Dear Friends:

Welcome to IPC/Senior Care of Colorado! We hope that you will find our primary care medical services satisfying for many years to come. Our team of doctors, physician assistants, nurse practitioners and staff are specially-trained in the needs of older adults. We see patients across the spectrum of care: not just in the clinic, but also at many retirement communities, assisted living, rehabilitation, and skilled nursing centers throughout Metro Denver. We provide personalized care coordination if you're hospitalized, and IPC hospitalists care for patients in select Denver hospitals.

As your primary care provider, here is what you can expect from us:

1. We try to be friendly and understanding at all times.
2. We do our best to respect your time and be on time for appointments.
3. We will work with you to find a team of clinicians (a doctor and either a physician assistant or nurse practitioner) whom you like and trust.
4. We endeavor to know where you are (at home, in the hospital, in a nursing facility, or elsewhere) and how you are doing.
5. We can see you in many settings (clinic, assisted living, rehab, nursing home, and some hospitals).
6. We educate our clinicians and staff about the most current knowledge in geriatric medicine so they can deliver the best care to you.
7. We respond quickly and respectfully to your concerns about the practice.
8. We do our best to have fun as we all struggle with the challenges of aging.

In order for us to serve you best, we need your help. This is what we ask of you:

- If you or your loved one goes to a hospital or a nursing facility, please let us know. Most of the time we are aware of these changes, but sometimes this information falls through the cracks. Please call us at **303.306.4326** to confirm these changes.
- Please be patient with us if we have unexpected emergencies and run late in the clinic.
- If you should need to reschedule an appointment, please phone our appointment line at **303.306.4329**.
- If you need to have a prescription refilled, call our dedicated prescription refill line at **303.306.4304.**

We look forward to many years of working with you, with your family, and with your good friends.

Sincerely,

Your IPC/Senior Care of Colorado Providers and Staff

Aurora Clinic
1400 S. Potomac St., Suite 150
Aurora, CO 80012

Porter Clinic
850 E. Harvard Ave., Suite 305
Denver, CO 80210

Swedish Clinic
499 E. Hampden Ave., Suite 100
Englewood, CO 80113

303.306.4321 | www.SeniorCareOfColorado.com

Dear New Patient:

Thank you for choosing IPC/Senior Care of Colorado to provide your healthcare. Your appointment is scheduled as follows:

Date: ____________________ Clinic Location: ______________________________________

Time: ____________________ Provider Name: ______________________________________

Please arrive 30 minutes before your appointment time to complete any additional paperwork that might be required.

Please bring the following with you:

- The IPC/Senior Care of Colorado forms that accompany this letter
- A photo ID
- Your medical insurance cards
- All medications you are currently taking.

We look forward to meeting you and addressing your medical questions and issues.

If you have any general questions prior to your appointment, please do not hesitate to call us at **303.306.4321**.

If you should need to reschedule, please phone our appointment line at **303.306.4329**.

Sincerely,

The IPC/Senior Care of Colorado Staff

Permission to Share Information

I, ______________________________, give permission for IPC/Senior Care of Colorado to discuss my medical condition with the following family members.

Name	Relationship
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

______________________________ ______________________________

Patient/POA Signature Date

Aurora Clinic
1400 S. Potomac St., Suite 150
Aurora, CO 80012

Porter Clinic
850 E. Harvard Ave., Suite 305
Denver, CO 80210

Swedish Clinic
499 E. Hampden Ave., Suite 100
Englewood, CO 80113

303.306.4321 | www.SeniorCareOfColorado.com

IPC/Senior Care of Colorado Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments.** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. **Nonpayment.** You will receive 2 notifications from our billing department when a balance is due. If you do not respond to these notifications, your account will be considered Past-Due. At this point the balance will be forwarded to our collection agency for follow-up. There will be a **$10.00** fee added to your balance should this occur.
8. **Missed appointments.** Our policy is to charge for missed appointments not canceled within a reasonable amount of time. The fee is **$25.00**. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

______________________________ ______________

Patient or Responsible Party Signature Date

Health Information Privacy Practices Notice Acknowledgement

Patient Name ______________________________ Date ____________

I acknowledge that I have received a document titled "Notice of Privacy Practices" from IPC/Senior Care of Colorado.

Patient's Signature ______________________________ ~ OR ~ Patient Representative's Signature ______________________________

Date ______________________________ Relationship to Patient ______________________________

FOR OFFICE USE ONLY		
I attempted to obtain the patient's signature on this form and was unable to because of the reason stated below. I affirm that the patient received a copy of the "Notice of Privacy Practices."		
Date:	**Initials:**	**Reason:**

Notice of Privacy Practices - IPC The Hospitalist Company

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. WE HAVE THE RIGHT TO CHANGE AND UPDATE THIS NOTICE.

