MCPN
METRO COMMUNITY PROVIDER NETWORK
Your neighborhood health home

Patient ID Number_____

ADMISSION FORM

A. PATIENT INFORMATION:

First Name & Middle Initial:_____ Last Name:_____

Home Address:_____ Apartment Number:_____

City:_____ State:_____ Zip:_____ Phone:_____ Home Cell

Second Phone:_____ Work Cell

Email Address:_____

Birth Date:_____

Gender Preference: ☐ Male ☐ Female ☐ Transgender Male from Female

SSN:_____

☐ Transgender Female from Male ☐ Gender Queer ☐ Other

Sexual orientation (check all that apply):

☐ Straight or Heterosexual
☐ Something Else/ Other
☐ Questioning/ Unknown
☐ Lesbian, Gay or Homosexual
☐ Bisexual
☐ Choose not to disclose

Preferred Gender Pronoun:

☐ He/Him
☐ She/Her
☐ Something Else_____

Employment Status: Retired Unemployed Employed Full Time Employed Part Time

B. GUARANTOR INFORMATION: (if same as above, skip to C)

First Name & Middle Initial:_____ Last Name:_____

Home Address:_____ Apartment Number:_____

City:_____ State:_____ Zip:_____ Home Phone:_____

Second Phone:_____ Work Cell Email Address:_____

Birth Date:_____ SSN:_____ Gender:_____ Relationship to Patient:_____

Employment Status: Retired Unemployed Employed Full Time Employed Part Time

C. ADDITIONAL INFORMATION:

What language/s do you speak at home?_____

Veteran Status: ☐ Veteran ☐ Non Veteran

Income:_____ Per Month

Family size:_____

Is it OK to call your Home phone? Yes No
Is it OK to leave a message? Yes No
Is it OK to call your Second phone? Yes No
Is it OK to leave a message? Yes No

Your housing situation: Do you live in:

☐ Personal residence/rental ☐ Street ☐ Shelter
☐ With family/friends (Doubled Up)
☐ Vehicle/Other

D. RACE INFORMATION:

☐ Asian
☐ American Indian/Native American
☐ Alaskan Native
☐ Black/African American
☐ Native Hawaiian
☐ Pacific Islander
☐ White/Caucasian
☐ More than one race
☐ Unreported/Refused

ETHNICITY:

☐ Hispanic/Latino
☐ Not Hispanic/Latino
☐ Not Reported

E. IN CASE OF AN EMERGENCY

Please give us the name of one person we can call if we can not reach you and have important medical information we need to inform you of immediately, (i.e. test results).

Name:_____ Phone:_____

Relationship to you:_____ Does this person know you are an MCPN patient? Yes No

G. INSURANCE PAYMENT AUTHORIZATION & RELEASE

I hereby authorize my insurance benefits to be paid directly to the above MCPN clinic, and acknowledge that I am financially responsible for unpaid balance. I also authorize MCPN to release any information to the insurance company.

_____ _____
Patient Signature Date

_____ _____
Guarantor/Guardian Signature Date

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MCPN USE ONLY

PATIENT ID:_____

MCPN CONSENTS AND ACKNOWLEDGEMENTS

Patient's Name:_____

Social Security Number:_____Date of Birth:_____

Consent Clinical Diagnosis and Treatment :

(Initial)_____I do hereby give consent to the clinical staff of the MCPN clinics to examine, treat, and counsel me. I understand that there are certain hazards and risks connected with all forms of treatment and my consent is given with this knowledge.

Consent to Authorize the Following People to Pick Up Protected Health Information:

_____ _____

_____ _____

Acknowledgement of receipt of Notice of Privacy Practices:

(Initial)_____I acknowledge receiving and reading a complete copy of the Notice of Privacy Practices on this _____ day of _____, 20_____. I further acknowledge that, as of today's date, I have no questions regarding the Notice of Privacy Practices.

Acknowledgement of receipt of Patient Bill of Rights and Responsibilities:

(Initial)_____I have received a copy of the Patient Bill of Rights and Responsibilities and have had a chance to read it and ask questions.

