

About our Practice

Continuity of Care

Our focus on quality of life means that we nurture all aspects of our patients' wellness: Physical, Cognitive, Functional, Social, Emotional, and Spiritual. To achieve our goals of individualized and comprehensive care, we collaborate with mobile diagnostic services, your medical specialists, therapists, medical equipment services, and your psychiatrist/psychotherapist to identify and implement any changes in a patient's care plan.

Holistic approaches may include: diet and lifestyle counseling, psychotherapy, massage, Chinese medicine/acupuncture, and ayurvedic medicine. While we do not ourselves provide many of these modalities, we are happy to support our patients in accessing these services.

Keeping track of medications, prioritizing them, and monitoring how the drugs are interacting and affecting the overall health of an aging person are critical components of eldercare.

This overall management is referred to as 'continuity of care,' and it makes all the difference.

"THE TRANSITION FROM ELDERLY TO ELDER IS A MIND, HEART, AND SOUL TRANSITION- NOT A PHYSICAL ONE." – DR. ELANE SHIRAR

A primary care provider is an integral part of the health care process for elderly people. In addition to being compassionate and experienced caregivers, our providers love their work. From listening to the unique stories of each of their patients to being a support system for families, we find joy in fostering relationships of trust and friendship. It is our mission to make people feel more comfortable from the inside out.

Services

Daily to monthly visits depending medical need

Regular physical examinations

Medication management

Appropriate laboratory testing

Continuity of care with specialists, providers, & family

Management of chronic diseases

Management of acute pain

The utmost in compassionate and attentive care

We service patients in Independent and Assisted Living, Skilled Nursing, and Long Term Care Communities.

Call our office at (720) 434-4876

Whether you are a patient, family or care-giver, we are here to be of service and happy to help.



NEW PATIENT INFORMATION

CHECK ONE	<input type="checkbox"/> INDEPENDENT LIVING <input type="checkbox"/> ASSISTED LIVING <input type="checkbox"/> LONG TERM CARE
PATIENT CONTACT INFORMATION	
NAME	
DATE OF BIRTH	
ADDRESS	
PHONE NUMBER	
FACILITY	
ROOM NUMBER	
UPDATED ADDRESS FOR MAILED STATEMENTS	
NAME & ADDRESS	
POWER OF ATTORNEY (IF APPLICABLE)	
NAME/RELATION	
ADDRESS	
PHONE NUMBER	
ADDITIONAL CONTACTS	
NAME/RELATION	
PHONE NUMBER	
NAME/RELATION	
PHONE NUMBER	
PATIENT INSURANCE (WE WILL STILL NEED A COPY OF YOUR INSURANCE CARD)	
COMPANY	
POLICY NUMBER	
PHONE NUMBER	
PREVIOUS PRIMARY CARE PROVIDER INFORMATION	
***PLEASE CHANGE THE PRIMARY CARE PROVIDER ON FILE WITH YOUR INSURANCE TO DR. ELANE L. SHIRAR	
NAME	
ADDRESS	
PHONE NUMBER	
FAX NUMBER	
ANNUAL WELLNESS VISIT	
LAST A.W.V. WAS:	<input type="checkbox"/> OVER A YEAR AGO <input type="checkbox"/> LESS THAN ONE YEAR AGO DATE: / /



PATIENT NAME:	DOB:	TODAY'S DATE:
---------------	------	---------------

CURRENT MEDICATIONS

NAME OF MEDICATION (LIST SEPERATLY IF NEEDED)	DOSE	FREQUENCY

ALLERGIES (MEDICATION, ENVIORNMENT, FOODS)

ALLERGEN	REACTION

ADDITIONAL CONCERNS

--

FORM REVIEWS

BY INITIALING BELOW, I AM INDICATING THAT I HAVE REVIEWED AND UNDERSTAND THE ATTACHED DOCUMENTS. I UNDERSTAND THAT I CAN CONTACT ROCKY MOUNTAIN SENIOR CARE IF I HAVE ANY QUESTIONS OR WISH TO REVOKE CONSENT FOR SERVICES AT ANY TIME. I UNDERSTAND THAT VERBAL AGREEMENT IS ACCEPTED AND MAY, AT ANY TIME, OVERRIDE THE INDICATIONS BELOW. I UNDERSTAND THAT, UNLESS NOTIFIED OTHERWISE, THESE AUTHORIZATIONS WILL NOT EXPIRE.