Uses and Disclosures

Treatment. Your health information may be used by IPC-The Hospitalist Company staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment.

Payment. Your health information may be used to seek payment from your health plan or other payers. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of IPC The Hospitalist Company. For example, information on the services you received may be used to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the State's public health department.

Other uses and disclosures require your authorization. Disclosure or use of your health information for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may revoke your authorization In writing. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.. We may also send you information describing other health-related products and services that we believe may interest you.

Information for Family Members, Caregivers, or Friends. Unless you object, we may use or disclose your medical Information to notify a family member, a personal representative, or another person responsible for your care of your location, general condition, or death.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to inspect and copy your medical information. However, IPC The Hospitalist Company may deny your request for certain specific reasons. If your request is denied, we will provide you with a written explanation for the denial and give you additional Information about your rights.

- The right to request additional confidentiality for protected health information when used by IPC The Hospitalist Company for the purposes of treatment, payment, or healthcare operations.

    - However, we have the right to approve or deny your request.
    - Additionally, if we approve your request, we have the right to terminate that agreement, provided we notify you in writing of our decision to do so.

- The right to request a correction or amendment to your health information. However, IPC The Hospitalist Company may deny your request for certain specific reasons. If your request is denied, we will provide you with a written explanation for the denial and give you additional Information about your rights.

- The right to receive an accounting of the disclosures of your medical information made by IPC The Hospitalist Company in the six years prior to your request. This right begins on April 14, 2003, and applies to disclosures made on or after April 14, 2003. However, the following disclosures do not require an accounting under federal law:

.

    - Disclosures made for treatment, payment, or other healthcare operations purposes;
    - Disclosures made to you;
    - Disclosures made in such a way that your identity was kept confidential by restricting the amount and type of information that was disclosed;
    - Disclosures made to health oversight agencies or law enforcement agencies if they provide us with a written statement that temporarily prevents us from making such an accounting;
    - Disclosures made for national security or intelligence purposes;
    - Disclosures made to correctional institutions or to law enforcement officials

- The right to request a paper copy of this Notice of Privacy Practices for Protected Health Information.

IPC The Hospitalist Company Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

IPC's Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the IPC Health Services Department or the IPC Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Kathleen Loya
Privacy Officer
IPC The Hospitalist Company
4605 Lankershim Blvd. Suite 400
North Hollywood, CA 91602

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint. You can also file a complaint with the Federal Office of Civil Rights.

Contact Person
The name and address of the person you can contact for further information concerning our privacy practices is:

Kathleen Loya
Privacy Officer
IPC The Hospitalist Company
4605 Lankershim Blvd. Suite 400
North Hollywood, CA 91602
(818) 753-6495

Effective Date
This Notice is effective on or after April 14, 2003.

Authorization and Consent

Authorization for Treatment

The undersigned hereby consents to and authorizes the administration and performance of medical care that may be in the judgment of the physician considered advisable and necessary, which may include the performance of certain blood tests for communicable diseases such as Hepatitis and HIV infection.

Release of Information to Insurance Carriers

IPC/Senior Care of Colorado and physicians are authorized to furnish information necessary to process claims to an insurer, compensation carrier, or welfare agency which may be providing financial assistance for hospital care.

Medicare Patient's Certification, Authorization to Release Information and Payment Request

I request that payment of authorized Medicare benefits be made either to me or on my behalf to IPC/Senior Care of Colorado. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I further authorize the Medicare program to furnish medical or other information acquired on this visit by its intermediary under the Title XVIII Program to the extent necessary to process any complementary coverage claim.

FINANCIAL RESPONSIBILITY

In consideration of the rendering of service to the patient, the undersigned guarantees the payment of any amount due for such services rendered by IPC/Senior Care of Colorado and physician over and above the amount covered by Medicare and/or insurance.

I hereby certify that I have read and fully understand the above authorizations.

