Health Center at AURARIA

Plaza Building, Suite 150 • Campus Box 20
P.O. Box 173362 • Denver, CO 80217-3362
Phone 303-615-9999 • **Fax** 303-556-3881 • **Web** healthcenter1.com

Patient Information

1. GENERAL INFORMATION

Social Security Number

Legal Name (First name, middle initial and last name)

Preferred Name

Preferred Pronouns (Optional)

Sex at Birth

☐ MALE ☐ FEMALE ☐ INTERSEX

Gender Identity (please check box below)

☐ MALE ☐ TRANSGENDER MALE / FEMALE-TO-MALE ☐ GENDERQUEER *(NEITHER EXCLUSIVELY MALE OR FEMALE)*

☐ FEMALE ☐ TRANSGENDER FEMALE / MALE-TO-FEMALE

Sexual Orientation (Please check box below)

☐ STRAIGHT ☐ GAY ☐ LESBIAN ☐ BISEXUAL ☐ OTHER ☐ UNKNOWN ☐ DECLINED

Date of Birth

MONTH DAY YEAR

Marital Status (Please check box below)

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ LEGALLY SEPARATED

Racial Group (please check box below)

☐ AFRICAN AMERICAN / BLACK ☐ ALASKAN NATIVE ☐ ASIAN ☐ CAUCASIAN / WHITE ☐ HISPANIC / LATINO

☐ MULTI-RACIAL ☐ NATIVE AMERICAN ☐ PACIFIC ISLANDER ☐ OTHER

Current Number of Credit Hours (If applicable)

Current Address (Number, street & apt or suite number)

City, State and ZIP Code

Personal Email Address

Home Phone

Cell Phone (For calling and texting)

Preferred Contact Number

☐ CELL ☐ HOME

School Status (Please check box below)

☐ STUDENT ☐ FACULTY ☐ STAFF

School Affiliation (Please check box below)

☐ AHEC ☐ CCD ☐ CU DENVER

☐ MSU DENVER ☐ CAMPUS GUEST

Student/Staff/Faculty ID#

Internal Use Only _____

2. EMERGENCY CONTACT INFORMATION

Emergency Contact Name	Phone Number	Relationship to You

If you are under 18, you must inform the front desk. Parent/guardian information required.

3. HEALTH INSURANCE INFORMATION

CATEGORY 1: I am currently enrolled and participate in Medicaid or Medicare (Please check boxes below)

Medicaid	Medicare
☐ YES ☐ NO	☐ YES ☐ NO

CATEGORY 2: I participate in one of the University Sponsored Student Health Insurance Plans (Please check boxes below)

MSU Denver Student Health Insurance	CU Denver International	CU Denver Domestic U.S. Plan
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

CATEGORY 3: I am insured with outside health insurance (Please provide details below)

Insurance Company Name		
Insurance ID Number	**Group Number**	
Name of Primary Insured / Subscriber	**Date of Birth** MONTH DAY YEAR	**Relationship to Patient**

CATEGORY 4: I do not have any health insurance

☐ I DO NOT HAVE HEALTH INSURANCE AND WILL PAY DIRECTLY FOR ANY SERVICES PROVIDED.

I, a patient of the Health Center at Auraria, do hereby voluntarily consent to medical and/or behavioral health care, encompassing diagnostic procedures and medical treatment by the Health Center staff. I am aware that the practice of medicine/surgery is not an exact science. I acknowledge that no guarantee or assurance has been made to me concerning the results of my treatment. I also understand that per state guidelines my medical records may be destroyed 7 years from my last date of service.

Authorization to release medical information: I authorize the release of medical information to my insurance company, for charges submitted to them for services billable by the Health Center, in order to process or pay my medical claims. I understand that University of Colorado Hospital, the contracting physician agency for medical services at the Health Center, will be provided with patient information. For detailed information on the release of protected health information, refer to the current Notice of Privacy Practices for the Health Center.

