Aspire Wellness, LLC
7000 East Belleview Avenue Suite 350 Greenwood Village, CO 80111
303-872-7344

Patient Information

Date: _____

Name: _____
(Last) (First) (Middle)

Home Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip Code: _____

Home: (_____) _____-_____ Cell: (_____) _____-_____ Work: (_____) _____-_____

Best # to leave a confidential voicemail: Home _____ Work _____ Cell_____

Date of Birth: _____/_____/_____ Age: _____ Gender: _____

Marital Status: _____ Education Level: _____

Email Address: _____

Occupation: _____ Race: _____ Religion: _____

EMERGENCY CONTACT

Name: _____
(Last) (First) (Middle)

Home Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip Code: _____

Home: (_____) _____-_____ Cell: (_____) _____-_____ Work: (_____) _____-_____

Relationship: _____

PARENT/GUARDIAN (IF DIFFERENT FROM ABOVE)

Name: _____
(Last) (First) (Middle)

Home Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip Code: _____

Home: (_____) _____-_____ Cell: (_____) _____-_____ Work: (_____) _____-_____

Relationship: _____

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Current Medical Providers and Pharmacy Information

PHARMACY: _____

Address: _____

City, State, Zip: _____

Phone #: _____

Fax: _____

PCP: _____

Address: _____

City, State, Zip: _____

Phone #: _____

Fax: _____

THERAPIST: _____

Address: _____

City, State, Zip: _____

Phone #: _____

Fax: _____

OTHER (Psychiatrist, Nutritionist, other Specialist, etc):

Name and Provider Type: _____

Address: _____

City, State, Zip: _____

Phone #: _____

Fax: _____

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Informed Consent for Assessment and Treatment

Name: _____ Date of Birth: _____/_____/_____

I understand that as a patient of Aspire Wellness, LLC I may receive a range of mental health and wellness services. The type and extent of services that I will receive will be determined following an initial assessment. The goal of the assessment process is to determine the best course of treatment for me.

I understand that after the initial assessment process it may be determined that Aspire Wellness, LLC is not the appropriate treatment center for me, and if so this will be communicated to me directly.

I understand that all information shared with Aspire Wellness, LLC is confidential and no information will be released without my consent. During the course of treatment at Aspire Wellness, LLC it may be necessary for my treatment team to communicate with other clinicians. Consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

A. When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.
B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child, and to inform the proper authorities.
C. When a valid court order is issued for medical records, Aspire Wellness, LLC is bound by law to comply with such requests.

I understand that while psychotherapy and/or medication, may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories.

Medications or supplements may have unwanted side effects.

If I have any questions regarding this consent form or about the services offered by Aspire Wellness, LLC, I may discuss them with my clinician. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by Aspire Wellness, LLC. I understand that either Aspire Wellness, LLC or I may discontinue treatment at any time.

Patient/Guardian Signature: _____ Date: ____/_____/_____

Cancellation Policy

We understand that there may be times that you need to cancel or reschedule your appointment. If you are unable to keep your appointment, please notify the office as soon as possible. Due to the busy schedule that we maintain, it is necessary for us to clearly state our cancellation policy. A "Cancelled Appointment" is defined as any cancellation within 24 hours of your scheduled appointment time. A "No-Show" is defined as an appointment where there was no attendance and no notice or call was made.

Appointments cancelled with less than 24 hours notice and no-show appointments will result in a **full fee charge**. Health insurance plans do not cover no-show fees. I understand Aspire Wellness, LLC's Financial and Cancellation Policies and understand my responsibility in planning my appointments accordingly, and will notify Aspire Wellness, LLC appropriately if I have difficulty with my appointments.

Patient/Guardian Signature: _____ Date: _____/_____/_____

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Thank you for choosing Aspire Wellness, LLC as your healthcare provider. The following is a statement of our Financial Policy, which we ask that you to read and sign, prior to being seen.

Please note that full payment is due at time of service. We accept cash or credit card payment.

Please note that we accept a limited number of insurance plans. We are Out-of-Network providers with all other insurance companies and as such will not directly bill your insurance company for payment of services. In addition, we cannot accept Medicare or Medicaid or any other federal, state, or local government pay program. As a courtesy to you, we can provide a Superbill for you to file with your insurance company, if applicable.

Please be aware that some of the services provided may be "non-covered" services and not considered reasonable and necessary under your insurance plan. You are responsible for payment in full, regardless of your insurance company's final determination of coverage.

We appreciate you reading and understanding the need for this financial policy. Please let us know if you have any questions or concerns.

I have read this financial policy and agree to all its provisions.

Patient/Guardian Name: _____

Patient/Guardian Signature: _____ Date: _____/_____/_____

Credit Card Authorization

Credit Card Type: □ Visa □ MasterCard □ Other: _____

Card Number: _____ Expiration Date: _____

Name on Card: _____ Security Code: _____

Billing Address: _____

City, State, Zip Code: _____

I hereby authorize Aspire Wellness, LLC to charge the credit card listed above for payment of service. I certify that I am a person who is authorized to use this credit card.

Patient/Guardian Name: _____

Patient/Guardian Signature: _____ Date: _____/_____/_____

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Authorization to Release Medical Records and Health Information

Patient Name _____ Date of Birth_____

I hereby authorize:

Aspire Wellness, LLC
7000 East Belleview Avenue Suite 350
Greenwood Village, CO 80111
Phone: 303-872-7344 fax: 303-770-6501

_____ to receive my health information from:

_____ to release my health information to:

Name: _____

Address: _____ City: _____ St: _____ Zip: _____

Phone: _____ Fax: _____

I authorize the following information to be released:

_____ Complete health records OR

_____ History and physical evaluation
_____ Progress notes
_____ Consultation reports
_____ Other (please specify): _____
_____ Discharge summary
_____ Laboratory tests
_____ Phone consult

Reason for authorization: _____at my request, or _____other: _____

This authorization will remain effective for 365 days unless otherwise noted here: _____

Treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

I understand that I have the right to revoke/withdraw this authorization, in writing, at any time, and that the revocation/withdrawal will be effective except to the extent that the above provider or entity releasing my information has already taken action in reliance on my authorization. My written statement that I want to revoke/withdraw my authorization should be delivered to Aspire Wellness, LLC or to the provider or entity listed above.

I expressly understand and agree that no liability of any nature shall attach to the physician, clinician or employee in acting upon this authorization and request.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, etc.)