

Patient's name \_\_\_\_\_ DOB \_\_\_\_\_

 Release from  Release to

- BOULDER COMMUNITY HOSPITAL, P.O. Box 9019, North Broadway & Balsam, Boulder, CO 80301-9019
- FOOTHILLS HOSPITAL, P.O. Box 9047, 4747 Arapahoe Avenue, Boulder, CO 80301
- MAPLETON CENTER, P.O. Box 9130, 311 Mapleton Avenue, Boulder, CO 80301-9130
- COMMUNITY MEDICAL CENTER, 1000 W. South Boulder Road, Lafayette, CO 80026
- OTHER Tepo - Center for Integrative Care
- Attn: Person or Program \_\_\_\_\_

 BOULDER COMMUNITY HOSPITAL IMAGING  
2750 Broadway, Boulder, CO 80304 Release from  Release to RMCC

**GENERAL AUTHORIZATION:** I authorize the above-named health care provider to release the information specified below to the organization/ agency/individual named on this request. Method of release shall be pertinent to the need and may include photocopies, fax copies, personal review, audio, video, electronic, or verbal communication by appropriate practitioner.

I understand that BCH may not refuse to provide treatment if I refuse to sign this authorization, unless this authorization is necessary to participate in a research study or if the purpose of the treatment is to provide information to the party listed in this authorization. I understand that except for drug and alcohol treatment records, information disclosed under this authorization may be redisclosed by the recipient and is no longer protected by privacy laws.

**SPECIFIC AUTHORIZATION:** I specifically authorize the release of information regarding the following conditions:

- Alcohol / Drug abuse information – I understand that my chemical dependency records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations (See reverse side for redisclosure prohibition)
- Psychosocial / Psychiatric information (excludes psychotherapy notes which require separate release)
- Other \_\_\_\_\_

**INFORMATION REQUESTED:**

- Complete copy of medical record
- History and physical exam
- Discharge summary
- Treatment plan
- Admitting Psychiatric Assessment
- Emergency Department record
- Other: consult/medical records
- Operative reports, consults
- Laboratory reports
- Imaging reports
- EKG
- EEG
- Physician's orders & progress notes
- Nurses' notes
- Therapy notes & dictation
- Psychological eval. (excludes psychotherapy notes)
- Neuropsych / Psych. testing & evals (does not include raw data or psychotherapy notes)

**CONDITIONS AND DATES OF CARE COVERED:**

- Regarding these treatment dates and/or for conditions: evaluation/treatment this admission
- All admissions or care at this facility provided as of the date of my signature.

**PURPOSE(S) FOR WHICH INFORMATION IS TO BE USED:**

- Further eval / treatment
- Insurance / reimbursement
- Legal
- Verify Treatment Status
- Personal use
- Worker's Compensation
- Other (specify) \_\_\_\_\_

**EXPIRATION OR REVOCATION OF AUTHORIZATION**

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my previous expressed revocation, this authorization will automatically expire 90 days from the date of my signature unless noted below.

- On \_\_\_\_\_
- No longer than \_\_\_\_\_ days from the date of my signature or under the following conditions: \_\_\_\_\_
- Upon fulfilling the purpose or need for information as specified above, but no longer than 365 days from the date of my signature.

**NOTE:** Federal regulations require consent to release alcohol or drug records last no longer than reasonably necessary to serve the purpose for which the release is given.

**SIGNATURE :** A copy of this authorization (including a facsimile copy) may be used with the same effectiveness as the original.

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_

Authorized representative name (please print) \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Authorized representative signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_



ROI

DOB: \_\_\_\_\_ /  
ACCT NO: \_\_\_\_\_ MR: \_\_\_\_\_  
< Place Label Here >  
ATTEND DR: \_\_\_\_\_

**HIPAA Release of Medical Information**

**Nutritional Information for Consultation**

Patient name: \_\_\_\_\_ Appointment: \_\_\_\_\_

Oncologist: \_\_\_\_\_

Diagnosis and/or primary reason for visit: \_\_\_\_\_

DOB: \_\_\_\_\_

Are you experiencing gastrointestinal side effects from cancer treatment?

\_\_\_\_\_ nausea/vomiting

\_\_\_\_\_ mouth or throat sores/mucositis

\_\_\_\_\_ difficulty swallowing

\_\_\_\_\_ diarrhea

Have you experienced significant weight loss since your diagnosis?

Height: \_\_\_\_\_ weight: \_\_\_\_\_ pre-diagnosis weight: \_\_\_\_\_

Do you or have you had:

feeding tube: \_\_\_\_\_ currently \_\_\_\_\_ in past 3 months

TPN: \_\_\_\_\_ currently \_\_\_\_\_ in past 3 months

Do you wish to lose weight to achieve your health goals?

Do you have specific questions about vitamins/minerals/herbs/supplements?

specify:

Are you interested in menus, recipes and meal plans to reduce cancer risk?

**Agreement For Treatment**

I agree to the provision of health care services by BCH employees, and medical staff. Such services as may be ordered by my physician may include, but not be limited to, diagnostic tests, intravenous therapy medications, surgery, anesthesia, injections and blood transfusions.

I agree to comply with the prescribed plan of care and accept the consequences of the services provided. I know the practice of medicine may involve the risk of injury or even death. No guarantee as to outcome has been made to me.

I understand it is my right to discuss any proposed service with my physician and I may refuse any such service.

I understand there may be additional consent forms requested of me for the services ordered by physician. It is the responsibility of my physician or allied health professional to advise me of the risks and benefits and other treatment options before I sign such consents.

**Valuables**

I understand BCH is not responsible for the safekeeping of any valuables or personal items unless they have been checked with Security.

