Please fax completed form to 303-647-3647

12600 W Colfax Ave, Suite B-200
Lakewood, CO 80215
Phone (303) 993-1330 Fax (303) 647-3647

New Patient Information

Name of Community: ____
Patient Name ______________________________________ Date of Birth:_____________
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

12600 W Colfax Ave, Suite B-200
Lakewood, CO 80215
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 opt out of disclosing my health information. I do not need to authorize disclosure of health information in order to receive treatment.

Initial here to OPT OUT of disclosing health information ______

• I understand that my records may be obtained through the use of CORHIO, and that I can opt out at any time by contacting the practice.

• 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: ____

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NO, DO NOT ENROLL ME, as I refuse this Medicare covered benefit. I have read and understand the above and do NOT want these additional clinical services. _______