BILLING ARBITRATION AGREEMENT	_____ INITIAL FOR CONSENT	_____ INITIAL TO DECLINE
USE OF MEDIA (PHOTOS AND RECORDED VISITS)	_____ INITIAL FOR CONSENT	_____ INITIAL TO DECLINE
CHRONIC CARE MANAGEMENT	_____ INITIAL FOR CONSENT	_____ INITIAL TO DECLINE
BEHAVIORAL HEALTH INTEGRATION	_____ INITIAL FOR CONSENT	_____ INITIAL TO DECLINE
HIPAA CONSENT ACKNOWLEDGEMENT	_____ INITIAL FOR CONSENT	_____ INITIAL TO DECLINE
NAME OF HIPPA AUTHORIZED INDIVIDUAL/PARTY		

SIGNATURES

PATIENT NAME	PRINTED NAME OF RESPONSIBLE PARTY (IF APPLICABLE)
DATE	SIGNATURE OF PATIENT/RESPONSIBLE PARTY

NAME:	DOB:	TODAY'S DATE:		
1. PLEASE LIST ANY UPDATES TO YOUR PAST MEDICAL HISTORY				
<i>For example: Any serious illnesses, injuries, surgeries, and/or hospital stays</i>		DATE:		
2. VACCINES – PLEASE ENTER LAST DATE RECEIVED				
Tetanus: _____	Influenza: _____	Pneumococcal: _____		
3. BLOOD PRESSURE, TOTAL CHOLESTEROL, GLUCOSE				
	Low/Normal	Borderline	High	
Last Blood Pressure Reading:	<input type="checkbox"/> Unknown <input type="checkbox"/> 120/80 or below	<input type="checkbox"/> 120/80 -139/89	<input type="checkbox"/> 140/90 or above	
Last Fasting Glucose Reading:	<input type="checkbox"/> Unknown <input type="checkbox"/> 200 or below	<input type="checkbox"/> 200 - 239	<input type="checkbox"/> 240 or above	
Last Hemoglobin A1c Level (if diabetic):	<input type="checkbox"/> Unknown <input type="checkbox"/> 6 or below	<input type="checkbox"/> 7	<input type="checkbox"/> 8 or higher	
4. WHAT OTHER PHYSICIANS DO YOU SEE AND FOR WHICH HEALTH CONCERNS?				
PHYSICIAN/PROVIDER:		PROBLEM:		
5. WHERE DO YOU GET YOUR MEDICATIONS AND MEDICAL SUPPLIES?				
SUPPLIER:		SUPPLIES:		
6. PLEASE INDICATE WHETHER YOUR FAMILY HAS HAD ANY OF THE FOLLOWING CONDITIONS:				
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Obesity	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other _____
7. TOBACCO USE				
Have you recently used tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Would you be interested in quitting tobacco use within the next month?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe	
Used a smokeless tobacco product?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
8. ALCOHOL USE				
In the past week, how many days did you consume alcohol?	<input type="checkbox"/> None <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5-6 <input type="checkbox"/> Daily			
On days when you drink alcohol, how many drinks are typically consumed?	<input type="checkbox"/> None <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> More than 4			
Do you ever drive after drinking OR ride with a driver who has been drinking?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
9. NUTRITION				
How many servings of fruit/vegetables per day? _____	How many servings of whole grain/fiber per day? _____			
How many servings of fried/high-fat foods per day? _____	How many sugar-sweetened beverages per day? _____			