Minor Acknowledgement:

(Initial)_____I am 15 years old or older, living apart from my parent(s) and manage my own money (pay my own rent and food bills) OR I am legally married.

_____ _____

Signature of Patient /Guardian Signature of Staff

_____ _____

Printed Name of Patient/Guardian Printed Name of Staff

_____ ☐ Verification of signer by valid ID

Todays Date

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ADULT HEALTH HISTORY

MR#_____(for office use only)

NAME_____ **TODAYS DATE**_____

DATE OF BIRTH_____ **GENDER:** **MALE / FEMALE**

PAST ILLNESS:

- ☐ Diabetes ☐ Stroke ☐ High Blood Pressure
- ☐ High Cholesterol ☐ Heart Disease ☐ Cancer (type) _____
- ☐ Other _____

ALLERGIES:

Please list any allergy to medicine or food	Reaction

MEDICATIONS:

Please list any medications you take, prescription and/or over the counter/herbal	How Often

SURGERY/HOSPITALIZATIONS:

Please list any surgery or hospitalizations you have had	Date

IMMUNIZATIONS:

If you have received any of the following immunizations, please indicate what year you received them.

- ☐ Pneumovax ☐ Tetanus ☐ Other_____

FAMILY HISTORY:

Please check the diseases which your parents, grandparents, brothers, sisters, aunts, and/or uncles have had.

- ☐ Diabetes ☐ Stroke ☐ Cancer (type) _____
- ☐ Asthma ☐ Heart Disease ☐ Other _____

SOCIAL/PERSONAL HISTORY: Please circle "YES" or "NO"

Do you always wear your seatbelt?	Yes	No	
Do you keep a gun in your home?	Yes	No	
Do you have smoke detectors in your home?	Yes	No	
Have you ever been physical or sexually abused?	Yes	No	If yes, when?_____

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SBIRT Form

MR#_____(for office use only)

NAME_____**TODAYS DATE**_____

DATE OF BIRTH_____

Please try to answer the following questions as honestly and openly as possible, to help us provide you with better care. Your answers will only be shared with your medical provider and the medical assistant involved in your care today. Please circle the appropriate response.

1. Have you felt down, depressed, or hopeless for more than 2 weeks in the past 3 months? **YES** **NO**
   a. Are you in treatment for depression? **YES** **NO**
      i. If yes, where do you go for treatment? _____
2. Have you EVER used ANY form of tobacco (cigarettes, cigars, chewing tobacco)?
   a. Do you currently use any form of tobacco? **YES** **NO**
      i. If yes, what type of tobacco do you use? _____
      ii. When did you start? _____
      iii. How much do you smoke/chew? _____ Per Day Per Week
   b. If you QUIT:
      i. When did you quit? _____
      ii. How long did you use tobacco? _____
      iii. How much did you smoke/chew before quitting? _____
3. Do you EVER drink alcohol? **YES** **NO**
   a. If yes, why type of alcohol do you usually drink? _____
   b. How much do you drink (type and amount)? _____ Per Day Per Week
   c. What is the MOST you have drank in one day in the past 3 months (type and amount)? _____
4. In the past 12 months, have you used drugs other than those required for medical reasons (street drugs or prescriptions)? **YES** **NO**
   a. If yes, what type of drugs have you used? _____
   b. Have you used Marijuana in the past 12 months? **YES** **NO**
      i. Do you have a Medical Marijuana card? **YES** **NO**

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Bill of Patients' Rights and Responsibilities

You have the RIGHT to...

⇒ Receive services that are necessary for your care without regard to race, color, creed, national origin, age, sex, sexual preference, marital status, number of pregnancies, type of contraceptive, disability, or political affiliation.

⇒ Be treated with courtesy, dignity, and respect.

⇒ Know the names and functions of doctors, nurse practitioners, nurses, and other people caring for you.

⇒ Be told by your caregivers what your condition and diagnosis is, what treatment they recommend, how they expect your condition to change, and what follow-up care is necessary.