Internal confidentiality of medical records: Routine processing of patients requires Health Center staff to access patient records, which include general medical, psychiatric and/or specialist physician notes. All medical records are kept confidential and all Health Center personnel must sign a "confidentiality agreement" as a condition of their employment. Inter-agency consultation may occur with the applicable campus Counseling Center(s) and/or CARE Teams to coordinate care when appropriate.

Authorization to pay benefits to the Health Center at Auraria: Patients using their health insurance for charges incurred do hereby assign payment directly to the Health Center at Auraria for billable charges, not to exceed contracted rate for each charge. Ancillary services received at the Health Center, such as lab testing or X-rays, may result in additional charges billed by a third-party. In addition, I understand that I will be responsible for payment to the Health Center at Auraria for any charges not covered by my medical insurance benefits and for any associated denials, co-payments, deductibles or co-insurance.

Payment Policies: Patients that are unable to use health insurance for payment are expected to pay at the time of service, unless prior arrangements have been made. A $20.00 charge will be assessed for all returned checks, disputed credit card charges and returned medications. If you have a scheduled appointment (for any service) and fail to notify us of any change (rescheduling) or cancellation 24 hours in advance, you can be assessed a fee due to our inability to utilize the time slot for other patients in need of our services. A service fee will be added on balances that are 60 days overdue and assessed every semester thereafter. Balance limits cannot exceed $400 with minimum monthly payments of no less than $25.

I understand and agree to the policies/terms outlined in this document and my signature signifies my agreement. I further understand and agree that my signature will remain valid for as long as (and whenever) I am a patient at the Health Center at Auraria. It is my responsibility to inform the Health Center of any changes to my personal information. If changes do occur (other than a name change), and my file is updated per information I provide, my original signature and agreement will remain in force and valid.

By signing below I acknowledge that I have provided accurate information and agree to the terms above.

Patient Signature	Date MONTH DAY YEAR

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Notice of Privacy Practices

THE HEALTH CENTER IS NOW REQUIRED BY FEDERAL LAW TO PROVIDE YOU A COPY OF OUR NOTICE OF PRIVACY PRACTICES. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW CAREFULLY AND SIGN/DATE ON THE REVERSE SIDE.
Effective 08/01/14

The Department of Health and Human Services and the Health Center at Auraria are committed to protecting your medical information. The Health Center at Auraria is required by law to maintain the privacy of your medical information by the terms of the most current notice of privacy practices, and to provide you with notice of its legal duties and privacy practices with respect to your health information. The Health Center at Auraria reserves the right to change the terms of this notice of privacy and to make any new notice provisions effective for all protected health information (known as "PHI"). The Health Center at Auraria will inform patients of changes to this notice by requesting that all patients read and sign a new and updated notice of privacy each time a change in content occurs. Health services provided are consistent with current professional knowledge.

I. Confidentiality Practices And Uses

The Health Center at Auraria, may access, use or share medical information:

1. **Treatment.** During the course of your care, protected health information (known as "PHI"), may be disclosed to medical/mental health providers as appropriate/necessary to ensure the quality and continuity of your care. For example, if another provider is treating you, we may discuss your case in order to coordinate care. In this instance, the kind of health care information we may disclose about you may include your diagnosis, x-ray reports, lab results, etc.
2. **Payment.** We may use and give your medical information to others to bill and collect payment for the treatment and services provided to you. For example, if you are seen at the Health Center for a sore throat, any associated charges and medical information necessary to process your claim may be provided.
3. **Regular Health Care Operations.** To maintain efficient, quality and cost effective medical care PHI is routinely reviewed by authorized personnel to ensure that the highest quality standards of patient care are consistently being practiced. For example, PHI may be seen by regulatory agencies that oversee clinical laboratories and during routine quality assurance procedures.
4. **Information provided directly to you or mailed to you.** For example, your medical provider may give you a copy of your lab results or you may receive a bill sent to your address on file for any outstanding balances.