______________________________ ______________________________

Patient Signature Date

______________________________ ~ OR ~ ______________________________

Witness Patient Representative

____

Relationship to Patient

Senior Care of Colorado

A medical group practice of ipc HEALTHCARE

Authorization for Release of Patient Information

Patient Last Name ______ First Name ______ MI ______ Date of Birth ___/___/___

Social Security Number ___–___–___ Telephone (   ) ___–___ Email Address ______

Please send my records from:

Name: ______

Address: ______

City: ______

State: ______ ZIP: ______

Phone: ______

Fax: ______

To: IPC/Senior Care of Colorado

☐ Aurora Clinic
1400 South Potomac St., Suite 150, Aurora, CO 80012
Fax: (303) 695-8627

☐ Porter Clinic
850 East Harvard Ave., Suite 305, Denver, CO 80210
Fax: (303) 722-1850

☐ Swedish Clinic
499 East Hampden Ave, Suite 100, Englewood, CO 80113
Fax: (303) 761-4391

I request and authorize the release of information to the organization, agency, or individual named above. I understand that the information to be released may include the following condition(s):

1. Drug Abuse/Alcohol Abuse (Federal Regulation 42C.F.R., Part 2)
2. Psychological or psychiatric conditions
3. A test for the presence of antibodies (HIV, virus which causes AIDS)
4. An AIDS diagnosis and/or an AIDS-related condition

Information Requested *(check those to be released)*

☐ Doctors' notes
☐ X-ray report
☐ Lab reports
☐ Other (specify): ______
☐ History & physical
☐ Psychological/psychiatric evaluation
☐ Pathology reports
☐ Diagnostic studies
☐ Complete chart

I certify that this request has been made voluntarily. This authorization is subject to written revocation at any time, except to the extent that action has already been taken to comply with it. In any event, this authorization expires 90 days from the date of signature. I release the above named from liability and claims of any nature pertaining to the disclosure of requested information contained in my medical records.

Signature of Patient or Patient Representative ______ Date ______

Senior Care of Colorado
A medical group practice of ipc

Comprehensive Patient Questionnaire

PATIENT DEMOGRAPHIC INFORMATION *(This section refers to the PATIENT ONLY)*

First Name: ____________________ Middle: ____________________ Last: ____________________

Address: ____

____

City: ____________________ State: ____________ Zip: ____________

Home Phone: ____________________ Cell Phone: ____________________

Date of Birth: ____/____/____ SSN: ____-____-____ Sex: (*Circle One*) Male Female

Email: ____

Marital Status: (*Circle One*)

Single Married Divorced Widowed Legally Separated Unknown

Spouse Name: *(If Applicable)* ____

Race: ____________________

Primary Language: ____________________

Employment Status: (*Circle One*) Employed Self-employed Unemployed Disabled
Retired Part-time student Full-time student

Employer Name: ______________________________ Work Phone: ____________________

How did you hear about IPC/Senior Care of Colorado?: ______________________________

First Name: ________________ Middle: ____________ Last: ____________________

INSURANCE INFORMATION

Please complete thoroughly. We will need a copy of your insurance cards.

Name of Policy Holder: ______________________________

Relationship to patient? ☐ Self ☐ Husband ☐ Wife ☐ Parent ☐ Other: ____________

Name of **Primary** Insurance: ______________________________

Member ID/Policy #: ____________________ Group #: ____________________

Name of **Secondary** Insurance: ______________________________

Member ID/Policy #: ____________________ Group #: ____________________

RESPONSIBLE PARTY/GUARANTOR INFORMATION

This is the person who should receive invoices, statements and financial correspondence. ***ONLY*** *complete this section if the Responsible Party/Guarantor is* ***NOT*** *the Patient or the Policy Holder.*

☐ Self (*Skip to Emergency Contact Section*) ☐ Policy Holder (*Skip to Emergency Contact Section*)

First Name: ________________ Middle: ________________ Last: ____________________

Address: ______________________________

City: ____________________ State: ____________ Zip: ______________

Home Phone: ____________________ Mobile Phone: ____________________

Work Phone: ____________________ Pager: ____________________

EMERGENCY CONTACT INFORMATION *(This section refers to the EMERGENCY CONTACT ONLY)*

Patient's Relationship to Contact: ______________________________

Emergency contact is Guardian? ☐ Yes ☐ No

First Name: ________________ Middle: ________________ Last: ____________________

Address: ______________________________

City: ____________________ State: ____________ Zip: ______________

Home Phone: ____________________ Cell Phone: ____________________

Work Phone: ____________________ Pager: ____________________

PREFERRED PHARMACY

Pharmacy Name: ______________________________

Address: ______________________________

City: ____________________ State: ____________ Zip: ______________

Phone: ____________________ Fax: ____________________

First Name: ______________________ Middle: ______________ Last: _________________________

COMPREHENSIVE QUESTIONNAIRE

Since this is your medical history and it will be used in evaluating your health, it is extremely important that the questions be answered as accurately and completely as possible. All information provided is kept confidential.

