| ROCKY MOUNTAIN SENIOR CARE POWERED BY ALPINE PHYSICIAN PARTNERS | NEW PATIENT & RFERRAL FORM Revised 8-3-22<br>PLEASE RETURN TO FAX: 303-215-7492 OR EMAIL: fax_records@myrmsc.com |
|---|---|
| MOVE IN DATE | |
| CIRCLE TYPE | INDEPENDENT LIVING ASSISTED LIVING LONG TERM CARE<br>MEMORY CARE |
| CIRCLE IF APPLICABLE | HOME CARE HOSPICE |
| **PATIENT CONTACT INFORMATION** | |
| NAME | |
| DATE OF BIRTH | |
| ADDRESS | |
| PHONE NUMBER | |
| ROOM NUMBER | |
| **UPDATED ADDRESS FOR MAILED STATEMENTS (IF DIFFERENT FROM ABOVE)** | |
| NAME & ADDRESS | |
| **POWER OF ATTORNEY (IF APPLICABLE)** | |
| NAME/RELATION | |
| ADDRESS | |
| PHONE NUMBER | |
| **ADDITIONAL CONTACTS** | |
| NAME/RELATION | |
| PHONE NUMBER | |
| NAME/RELATION | |
| PHONE NUMBER | |
| **PATIENT INSURANCE** | |
| COMPANY | |
| POLICY NUMBER | |
| **LIST CURRENT MEDICATIONS** | |
| | |
| | |
| | |
| **PHARMACY NAME:** | **PHONE NUMBER:** |
| **ALLERGIES (MEDICATION, ENVIORNMENT, FOODS)** | |
| ALLERGEN | REACTION |
| | |
| | |
| | |
| **DIET (CIRCLE THOSE THAT APPLY)** | |
| **REGULAR DIABETIC LOW SALT GLUTEN FREE VEGAN OTHER:** | |
| **SUPPORTIVE DEVICES (CIRCLE THOSE THAT APPLY)** | |
| **WALKER CANE EYEGLASSES HEARING AID OXYGEN CPAP-Responsible Party:** | |

ROCKY MOUNTAIN SENIOR CARE
POWERED BY ALPINE PHYSICIAN PARTNERS

A: 5920 McIntyre Street, Golden, CO 80403 P: (720) 434-4876 F: 303-215-7492 E: fax_records@myrmsc.com

CHRONIC CARE MANAGEMENT PROGRAM

Dear Valued Patient,

We would like to offer you a program at Rocky Mountain Senior Care that will help us work together to improve your health. As a patient with one or more chronic conditions, such as diabetes, high blood pressure, dementia, heart disease, depression, osteoporosis, or many others you may benefit from a program covered by insurance 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 accomplish this. A lot goes on outside of your direct provider visits to ensure your medications are up to date; labs, radiology and other testing is ordered and acted upon; home care certifications and orders are updated and revised as well as coordination of your care with other providers and facilities.

The program offers:

- Access to around-the-clock (24/7) services from your care team at Rocky Mountain Senior Care. This care team includes physicians, Nurse Practitioners, Physician Assistants, Pharmacist, Nursing Staff and Medical Assistants
- Management of your medications
- Coordination of visits with your doctors, facilities, labs, radiology, or others
- Provide you with a personalized and comprehensive care plan management
- Assist you with scheduling preventive care services, many of which are covered by Medicare

We are approved 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 verbal consent to your provider to participate.**

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.

**If You agree and consent the following will take place:**

- As needed, we will share your health information electronically with others involved in your care 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 will be submitted. Although you may or may not see a provider every month, your account will reflect this charge and you will be responsible for payment when applicable. Further information about co-pays can be found by contacting the billing office at **720-355-0539**
- 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/practice can bill for this service for you.

**You have a right to:**

- Discontinue or transfer this service at any time for any reason by notifying your provider.

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. You have access to consent to this program by discussing directly with your provider who will also answer any questions you may have.

Sincerely,

Rocky Mountain Senior Care

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A: 5920 McIntyre Street, Golden, CO 80403 P: (720) 434-4876 F: 303-215-7492 E: fax_records@myrmsc.com

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

Name of facility releasing information_____

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_____

Revised 8-3-22