⇒ Know the reason for various tests and treatments given to you and the names of the persons administering them to you.

⇒ Know the benefits, risks, and discomforts of any procedure or treatment recommended to you.

⇒ Refuse treatment and to be informed of the medical or other possible outcomes of your refusal.

⇒ Be given an estimate of the charges for any medical procedures that you might undergo during your treatment. Patients are cautioned that actual charges might differ from those estimated due to any changes in diagnosis, unanticipated complications, changes in insurance information, etc.

⇒ Know how to get after-hours, weekend, and emergency care.

⇒ A full explanation of all papers that MCPN staff ask you to sign.

⇒ Receive information necessary to give informed consent prior to the start of any procedure and/or treatment, except for emergency situations.

⇒ Refuse to sign a consent form until you understand it.

⇒ Cross out any part of the consent form that you do not want applied to your care.

⇒ Change your mind before undergoing a procedure for which you have given your consent.

⇒ Refuse to participate in research projects.

⇒ Have access to your MCPN medical records (this ***does not*** include records MCPN has received from other providers, i.e. referrals, old records).

⇒ Expect that records related to your care remain confidential. *Note: Information in these records can be released only under the following circumstances:
- You authorize the release.
- There is immediate danger.
- A duly authorized court order is issued.

⇒ Arrange to meet with another provider for a second opinion.

⇒ Arrange to change providers, clinics, or hospitals.

⇒ Expect that staff will respect your personal privacy to the fullest extent allowed by the care you need. You may also request a chaperone for any exam.

⇒ Upon request examine and receive explanation of your bill.

⇒ Express spiritual and cultural beliefs that do not harm others or interfere with their care.

⇒ Give us ideas about how to improve our services.

⇒ Be informed of the clinic's complaint and formal grievance procedure.

⇒ File a complaint or formal grievance and have it acknowledged and resolved in a timely and orderly fashion.

⇒ Know the facility's rules and regulations that apply to you conduct as a patient.

⇒ Participate in decisions involving your health care

⇒ Information regarding advance directives.

⇒ Choose participation in a medical home

Responsibilities

⇒ Treat others with courtesy, dignity, and respect.

⇒ Identify MCPN as your primary medical home.

⇒ Consider the rights of other patients and staff and to help control noise.

⇒ Keep your appointments and be on time (note: if you cancel or change your appointment, we request 24-hour notice).

⇒ Give, upon request, necessary records for registration, billing, ability to pay, and authority to consent.

⇒ Give truthful and complete information about your present symptoms, past illnesses, other times you have sought medical care or been hospitalized, medicine you are taking, and other questions about your health.

⇒ Take part and participate in all goal setting for your healthcare and follow through with treatment/ care plans and referral processes..

⇒ Accept the results if you refuse treatment or do not follow the caregiver's instructions.

⇒ Ask questions if you do not understand papers you are asked to sign or information given to you.

⇒ Tell your caregiver when you are not pleased with your care.

⇒ Inform Medical care team of any and all decisions regarding end of life care (existing living will, medical power of attorney, or other advance directives that may impact your healthcare.)

⇒ Keep your personal belongings in a safe place.

⇒ Bring insurance or Medicaid card to each clinic visit

⇒ Assure that your bill is paid.

⇒ Pay your co-pay or self-pay fees at the time of check-in for each visit.

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note: lack of regard for any of the following responsibilities can result in dismissal from the MCPN practice. Do not...

⇒ Miss more than three appointments (this applies to financial screening appointments as well as medical appointments).

⇒ Commit physical violence on the premises of MCPN.

⇒ Threaten or verbally attack other patients or staff.

⇒ Commit illegal activities on the MCPN premises.

⇒ Commit racial or ethnic intimidation on the MCPN premises.

⇒ Destroy MCPN or patient property.

⇒ Use obscenities on the MCPN premises.

I have received a copy of the Patient Bill of Rights and Responsibilities and have had a chance to read it and ask questions.

