Aspire Wellness, LLC 6053 S. Quebec St. Suite 100 Centennial, CO 80111 303-872-7344

Patient Information

Date: _____

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

Home Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip Code: _____

Cell: _____ Home: _____

Best # to leave a confidential voicemail: Cell: _____ Home: _____

Date of Birth: _____ Age: _____ Gender: _____

Marital Status: _____ Education Level: _____

Email Address: _____

Occupation: _____ Race: _____

Emergency Contact:

Name: _____

Address: _____ Apt: _____

City/State/ZIP: _____

Cell: _____ Home: _____ Work: _____

Relationship: _____

Pharmacy: _____

Address: _____

City, State, Zip Code: _____

Phone #: _____

PCP: _____

Address: _____

City, State, Zip Code: _____

Phone #: _____ FAX: _____

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Therapist: _____

Address: _____

City, State, Zip Code: _____

Phone #: _____ FAX: _____

Other Specialists: _____

Address: _____

City, State, Zip Code: _____

Phone #: _____

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 option 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 though 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:

-When there is risk of imminent danger to myself or to another person the clinician is ethically bound to take necessary steps to prevent danger.
- When there is suspicious 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 or elder and to inform the proper authorities.
- 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 medication and/or psychotherapy 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 and supplements may have unwanted side effects.

If I have 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 information. 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 Signature: _____ Date: _____

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Cancellation Policy

We understand that may be times that you need to cancel or reschedule your appointment. If you are unable to keep an 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 made at least 24 hours in advance 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 insurances 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 difficulties with my appointments.

Patient Signature: _____

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 the time of service. We accept cash or credit card payment.

Please note that we accept a limited number of health 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.

Patient's name: _____

Patient Signature: _____

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 services. I certify that I am a person who is authorized to use this credit card.

Patient Name: _____

Patient Signature: _____

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Authorization to Release Medical Records and Health Information

Patient Name: _____ Date of Birth: _____

I hereby authorize:

Aspire Wellness, LLC
6053 South Quebec Street Suite 100
Centennial, CO 80111

☐ to release my health information from:

☐ to release my health information to:

Name: _____

Address: _____

Phone: _____ FAX: _____

I authorize the following information to be released:

☐ Complete health records OR

☐ Progress notes

☐ Telephone consult

☐ Other (please specify) _____

Reason for authorization:

☐ at my request

☐ other: _____

This authorization will remain in effect 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 Signature Date