MEDICATIONS

1. List all medicines that you use. (Prescriptions, Non-Prescriptions/Over-the-Counter, Natural Products)

Name of Current Medications Used Regularly	What Strength/Dose?	How do you use it? (How many? How many times a day?)
Example: Tylenol	500 mg	1 pill 3 times a day by mouth

2. Do you have any medication allergies/adverse reactions? ☐ Yes ☐ No
   If Yes, please specify below:

NAME OF MEDICATION	REACTION

3. Do you take a daily aspirin? ☐ Yes ☐ No

First Name: ______________________ Middle: ______________ Last: _________________________

SURGERIES

1. List Surgeries (Operations)   Use separate page, if needed.

DATE	SURGERY (OPERATIONS)

HOSPITALIZATIONS

1. List Other Hospitalizations (Last 3 years)   Use separate page, if needed.

DATE	REASON

First Name: ____________ Middle: ________ Last: ______________

IMMUNIZATIONS

A. When was your last **tetanus** shot? ___/___/___

B. When was your last **influenza** vaccination? ___/___/___

C. Do you get an **annual** influenza vaccination? ☐ Yes ☐ No

D. Have you had a **pneumonia** vaccination (Pneumovax)? ☐ Yes ___/___/___ ☐ No

E. Have you had a **shingles** vaccination (Zostavax)? ☐ Yes ___/___/___ ☐ No

F. Have you had a **tuberculosis skin test** (PPD or Tine)? ☐ Yes ☐ No

If yes, was it negative? ☐ Yes ☐ No Date of test? ___/___/___

DIAGNOSTIC STUDIES & SCREENINGS

1. Please check all of the diagnostic studies and/or screenings you have had performed and enter a four digit year.

TEST	YEAR	MONTH	COMMENTS
Please include the year and month for below:			
☐ Sigmoidoscopy or Colonoscopy			
☐ Prostate Cancer			
☐ Sonogram (AAA)			
☐ Bone Densitometry			
☐ Mammogram			
☐ Pelvic Exam/Pap Smear			

HEARING EVALUATION

Have you had a hearing evaluation? ☐ Yes ☐ No

DEPRESSION SCREENING

1) Do you have little interest or pleasure in doing things? ☐ Positive ☐ Negative

2) Are you feeling down, depressed or hopeless? ☐ Positive ☐ Negative

ADDITIONAL QUESTIONS

1) Are you a current smoker? ☐ Yes ☐ No

2) Are you a non-smoker? ☐ Yes ☐ No

3) Are you a former smoker? ☐ Yes ☐ No

4) Have you ever used illegal or illicit drugs? ☐ Yes ☐ No

5) Did you have a drink containing alcohol in the past year? ☐ Yes ☐ No

First Name: ______________________ Middle: ______________ Last: _________________________

FAMILY HISTORY

1. Age at death

Father	Mother	Brother	Sister
________	________	________	________

2. Do any members of your family have/had any of the following conditions? (Check all that apply.)

CONDITION	Father	Mother	Brother	Sister	Child
☐ Dementia or Alzheimer's disease	☐	☐	☐	☐	☐
☐ Cancer, of what?	☐	☐	☐	☐	☐
☐ Heart disease	☐	☐	☐	☐	☐
☐ Kidney disease	☐	☐	☐	☐	☐
☐ Liver disease	☐	☐	☐	☐	☐
☐ Hypertension	☐	☐	☐	☐	☐
☐ Stroke	☐	☐	☐	☐	☐
☐ Diabetes	☐	☐	☐	☐	☐
☐ Depression	☐	☐	☐	☐	☐
☐ Other: ______________	☐	☐	☐	☐	☐

3. Did anyone in your family die at a young age? (< 60) ____________________________

PLANNING FOR FUTURE HEALTH CARE

1. Do you have a medical Durable Power of Attorney?

   ☐ Yes (If yes, please bring a copy) ☐ No

2. Do you have a living will?

   ☐ Yes (If yes, please bring a copy) ☐ No

3. Would you like us to provide you with:

   ☐ 5 Wishes ☐ Colorado MOST Form

4. Are there any religious or social issues we need to be aware of in advising you about your advanced directives? (Blood transfusions/Feeding tubes)

   ☐ Yes ☐ No

   If yes, please explain: ____

   ____

   ____

   ____

   ____

First Name: ______________________ Middle: ________________ Last: ___________________________

FUNCTIONAL ABILITY

ACTIVITIES OF DAILY LIVING

1. We want to know if you need help with any of the following tasks and who helps you.

Task	Don't need help	Need Help
Feeding yourself		
Getting from bed to chair		
Getting to the toilet		
Getting dressed		
Bathing		
Using the telephone		
Taking your medicines		
Preparing meals		
Managing money		
- Financial affairs		
- Checkbook		
Doing laundry		
Doing house work		
Shopping for groceries		
Driving		
Doing "handyman" work		
Climbing a flight of stairs		
Getting to places beyond walking distance		