ROCKY MOUNTAIN SENIOR CARE

Address: 5920 McIntyre Street, Golden, CO 80403 Phone: (720) 434-4876 Fax: (303) 225-4246

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.

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NEW PATIENT INFORMATION

CHECK ONE	☐ INDEPENDENT LIVING ☐ ASSISTED LIVING ☐ LONG TERM CARE
PATIENT CONTACT INFORMATION	
NAME	
DATE OF BIRTH / SS#	
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:	☐ OVER A YEAR AGO ☐ LESS THAN ONE YEAR AGO DATE: _____ / _____ / _____

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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 (ANNUAL RENEWAL)	_____ 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**

Annual Wellness Visit Health Risk Assessment

PLEASE FAX COMPLETED FORM TO: 303-215-7315

ROCKY MOUNTAIN SENIOR CARE

NAME:	DOB:	TODAY'S DATE:

1. PLEASE LIST ANY UPDATES TO YOUR PAST MEDICAL HISTORY

For example: Any serious illnesses, injuries, surgeries, and/or hospital stays	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:	☐ Unknown	☐ 120/80 or below	☐ 120/80 -139/89	☐ 140/90 or above
Last Fasting Glucose Reading:	☐ Unknown	☐ 200 or below	☐ 200 - 239	☐ 240 or above
Last Hemoglobin A1c Level (if diabetic):	☐ Unknown	☐ 6 or below	☐ 7	☐ 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:

☐ Alcoholism ☐ Cancer ☐ Heart Disease ☐ Rheumatoid Arthritis ☐ Stroke
☐ Arthritis ☐ Diabetes ☐ Obesity ☐ Seizures ☐ Other _____

7. TOBACCO USE

Have you recently used tobacco? ○ Yes ○ No Used a smokeless tobacco product? ○ Yes ○ No	Would you be interested in quitting tobacco use within the next month? ○ Yes ○ No ○ Maybe

8. ALCOHOL USE

In the past week, how many days did you consume alcohol?	☐ None ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ Daily
On days when you drink alcohol, how many drinks are typically consumed?	☐ None ☐ 1-2 ☐ 3-4 ☐ More than 4
Do you ever drive after drinking OR ride with a driver who has been drinking?	☐ Yes ☐ 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? _____

Annual Wellness Visit Health Risk Assessment

PLEASE FAX COMPLETED FORM TO: 303-215-7315

ROCKY MOUNTAIN SENIOR CARE

NAME:	DOB:	TODAY'S DATE:

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

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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 AUTHORING 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**

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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.

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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 that 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.

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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. You must provide your consent to participate once a year.

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

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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. Piggarlia 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., von 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

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PATIENT HIPAA CONSENT

I hereby give my consent for Rocky Mountain Senior Care to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Rocky Mountain Senior Care describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Rocky Mountain Senior Care reserves the right to revise its Notice of Privacy Practices at any time. The Notice of Privacy Practices may be obtained by forwarding a written request to 5920 McIntyre Street, Golden, Colorado 08403 or by downloading the revised form from the practice website: www.rockymntseniorcare.com. The Notice of Privacy Practices is posted in our office.

With this consent, Rocky Mountain Senior Care may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to the patient's clinical care, including laboratory test results.

With this consent, Rocky Mountain Senior Care may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Rocky Mountain Senior Care may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Rocky Mountain Senior Care restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By initialing the corresponding preference on the New Patient Information packet, I am consenting to allow Rocky Mountain Senior Care to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not provide consent, or later revoke it, Rocky Mountain Senior Care may decline to provide treatment to me.

Consent is effective immediately and applies to all PHI produced or collected while in the care of Rocky Mountain Senior Care unless Rocky Mountain Senior Care is notified in writing.