NAME:	DOB:	TODAY'S DATE:
10. GENERAL HEALTH		
In general, how would you rate your health?	<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
How would you rate the condition of your mouth and teeth?	<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
How much pain are you in on average?	<input type="checkbox"/> None	<input type="checkbox"/> Minor <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Do you have trouble hearing when others do not?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Sometimes
Has anyone told you that you snore?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Sometimes
How many hours of sleep do you get per night on average?	<input type="checkbox"/> 0-4	<input type="checkbox"/> 4-7 <input type="checkbox"/> 7-10 <input type="checkbox"/> 10+
How often do you feel sleepy during the day?	<input type="checkbox"/> Always	<input type="checkbox"/> Usually <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely <input type="checkbox"/> Never
11. ACTIVITIES OF DAILY LIVING		
Do you need help from others to perform everyday activities like eating, grooming, or walking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Sometimes
Do you need help from others to complete tasks such as laundry, transportation, and banking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Sometimes
Do you always fasten your seatbelt when you are in a vehicle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Sometimes
Is your home safe? (assistance rails installed, proper lighting, rugs or trip hazards in the hallways)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. PHYSICAL ACTIVITY		
In the last 7 days, how many days did you exercise?	<input type="checkbox"/> None	<input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5-6 <input type="checkbox"/> Daily
For approximately how many minutes?	<input type="checkbox"/> None	<input type="checkbox"/> 0-20 <input type="checkbox"/> 20-40 <input type="checkbox"/> 40-60 <input type="checkbox"/> 60+
Average intensity?	<input type="checkbox"/> N/A	<input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy <input type="checkbox"/> Very Heavy
13. FALL RISK		
Are you afraid of falling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you fallen two or more times in the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
During the past four weeks, how often have you fallen or felt dizzy when standing up?	<input type="checkbox"/> Always	<input type="checkbox"/> Usually <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely <input type="checkbox"/> Never
14. DEPRESSION, ANXIETY, SOCIAL/EMOTIONAL SUPPORT		
How often do you feel down, depressed, or hopeless?	<input type="checkbox"/> Always	<input type="checkbox"/> Usually <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely <input type="checkbox"/> Never
How often do you feel little pleasure/interest in things?	<input type="checkbox"/> Always	<input type="checkbox"/> Usually <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely <input type="checkbox"/> Never
How often do you feel nervous, anxious, or on edge?	<input type="checkbox"/> Always	<input type="checkbox"/> Usually <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely <input type="checkbox"/> Never
How often are you unable to stop/ control your worrying?	<input type="checkbox"/> Always	<input type="checkbox"/> Usually <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely <input type="checkbox"/> Never
How often is stress a problem dealing with daily activities?	<input type="checkbox"/> Always	<input type="checkbox"/> Usually <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely <input type="checkbox"/> Never
How often are you getting social/emotional support?	<input type="checkbox"/> Always	<input type="checkbox"/> Usually <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely <input type="checkbox"/> Never
Have your feelings caused distress or interfered with your ability to get along with friends & family	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15. DEMOGRAPHICS		
Age: <input type="checkbox"/> 64 or younger <input type="checkbox"/> 65-69 <input type="checkbox"/> 70-79 <input type="checkbox"/> 80 or older	Gender: <input type="checkbox"/> Male	<input type="checkbox"/> Female



**ROCKY MOUNTAIN
SENIOR CARE**

A: 5920 McIntyre Street, Golden, CO 80403

P: (720) 434-4876

F: 303-215-7492

E: fax_records@myrmsc.com



RELEASE OF MEDICAL RECORDS TO ROCKY MOUNTAIN SENIOR CARE

I AUTHORIZE THE USE OR DISCLOSURE FOR THE BELOW NAMED INDIVIDUAL

NAME

DOB

FROM: _____

TO: ROCKY MOUNTAIN SENIOR CARE
5920 MCINTYRE STREET
GOLDEN, CO 80403

REASON FOR DISCLOSURE: _____

- TYPE OF RECORDS: **PAST (1) YEAR OF RECORDS TO INCLUDE**
- SPECIALIST NOTES, MOST RECENT VISIT NOTE
- PRIMARY CARE PROVIDER: RECENT H&P, LABS, DIAGNOSTIC RESULTS, MEDICATION LIST
- HOSPITAL: ADMISSIONS, DISCHARGE SUMMARY, LABS, DIAGNOSTIC RESULTS, MEDICATION LIST
- OTHER (PLEASE LIST SPECIFICS) _____
- ALL

I UNDERSTAND THAT RECORDS COPIED FOR MY PERSONAL USE MAY BE CHARGED TO ME AT THE RATE CURRENTLY SET BY THE STATE OF COLORADO AS REASONABLE AND CUSTOMARY. I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING. I UNDERSTAND THAT THE REVOCATION DOES NOT APPLY TO INFORMATION RELEASED TO MY INSURANCE COMPANY IF ASSOCIATED WITH CLAIMS FOR PAYMENT OF SERVICES RENDERED. I UNDERSTAND THAT AUTHORIZING THE DISCLOSURE OF THIS INFORMATION IS VOLUNTARY, I HAVE THE RIGHT TO COPY (AT MY OWN EXPENSE) OR INSPECT THE RECORDS BEING DISCLOSED AS PROVIDED IN CFR 164-524. I UNDERSTAND THAT THE DISCLOSURE OF INFORMATION CARRIES THE POTENTIAL OF DISCLOSURE AND THAT ANY INFORMATION MAY NOT BE PROTECTED BY FEDERAL CONFIDENTIALITY RULES.