_____

Patient Signature

_____

Date

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: This Notice of Privacy Practices is effective on January 1, 2015.

I. Understanding Your Health Information

Each time you visit our community health center, we create a record of your visit. This record usually contains your name and other information that may identify you: your symptoms, examination and test results, diagnoses, treatment, plan for future health care, and financial information. This record is sometimes referred to as your "health record." This record allows us to provide you with quality health care, to obtain payment for the services we provide to you, and to enable us to meet our legal obligations in operating this community health center. We are required by law to maintain the privacy of your health information, to provide you with notice of our legal duties and privacy practices with respect to your health information, and to notify you following a breach of your unsecured protected health information. We will not use or give to others your health information without your written permission, except as stated in this Notice.

II. Organized Health Care Arrangement ("OHCA")

Metro Community Provider Network, Inc. ("MCPN"), Jefferson Center for Mental Health (" JCMH"), Aurora Comprehensive Community Mental Health Center, Inc. d/b/a Aurora Community Mental Health Center ("AUMHC"), Arapahoe Mental Health Center, Inc. d/b/a Arapahoe/Douglas Mental Health Network ("ADMHN"), and Arapahoe House, Inc. ("Arapahoe House") have agreed to form and to enter into an organized health care arrangement (the "Integrated Care OHCA"). Members of the Integrated Care OHCA may share your health information with other members of the Integrated Care OHCA for the purposes of treatment, payment, and health care operations in order to better address your health care needs.

III. How We Will Use and Give Out Your Health Information

a. Treatment, Payment, and Health Care Operations

We use and share your health information, without your consent, for treatment, payment, and health care operation purposes:

- Treatment. We use and share your health information to provide you with health care and related services. For example, we may share your health information with other doctors, nurses, or hospital staff who help provide care for you.

- Payment. We use and share your health information to get paid for the services we provide you. For example, we may send a bill to your health insurance plan, Medicaid, or you.

- Health Care Operations. We may use and share your health information to review our performance and to make sure you receive quality health care. For example, we may use and share your health information to evaluate the performance of our staff who care for you.

b. Organized Health Care Arrangement

The Integrated Care OHCA members have agreed to either participate (1) as a clinically integrated care setting where patients may receive health care services from more than one provider; or (2) in a joint arrangement and to conduct at least one of the following joint activities: (a) utilization review, in which the Integrated Care OHCA members review the other members' health care decisions (or have a third party do so); (b) quality assessment and improvement activities, in which treatment provided by the Integrated Care OHCA members is assessed by other Integrated Care OHCA members (or a third party on its behalf); or (c) payment activities, if the financial risk for delivering health care is shared, in part or in whole, by participating Integrated Care OHCA members and if PHI created or received by a covered entity is reviewed by other OHCA members or by a third party on their behalf for the purpose of administering the sharing of financial risk.

c. Other Uses and Disclosures Allowed or Required by Law

We may use or share your health information, without your consent, for the following purposes under limited circumstances:

- Notify and Communicate with Family. We may use or share your information to people who are involved in, or help pay for your care, such as your family, your close personal friends, or any other person chosen by you, to notify them of your location, general health, and to assist you in your health care (such as to pick-up medicine or to help with follow-up care).

- Public Health and Safety. We may share your health information with public health authorities in certain situations. The following are some examples of how we may share your health information for public health and safety purposes: to prevent disease; to help with product recalls; to report adverse reactions to medications; to report suspected abuse, neglect, or injuries related to or suspected to be related to domestic violence, which may include sexual assault; or to prevent or reduce any serious threat to the health or safety to you or others, which may include if you are gravely disabled.

- Research. We may use or share your health information for research studies.

- Required by Law. We will share your health information with government agencies, as required by state or federal laws. For example, we will share your health information with government agencies that oversee our community health center for licensing or certification purposes.

- Organ and Tissue Donation Requests. We may share your health information with organ donor agencies.

- Coroners and Funeral Directors. We may share your health information with a coroner, medical examiner, or funeral director to help them carry out their duties.

