORCED/ WIDOWED/ SEPERATED/ OTHER_____	**Notes**	
Occupation ____	**Notes**	
Deaf or serious difficulty hearing: YES OR NO	**Notes**	
Blind or serious difficulty seeing: YES OR NO	**Notes**	
Difficulty concentrating, remembering or making decisions: YES OR NO	**Notes**	
Difficulty walking or climbing stairs: YES OR NO	**Notes**	
Difficulty dressing or bathing : YES OR NO	**Notes**	
Difficulty doing errands alone: YES OR NO	**Notes**	

Aurora Denver Cardiology Associates

Patient Name____

Past Medical History

	Y/N	Notes
Est Pts: Any new problems since last visit?		
High Cholesterol		
Myocardial Infarction		
Stroke/TIA		
Hypertension		
Diabetes		
Aneurysm		
Coronary Artery Disease		
COPD/Lung Disease		
Asthma/Allergies		
Anemia/Bleeding Disease		
Murmur		
Abnormal Heart Rhythm		
Rheumatic Fever		
Heart Burn/Peptic Ulcers/Reflux		
Autoimmune Disorders		

	Y/N	Notes
Thyroid Disorders		
Sleep Apnea		
Cancer		
Depression/Anxiety		
Gastrointestinal		
Hematologic/Lymphatic		
Other		
Carotid Artery Disease		
Chest Pain		
Congestive Heart Failure		
Obesity		
Peripheral Vascular Disease		
Pulmonary Hypertension		
Syncope		
Valvular Disease		

Family History

	Heart Disease	High blood Pressure	Stroke	Heart Attack	Cancer	High Cholesterol	Diabetes	Seizures	Pacemaker Treatment	Congenital Defects
Father										
Mother										
Brother										
Sister										

Patient Name/Date of Birth: __________________________________ Date: _______________

We are committed to providing the safest environment for our patients and together we can prevent the spread of germs!!

Please complete the questionnaire below. If you answer yes to any of the questions, please be considerate of others around you and act appropriately such as covering your cough and washing your hands.

For the protection of our patients, we gladly supply and encourage the use of tissues, masks, and hand sanitizer.

Do you have any of the following symptoms? *YES* *NO*

(If yes please circle the symptoms you have now or have had over the past seven days).

- Fever
- Night sweats
- Sneezing or runny nose
- Cough
- Sore throat

In the past 3 weeks have you traveled outside of the U.S.? *YES* *NO*

If yes please list where: _______________________________

In the past 3 weeks have you had close contact with someone who has traveled outside of the U.S.? *YES* *NO*

If yes, please list where: _______________________________

Fall Risk Assessment: Required for all Patients 65+

Patient Name: ___________________________
Patient DOB:_____________________________
Date Screened:___________________________

If NON-Ambulatory:

- ☐ Does not walk/Unable to walk
- ☐ Does not initiate/Unable to initiate walking
- ☐ Wheelchair bound
- ☐ Dependent on helper pushing wheelchair
- ☐ Independent in wheelchair

If Ambulatory:

Increased Fall Risk Factors: Please check all that apply.

- ☐ 3 or more Active Chronic Conditions (Predisposing Conditions)
- ☐ History of falls within 3 months
- ☐ Bladder Incontinence
- ☐ Visual Impairment (difficulty with vision)
- ☐ Difficulty ambulating (walks with cane or walker)
- ☐ Environmental hazard (stairs/ loose rugs in home, etc.)
- ☐ Takes 3 or more medications that adversely affects muscle function, coordination, and physical stability
- ☐ Pain affecting level of function, pain impacts activities of daily living
- ☐ Cognitive impairment

History of Falls in the Past Year?

- ☐ No falls in the past year
- ☐ One fall with injury in the past year
- ☐ Two or more falls with injury in the past year
- ☐ One fall without injury in the past year
- ☐ Two or more falls without injury in the past year

Office Use Only:

Provider Addressed:

- ☐ Patient Education
- ☐ Referred to PCP for further evaluation
- ☐ Referred to Specialist for further evaluation
- ☐ Patient and/or family counseling
- ☐ Physical Therapy
- ☐ Other (specify):_________________________________