PATIENT/GUARDIAN SIGNATURE

DATE

BILLING AGREEMENT

I hereby acknowledge and agree that I am voluntarily seeking health care services from Rocky Mountain Senior Care and its providers. Electing to be seen by our provider establishes this agreement and all individuals legally capable of contracting, and the legal representatives of all Individuals incapable of contracting, agree to all provisions of this individual agreement.

I understand and agree that payment for the services I receive is my responsibility. I understand and agree that Rocky Mountain Senior Care may bill my insurance/third party payor or other responsible insurance as a courtesy but is not obligated to do so.

I acknowledge, understand and agree that it is my sole responsibility to determine what my health insurance covers, whether the health care provider I am seeing is a participating provider under my health insurance and whether my health insurance covers the health care services I receive from or through Rocky Mountain Senior Care. I understand and agree that I am solely responsible for payment of my entire account balance and that all payments are required in full, unless prior arrangements are made. Billing notices will be sent to the most recent address Rocky Mountain Senior Care has on file and that I am responsible for notifying Rocky Mountain Senior Care of any change in address.

I understand and acknowledge that Rocky Mountain Senior Care does not participate in all insurance plans and that Rocky Mountain Senior Care is not responsible for obtaining referrals, approvals or authorizations, or for knowing the requirements of my health insurance plan. I acknowledge and agree that it is my sole responsibility to know, understand and comply with the requirements of my health insurance plan.

I understand that Rocky Mountain Senior Care does not discriminate in our employment practices or in the delivery of health care services on the basis of age, race, color, national origin, religion, sex, sexual orientation, or physical or mental disability.

Except as preempted by federal law, this individual agreement will be governed in accord with Colorado law, and may be modified from time to time by us as those laws may require, and any provision that is required to be in this agreement by state or federal law shall bind Individuals and enforce any provision of this agreement will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

I acknowledge that, with the exception of exempted claims, my participation in services provided by Rocky Mountain Senior Care requires that all claims by me, my spouse, my heirs, or anyone acting on your or my behalf, against Rocky Mountain Senior Care or any employees or shareholders of these entities, or providers or affiliated physicians, must be submitted to binding arbitration before a single neutral arbiter. By engaging in our services, you have agreed to the use of binding arbitration in writing within 60 days of the alleged incident(s) or occurrence(s). The arbitration hearing will be conducted in accord with the Colorado Uniform Arbitration Act and the Federal Arbitration Act.



MEDIA CONSENT

CONSENT TO AUDIO RECORD PATIENT VISITS

Rocky Mountain Senior Care medical providers feel it is important to spend time with our patients. As much is possible, we prefer to be in the presence of our patients rather than to spend our time typing notes into a computer. Our electronic medical record system allows us to audio record visits for future reference, thus minimizing the time your provider spends typing chart notes.

With that objective in mind, I give my Rocky Mountain Senior Care provider consent to audio record my medical visits.

CONSENT TO PHOTOGRAPH

Clinical photography of patients may be appropriate for the diagnosis and treatment of medical conditions. Clinical photography can be accomplished through a variety of multimedia technology to collect, analyze, and store patient protected health information. Use of these medias will be carefully controlled and executed in compliance with all state and federal regulations as well as other organizational policies and procedures.

Requests for external disclosures of clinical photography that are not for treatment, payment, or operations requires the patient's specific informed consent prior to the release. Examples or external disclosures requiring authorization include, but are not limited to:

- Requests by law enforcement
- Requests by social services
- Requests for marketing
- Requests for medical publication

I understand that this authorization is valid until I give written notification to withdraw my consent.

CHRONIC CARE MANAGEMENT

Dear Valued Patient,

As a patient with two or more chronic conditions, you may benefit from a program through Centers for Medicare and Medicaid Services that Rocky Mountain Senior Care is offering to all qualifying patients called Chronic Care Management (CCM). We want to ensure you get the best care possible from everyone that is involved with your health concerns. Through CCM, we can help coordinate your visits with other doctors, facilities, lab, radiology, or other testing; we can talk to you on the phone about your symptoms; we can help you with the management of your medications; we will provide you with a personalized comprehensive care plan; and you can access our clinical team 24/7 for care and coordination. We are able to bill for these services during any month that we have provided at least 20 minutes of non-face-to-face care for you and your conditions. Time accrued for these services will reset on the first of every month.

Sometimes staff from our practice other than your primary care provider, will talk to you or handle issues related to your care, but please know that your assigned clinician will supervise all care provided by our staff or clinicians who may be involved in your care.