II. Disclosures Not Requiring Your Permission

1. **Notification and Communication with Family.** We may disclose your health information to notify or assist in notifying a family member, your emergency contact or another person responsible for your care about your location, general condition or in the event of your death. However, if you are able and available to agree or object, we will give you the opportunity to do so prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgement in communication with your family and others.
2. **Required by Law.** As required by law, we may use and disclose your health information.
3. **Public Health.** As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the FDA problems with products and reactions to medications; and reporting disease or infection exposure.
4. **Health Oversight Activities.** We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings.
5. **Judicial and Administrative Proceedings.** We may disclose your health information in the course of any administrative or judicial proceeding.
6. **Law Enforcement.** We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.
7. **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official.

8. **Deceased Person Information.** We may disclose your health information to coroners, medical examiners and funeral directors.
9. **Organ Donation.** We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
10. **Research.** We may disclose your health information to researchers conducting research that has been approved.
11. **Public Safety.** We may disclose your health information to appropriate persons in order to prevent, lessen or coordinate a response to a serious and imminent threat to the health/safety of a particular person, the campus community or the general public.
12. **Specialized Government Functions.** We may disclose your health information for military, national security, intelligence and/or protective services for the President, prisoner and government benefits required by law.
13. **Worker's Compensation.** We may disclose your health information as necessary to comply with worker's compensation laws.
14. **Marketing.** We may contact you to provide appointment reminders or to give you information about other treatments or health-related benefits and services that may be of interest to you.
15. **Fund-Raising.** We may contact you to participate in fund-raising activities associated with the Auraria Campus.

III. Your Rights to Privacy

Except as described in this Notice of Privacy Practices, the Health Center at Auraria will not use or disclose your health information without your written authorization. If you do authorize the Health Center at Auraria to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

The Health Center at Auraria has procedures to assist you with your rights to your medical information. You may ask the Health Center staff for a hard copy of this notice at any time. An electronic copy of this notice is also available on our web site at: www.healthcenter1.com

All requests of the Health Center at Auraria must be submitted in writing, including complaints. All required forms are available in our offices.

You have the right to:

1. Request restrictions on certain uses and disclosures of your health information. The Health Center at Auraria is not required to agree to the restriction that you requested.
2. Request the Health Center at Auraria contact you by mail or fax, at a specific address or phone number.
3. Inspect (w/no charge) and receive a copy of your health information. If copies are requested, you may be charged for copies and any associated postage fees. If chart summaries are requested, a fee may be assessed for this service.
4. Change or add information to your designated records. However, the Health Center at Auraria may not change the "original" documents.
5. An accounting of disclosures of your health information made by the Health Center at Auraria, except that the Health Center at Auraria does not have to account for the disclosures described in numbers 1 (treatment), 2 (payment), 3 (health care operations), 4 (information provided to you) of section I and number 11 (specialized government functions) of section II of this Notice and disclosures authorized by the patient.

IV. Complaints

V. If you need more information, have complaints or feel that your privacy rights have been violated contact: privacy officer at 303-615-9999, Health Center at Auraria, Plaza 150, Campus Box 20, P.O. Box 173362, Denver, CO 80217-3362.

VI. If you are not satisfied how the Health Center at Auraria handles your concern, you may submit a formal complaint to: DHHS-Office of Civil Rights, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, DC 20201

If you file a complaint, we will not take any action against you or change our treatment of you in any way.

Please sign and date indicating receipt of this notice. Then return notice to front desk. You may request a copy of this notice at any time. This notice is available in several other languages and in larger print.

