Please fax completed form to 303-647-3647

10900 W 44th Ave, Suite 200
Wheat Ridge, CO 80033
Phone (303) 993-1330
Fax (303) 647-3647

New Patient Information

Name of Community: _____
Patient Name: _____
Street Address: _____ APT/ROOM#: _____
City, State, Zip: _____
Phone: _____ Fax: _____

Gender Identity: ☐Female ☐Male ☐Transgender Female ☐Transgender Male ☐Non Binary ☐Un-Specified

Are you Hispanic/Latin/a/o/x? ☐Yes ☐No ☐Decline to Provide

Race(s) check all that apply: ☐American Indian/Alaskan Native ☐Asian ☐Black, African American
☐Native Hawaiian/Pacific Islander ☐Other ☐White ☐Decline to Provide

Preferred Language: ☐English ☐Spanish ☐German ☐Russian ☐Chinese ☐Other ☐Decline to Specify

If patient is a new move in, please include move in date: _____
☐Independent Living ☐Assisted Living ☐Memory Care ☐Home

Additional Services:
Home Health: _____ Hospice: _____

INSURANCE INFORMATION:
Medicare ID#: _____ SS #: _____
Primary Insurance: _____ Policy #: _____
Secondary Insurance: _____ Policy #: _____

Medications: _____
_____
Allergies: _____
Pharmacy Address: _____ **Pharmacy Phone**: _____

Social History (Please check all that apply):
Diet ☐Regular ☐Diabetic ☐Low Salt ☐Gluten Free ☐Vegan ☐Other: _____
Support at Home: ☐Wheelchair ☐Walker ☐Cane ☐Eye Glasses ☐Hearing Aid ☐Oxygen

Billable party (if other than patient):
Name: _____ Phone: _____
Street Address: _____
City, State, Zip: _____
Relationship to Patient: _____POA YES/NO
Primary Contact (if different than patient):
Name: _____ Phone: _____
Relationship to Patient: _____POA YES/NO

Please attach **2** signature pages signed by patient or POA

Bloom Healthcare – New Patient Authorization Form

10900 W 44th Ave, Suite 200
Wheat Ridge, CO 80033
Phone (303) 993-1330 • Fax (303) 647-3647

I hereby authorize the following provider to disclose my heath record.

Name of Facility Releasing Information: _____

Purpose of disclosure: TREATMENT

Please FAX requested information to (303) 647-3647 or mail to the above address.

Information to be used/disclosed:

- Progress notes
- Consultations
- Most recent history and physical
- Immunization Record
- Laboratory reports
- Radiology/Imaging reports
- Radiology films
- Entire medical record

Date Range of Information Disclosed (for office use):

Start Date: _____

End Date: _____

By signing this authorization, I agree to the following:

• I understand that authorizing the use and disclosure of this health information is voluntary and that I can refuse to sign this authorization. I do not need to sign this form in order to receive treatment.
• I understand that I may inspect a copy of the information to be used or disclosed.
• I understand that I can revoke this authorization at any time by contacting my provider, but any revocation will not apply to the extent that my provider has acted in reliance of this authorization.

In addition, my signature and date below authorizes/acknowledges authorization to bill, including each of the following:
• Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s) on my behalf.
• Release of my medical information to my insurance providers and their agents.
• Bloom Healthcare and/or any of their corporate affiliates to obtain medical or other information necessary in order to process claim(s), including determining eligibility and seeking reimbursement for medical supplies and/or medication(s) provided.

Signature: _____

Patient's name: _____ Date of birth: _____

If not signed by patient, list personal representative's authority to act for the patient: _____

Consent Agreement
for Provision of Chronic Care Management

By signing this Agreement, you consent to Bloom Healthcare (referred to as "Provider"), providing chronic care management services (referred to as "CCM Services") to you as more fully described below.

CCM Services are available to you because you have been diagnosed with two (2) or more chronic conditions which are expected to last at least twelve (12) months and which place you at significant risk of further decline.

CCM Services include 24-hours-a-day, 7-days-a-week access to a health care provider in Provider's practice to address acute chronic care needs; systematic assessment of your health care needs; processes to assure that you timely receive preventative care services; medication reviews and oversight; a plan of care covering your health issues; and management of care transitions among health care providers and settings. The Provider will discuss with you the specific services that will be available to you and how to access those services.

Provider's Obligations When providing CCM Services, the Provider must:

- Explain to you (and your caregiver, if applicable), and offer to you, all the CCM Services that are applicable to your conditions.
- Provide to you written or electronic copy of your care plan upon request.
- If you revoke this Agreement, provide you with a written confirmation of the revocation, stating the effective date of the revocation.

Beneficiary Acknowledgment and Authorization By signing this Agreement, you agree to the following:

- You consent to the Provider providing CCM Services to you.
- You authorize electronic communication of your medical information with other treating providers as part of coordination of your care.
- You acknowledge that only one practitioner can furnish CCM Services to you during a calendar month.
- You understand that cost-sharing will apply to CCM Services, so you may be billed for a portion of CCM Services even though CCM Services will not involve a face-to-face meeting with the Provider.

Beneficiary Rights You have the following rights with respect to CCM Services:

- The Provider will provide you with a written or electronic copy of your care plan.
- You have the right to stop CCM Services at any time by revoking this Agreement effective at the end of the then-current month. You may revoke this agreement verbally (by calling 303.993.1330) or in writing (to 10900 W 44 th Ave, Suite 200, Wheat Ridge, CO 80033). Upon receipt of your revocation, the Provider will give you written confirmation (including the effective date) of revocation.

Signature: _____ Date of Birth: _____

Patient's name (please print clearly): _____

If not signed by patient, list personal
representative's authority to act for the patient: _____

I have read and understand the Medicare benefits as outlined above and even though this is a Medicare covered benefit I choose NOT to receive this additional Medicare benefit. _____