You agree and consent to the following:

- As needed, we will share your health information electronically with others involved in your care in order to maximize the benefits of collaboration. Please rest assured that we continue to comply with all laws and related to the privacy and security of your health information.
- We will bill insurance for chronic care management once a month *only if* 20 minutes of CCM is reached. Some patient responsibility may be applied and supplementary insurance claims may be submitted. Although you may or may not come into the office every month, your account will reflect this charge and you will be responsible for payment when applicable. Our office will have a record of our time spent managing your care if you ever have a question about what we did each month.
- Only one physician can bill for this service for you. Therefore, if another one of your physicians has offered to provide you with this service, you would need to choose which physician is best able to treat you and all of your conditions. Please let your physician or our staff know if you have entered into a similar agreement with another physician/practice.

You have a right to:

- A comprehensive Care Plan from our practice to help you understand how to care for your conditions so that you can be as healthy as possible.
- Discontinue or transfer this service at any time for any reason.

Our goal is to provide you with the best care possible, to keep you out of the hospital, and to minimize costs and inconvenience to you due to unnecessary visits to doctors, emergency rooms, labs, or hospitals. We know your time and your health is valuable and we hope that you will consider continued participation in the program with our practice.

Sincerely,

Rocky Mountain Senior Care

BEHAVIORAL HEALTH INTEGRATION

We are proud to announce that Rocky Mountain Senior Care is one of the first practices in the country to offer behavioral health management as an everyday aspect of the care provided by our practice. This model is called Behavioral Health Integration.

Research demonstrates that integrated models of primary care and mental health improve access to mental health services and treatment, [i],[ii] increase adherence to treatment and medication, [iii],[iv] and result in better health outcomes.[v] This is especially important when considering our patients and the effect mental and emotional wellbeing can have on comorbidities.

Behavioral Health Integration allows Rocky Mountain Senior Care to provide oversight of all psychiatric medications by a psychiatrist without requiring a patient to travel to an external office. This oversight includes the ability to provide new or alternate medication options and oversee gradual dose reductions programs. Rocky Mountain Senior Care can also track changes in behaviors allowing us to provide measurement-based treatment decisions as well as identify the development of new behaviors and revise a patient's overall care plan accordingly. Patients can also see an outside psychiatrist or therapist if desired, and we will work with them to make sure that care is integrated into the overall plan.

As this is a Medicare approved service, we are required to obtain consent in order for a patient to participate with our practice. Consent can be communicated directly to your health care provider, by providing consent upon admission through the new patient paperwork, or by calling our office and notifying a member of our staff.

By offering consent, you agree to allow Rocky Mountain Senior Care to share applicable Personal Health Information (PHI) with other providers within the practice as well as mental health specialists that play an active role in a patient's care plan.

Our goal is to provide our patients with the best care possible and to ensure they receive recommendations that incorporate a comprehensive understanding of a patient's medical and mental health conditions. We invite you to contact our office if you have any questions regarding participation in the Behavioral Health Integration program with Rocky Mountain Senior Care.

[i] Kilbourne, A. Piggaglia P., Lai, Z., Bauer, M., Charns, M., et al. (2011, Aug). Quality of General Medical Care Among Patients With Serious Mental Illness: Does Co-Location Matter? *Psychiatric Services*, 62(8), 922-8. doi: 10.1176/appi.ps.62.8.922

[ii] Druss, B., van Esenwein S., Compton, M., Rask, K., Zhao, L., et al. (2010, Feb). A Randomized Trial of Medical Care Management for Community Mental Health Settings: The Primary Care Access, Referral and Evaluation (PCARE) Study. *American Journal of Psychiatry*, 167: 151-159. doi: 10.1176/appi.ajp.2009.09050691

[iii] Mertens, J., Flisher, A., Satre, D., & Weisner, C. (2008, Nov 1). The role of medical conditions and primary care services in 5-year substance use outcomes among chemical dependency treatment patients. *Drug Alcohol Dependence*, 98 (1-2):45-53. doi: 10.1016/j.drugalcdep.2008.04.007.

[iv] Roy-Byrne, P., Katon, W., Cowley, D., & Russo, J. (2001, Sep). A Randomized Effectiveness Trial of Collaborative Care For Patients with Panic Disorder in Primary Care. *Archives of General Psychiatry*, 58(9): 869-76.

[v] Rost, K., Pyne, J., Dickinson, M., & LoSasso, A. (2005, Jan 1). Cost-Effectiveness of Enhancing Primary Care Depression Management on an Ongoing Basis. *Annals of Family Medicine*, 3(1):7-14. Retrieved from <http://www.annfammed.org/content/3/1/7>