- Workers' Compensation. We may share your health information as necessary to comply with workers' compensation laws.

- Specialized Government Functions. We may share your health information for military or national security purposes, or to correctional institutions or law enforcement officers that have you in their lawful custody.

- Law Enforcement. We may share your health information with law enforcement in order to: identify or locate a suspect, fugitive, or missing person; or assist with other law enforcement purposes.

- Judicial and Administrative Proceedings. We may share your health information when ordered to do so by a court or judge.

- Marketing. We may share your health information to contact you about new treatments or medicine that may help you, so long as we do not receive any payment for these communications.

- Proof of Immunization. We will share proof of immunization to a school that requests it before admitting a student if you have agreed to the disclosure on your behalf or on behalf of your dependent.

- Health Information Exchange: We may share your health information with other organizations through a Health Information Exchange (HIE) network. These other organizations may include hospitals, laboratories, health care providers, public health departments, health plans, and other participants. HIE participants are required to meet rules that protect the privacy and security of your health and personal information. If you wish to opt-out of any HIE, you must submit an "Opt-Out" form to MCPN. You can obtain an Opt-Out form by asking for this form at the front desk at any of our MCPN clinic locations. If you have previously opted-out elsewhere and would like to opt back in, you can obtain an "Opt-In" form at the front desk at any of our MCPN clinic locations. You may obtain information regarding the HIE at the front desk at any of our MCPN clinic locations.

d. Other Uses and Disclosures Requiring Your Written Permission

Except as stated within this Notice, we will not use or share your health information without getting your written authorization on an Authorization form. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

IV. Your Rights Regarding Your Health Information

- Right to Request Restrictions. You have the right to request that we restrict how we use or share your health information when carrying out certain activities. We are not required to agree to your request. However, we must grant your request to not share information with your health plan for a health care service or item if you paid in full out-of pocket for that service or item, unless a law requires us to share that information.

- Right to Receive Confidential Communications. You have the right to request that we contact you in a specific way or that we send our correspondence to a specific location. For example, you may ask that we contact you via a particular email account or that we send mail to your work address. We will comply with all reasonable requests.

- Right to Inspect and Copy. You have the right to request a copy of your health record and a right to receive an electronic copy of your health record if it exists in electronic format. Only in a few very select circumstances may we deny you access to your health record. If we do deny you access to your health record, then you have the right to have our denial reviewed by a licensed healthcare professional. We may charge a reasonable, cost-based fee.

- Right to Request a Change. You have the right to ask us to correct information in your health record that you think is incorrect or incomplete. We may refuse to change your record, but we will explain the reason for our refusal.

- Right to Receive an Accounting. You have the right to ask for a list (accounting) of the times that we have shared your health information. We will not include disclosures related to treatment, payment, or healthcare operations, or certain other disclosures.

- Right to Copy of Notice of Privacy Practices. You have the right to get a paper copy of this Notice of Privacy Practices at any time, even if you agreed to receive the Notice of Privacy Practices electronically.

- Breach Notification. If a breach of your secured protected health information occurs, we will notify you as required by law.

V. Changes to this Notice

We may change our Notice of Privacy Practices at any time in the future. Until such changes are made, we will comply with the terms of the Notice of Privacy Practices currently in effect. We will notify you of any changes to our Notice of Privacy Practices by posting the changed Notice of Privacy Practices at our community health center and on our web site.

VI. Concerns and Complaints

If you have any questions or want to talk about any of the information in this Notice of Privacy Practices, please contact our Privacy Officer listed below. If you believe your privacy rights have been violated, you may file a written complaint with our community health center or with the Secretary of the Department of Health and Human Services (HHS). You will not be penalized in any way for filing a complaint.

To file a complaint with our community health center, contact our Privacy Officer:

Cyndy Story
303-761-1977

To file a complaint with the Secretary of HHS, submit your complaint to:

Office for Civil Rights
U.S. Department of Health and Human Services
999 18th Street, Suite 417
Denver, CO 80202
(800) 368-1019