ROCKY MOUNTAIN SENIOR CARE

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

I Hereby authorize the following provider to disclose my health record,

Name of facility releasing information_____
Phone number_____ Fax Number_____
Patient Name: _____ Patient DOB: _____

Reason for disclosure: Treatment
Please fax requested information to (303)225-4246 or mail to the above address.

Information to be disclosed:
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 or Guardian Signature/ Date

_____Date_____

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Rocky Mountain Senior Care Referral

Name of Community _____

Patient Name: _____ Sex: M F DOB: _____

SSN: _____ Street Address: _____ APT/Room#_____

City, State, Zip_____ Phone: _____Fax: _____

If patient is a new move in, Move in date: _____

__ Independent Living __ Assisted Living __ Memory Care __Long Term Care __

Additional Services

Home Health: _____ Hospice: _____

Insurance

Primary Insurance: _____ Policy Number: _____

Secondary Insurance: _____ Policy Number: _____

Medications:_____

_____

_____

Allergies:_____

Pharmacy Information: _____Phone: _____

Social History (please circle all that apply)

Diet

Regular Diabetic Low Salt Gluten Free Vegan Other_____

Supportive devices

Wheelchair Walker Cane Eye Glasses Hearing Aid Oxygen CPAP

Responsible Party (if other than patient):

Name: _____

Street Address: _____

City, State, Zip: _____

Phone: _____

Relationship to Patient: _____ POA: Y N

Primary Contact (if other than Patient):

Name: _____

Phone: _____

Relationship: _____ POA: Y N

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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