Print Name	**Date of Birth** / / MONTH DAY YEAR
Patient Signature	**Today's Date** / / MONTH DAY YEAR

Metropolitan State University of Denver ~ Department of Athletics
PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

Name of Patient: _____ Date of Birth: _____

Medicines & Allergies: Please list all of the prescription and over-the-counter & supplements (herbal & nutritional) that you are currently taking:

_____

_____

Do you currently or have you previously used: ☐ Tobacco ☐ Alcohol ☐ Marijuana ☐ Illegal drugs: _____

Do you have any allergies? ☐ Yes ☐ No If yes, write specific allergy & reaction: _____

_____

Mark an "X" in the appropriate box below.

Explain "Yes" answers below. If more space is needed, please use the back of this page.

GENERAL QUESTIONS	YES	NO
1. Has a doctor ever denied or restricted your participation in sports for any reasons?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ (Pre)Diabetes ☐ Infections ☐ Other: _____		
3. Have you ever been hospitalized? If so, explain: _____ _____		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**YES**	**NO**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki Disease ☐ Other:_____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**YES**	**NO**
13. Has a family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexpected car accident, or SIDS)?		
14. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
15. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**YES**	**NO**
16. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
17. Have you ever had any broken or fractured bones or dislocated joints?		
18. Do you have any incompletely healed injuries?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy , a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down Syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone or muscle or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	YES	NO
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you ever had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you ever had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with the doctor?		
52. Do you feel that there is any reason that you should not be able to compete?		
FEMALES ONLY	**YES**	**NO**
53. Have you ever had a menstrual period?		
54. How old were you when you had your first menstrual period?		
55. How many periods have you had in the last 12 months?		
56. Do you have painful or heavy menstrual periods?		
57. Do you take medication during your menstrual periods?		
58. Do you take birth control pills? If yes, which? _____		
59. Have you had a pelvic exam within the last year?		
MENTAL HEALTH QUESTIONS		
60. Have you ever been diagnosed with mental health issues including depression, anxiety, or bipolar?		
61. Have you ever been diagnosed with ADD or ADHD?		

Explain "Yes" answers here: _____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Patient signature: _____ Date: _____

Health Center at AURARIA

Student Athlete Acknowledgement of Collaborative Interdepartmental Sports Medicine Partnership and Authorization for Release of Information

The Health Center at Auraria provides Sports Medicine medical coverage for the MSU Denver Athletic Department and the athletes associated with this department. This collaborative partnership requires that Health Center at Auraria medical personnel communicate to MSU Denver Athletic Department personnel (i.e., sports medicine staff, including all associated physicians/medical personnel, coaching staff and Athletic Department administrators) regarding the health status and medical conditions identified during medical examinations involving University athletes who participate in officially sanctioned MSU Denver athletic programs.

As part of this collaborative partnership each athlete seeking medical care at the Health Center at Auraria must be made aware of this interdepartmental relationship and have a signed authorization for the release of medical information on file at the Health Center at Auraria.

I, _____, understand the above described interdepartmental Sports Medicine partnership between the Health Center at Auraria and the MSU Denver Athletic Department. My signature below authorizes personnel at the Health Center at Auraria to directly communicate to the MSU Denver Athletic Department, as outlined above, regarding my health status and medical conditions. I also authorize Athletic Department personnel to directly communicate information regarding my medical conditions to personnel at the Health Center at Auraria. I understand that this authorization will remain in force as long as I am a student athlete at MSU Denver.

_____ _____

Printed Name of Student Athlete Associated Sport

_____ _____

Student ID Number Date of Birth

_____ _____

Signature of Student Athlete Today's Date

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Patient Rights & Responsibilities

1. PATIENT RIGHTS

Each patient treated at the Health Center of Auraria has the right to:

1. Be treated with respect, consideration, and dignity.
2. Voice grievances and complaints regarding treatment or care that is (or fails to be) furnished.
3. Be fully informed about a treatment or procedure and the expected outcome before it is performed.
4. Receive care in a safe setting by competent and appropriately qualified personnel.
5. Be free from all forms of abuse or harassment.
6. Be given the name of their provider, the names of all other providers directly assisting in their care, and the names and functions of other health care persons having direct contact with the patient.
7. Have records pertaining to their medical care treated as confidential.
8. Know what Health Center rules and regulations apply to their conduct as a patient.
9. Expect emergency procedures to be implemented without necessary delay.
10. Expect the absence of clinically unnecessary diagnostic or therapeutic procedures.
11. The expedient and professional transfer to another facility when medically necessary and to have the responsible person and the facility that the patient is transferred to notified prior to transfer.
12. Treatment that is consistent with clinical impression or working diagnosis.
13. Good quality care and high professional standards that are continually maintained and reviewed.
14. An increased likelihood of desired health outcomes.
15. Full information in layman's terms concerning appropriate and timely diagnosis, treatment, and preventive measures; if it is not medically advisable to provide this information to the patient, the information shall be given to the responsible person on his/her behalf.
16. Accessible and available health services; information on after-hour and emergency care.
17. Receive an informed consent document at the start of a procedure.
18. Be advised of participation in a medical care research program or donor program.
19. Receive appropriate and timely follow-up information of abnormal findings and tests.
20. Receive appropriate and timely referrals and consultation.
21. Receive information regarding "continuity of care".
22. An informed refusal of medical treatment or care.
23. Medical and nursing services without discrimination based upon age, race, color, religion, sex, sexual orientation, national origin, handicap, disability, or source of payment.
24. Have access to interpretive services as required.
25. Be provided with, upon written request, access to all information contained in their medical record with limited exceptions.
26. Accurate information regarding the competence and capabilities of the organization.
27. Change primary or specialty physicians if other qualified physicians are available and when warranted.
28. Health services provided are consistent with current professional knowledge.

2. PATIENT RESPONSIBILITIES

Each patient treated at the Health Center of Auraria has the responsibility to:

1. Show up on time for your appointment or notify the staff within 24 hours of appointment to avoid associated fees.
2. Read and understand all consents you sign. Please ask questions for clarification before signing consents.
3. Be honest, accurate and complete in giving your medical history.
4. Carry identification with you, i.e. Auraria Campus ID.
5. Let us know if you don't understand any part of your treatment. Ask questions and take part in your healthcare decisions.
6. Following the treatment plan established by the provider, including instructions of health care professionals as they carry out the provider's orders.
7. Pay your financial obligations promptly; if there is a hardship, let us know as soon as possible so we may help.
8. Treat staff and others with respect. Regard other patients' medical information as confidential.
9. Let us know when you are having pain or when your pain is not being managed.
10. Respect the Center's property and equipment.
11. Inform staff about any advance directive that you have in place.
12. Provide the Health Center staff with all medical information that may have a direct effect on the care provided.
13. Provide the Health Center with all information regarding third-party insurance coverage.
14. Fulfill financial responsibility, for all services received, as determined by the patient's insurance carrier and/or Health Center policy.
15. Comply with requests regarding public health and/or safety.

3. GRIEVANCE & COMPLAINTS

1. All complaints must be immediately reported to Health Center staff.
2. Any complaint received from a patient will be routed to the office manager. The office manager will channel the complaint to the appropriate department if necessary.
3. All alleged violations/grievances relating, but not limited to, mistreatment, neglect, verbal, mental, sexual, or physical abuse, must be fully documented in writing.
4. The Health Center will respond to a grievance made by a patient or the patient's representative, regarding treatment or care that is (or fails to be) furnished.
5. Patient complaints will be addressed as soon as possible and every effort will be made to resolve the patient's problem.
6. If the patient is not satisfied with the resolution of the problem, the issue is then escalated to next level of management at patient's request.
7. Patient may contact the Health Center at Auraria by the following means:

   Mailing Address: Campus Box 20, PO Box 173362, Denver, CO 80217-3362

   Telephone: 303.615.9999

   Website: www.healthcenter1.com