**Hospital Directory - (applies to IP & ER patients only)**

As a convenience for our patient's family and friends, the Hospital Directory lists your name, location in the Hospital, general condition and religious affiliation. The Directory information (except religious affiliation) is disclosed to persons who ask for you by name.

I have been given the opportunity to be excluded from the Directory.

**Release of Information**

I authorize the release of my medical information for treatment, payment, and health care purposes as defined in the boulder Community Hospital Joint Notice of Privacy Practices.

**Payment Agreement**

I agree to pay Boulder community Hospital for all services not paid by my health plan including any co-payments, deductibles, coinsurance, non-covered services and costs of collection, including attorney's fees. If I do not have a Health Plan or my Health Plan does not contract with Boulder Community Hospital I understand I am responsible for payment for all services provided.

I authorize Boulder community Hospital to bill and collect from Medicare, Medicaid or other Health Plans for any benefits I may be entitled to under such plans.

I understand I may be asked to sign additional documents to be responsible for payment for specific services that may not be covered by Medicare or other Health Plans.

Medicare beneficiaries: OUTPATIENT services are covered by Medicare Part B. If you are an OUTPATIENT at the hospital or any off-campus department, we can't always determine coinsurance in advance because we do not know which services will be required. Coinsurance is 20% of the Medicare-approved amount for services after you meet the annual \$100 deductible.

**Billing From Other Providers**

I understand that I will receive separate billings for the professional services of radiologists, anesthesiologists, emergency room physicians, cardiologists, attending physicians, pathologists, outside laboratory services and/or other health care providers who provide services while I am an inpatient or outpatient at the hospital.

**Rights Related to Psychotherapy**

I understand that if seen by a psychologist, counselor or social worker at BCH. I have the right to receive information about that person's credentials, methods, duration of the therapy and fee structure. I understand that I may seek a second opinion or terminate therapy at any time. I understand information I may provide in counseling is confidential and exceptions that arise during the therapy will be discussed with me. Sexual intimacy within a professional relationship is never appropriate and should be reported to the State Grievance Board at 1560 Broadway, Suite 1340, Denver, CO 80202 (303) 894-7766.

Signature of Patient or Responsible Party \_\_\_\_\_

Date \_\_\_\_\_

The Patient is unable to consent or sign because: \_\_\_\_\_

**Notice of Privacy Practices**

I understand that Boulder community Hospital will need to use and disclose certain medical information about me as it relates to my treatment, payment for treatment and health care operations. The hospital has provided me with a Notice that describes how my medical information may be used and disclosed and how I can access this information. \_\_\_\_\_ (initials)



**GENERAL CONDITIONS OF ADMISSION**

PATIENT LABEL

DOB: \_\_\_\_\_ R/B: /  
ACCT. NO: \_\_\_\_\_ MR: \_\_\_\_\_  
< Place Label Here >

COA



CENTER FOR INTEGRATIVE CARE  
PATIENT SERVICE AGREEMENT

Patient Name: \_\_\_\_\_

1. Cancellation Policy – We request a minimum of 24 hours notice if you are unable to attend a scheduled appointment. Late notice or no shows will be charged a \$25.00 fee, payable at the next visit.

Exceptions will be made for illness, emergencies, and bad weather.

***Please call 720.854.7292 to cancel an appointment.***

2. Three missed sessions due to no shows or late cancellations may result in a termination of therapy.

3. Our standard treatment is a 50-minute hour.

4. We request that you notify the person providing the service of any health condition that might affect the safety or effectiveness of the service including but not limited to:

- Fever equal to or greater than 100.5°
- Unrelenting cough
- Ongoing infectious disease process
- An INR count of greater than 3 when on anticoagulants
- Extreme weakness

5. In order to protect your well being, we will not provide services if you have any of the following conditions:

- Absolute neutrophil count of 500 or less
- A platelet count of 25,000 or less

By signing below I confirm that I have read and understood the above policies.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Please keep this information for future reference.*



Boulder Community Hospital

**Disclosure Statement  
Acupuncture Treatment**

Colorado law requires that all acupuncturists provide the following information to patients at the first visit:

**Acupuncturist Information**

Acupuncturists in the Center for Integrative Care are employees of Boulder Community Hospital. Information regarding individual licensure and educational background is on file in the Human Resources Department.

**Disclosure Statement**

Patients are entitled to receive information about the methods of therapy, the techniques used and the duration of therapy if known.

The Center for Integrative Care at Boulder Community Hospital adheres to all rules and regulations pertaining to acupuncture as specified by the Colorado Department of Health, including the proper cleaning and sterilization of equipment. Sterile, disposable needles are used for all acupuncture treatments.

Patients may seek a second opinion from another health care professional or may terminate therapy at any time.

Sexual intimacy is never appropriate in a professional relationship and any questions or complaints about inappropriate behavior should be reported to the management of the Center for Integrative Care at 303.440.2469 or 720.854.7026 and to:

Director of the Division of Registration in the Department of Regulatory Agencies:  
Office of Acupuncturists Registration  
1560 Broadway, Suite 1545  
Denver, CO 80202                      303.894.2464

**Payment, Fee Schedule and Patient Responsibility**

You are responsible for payment at the time service is rendered. If you need to cancel your appointment please give 24 hours notice. If you cancel without giving 24 hours notice, except in emergency situations or extreme weather, you will be charged a \$25.00 cancellation fee.

I have read and agree to the above conditions prior to treatment.

\_\_\_\_\_ Date \_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship to Patient

**Center for Integrative Care**  
Consent to Services

Name: \_\_\_\_\_

Date: \_\_\_\_\_

I have requested and voluntarily consent to the services described below. Please initial all that apply.

- \_\_\_ Acupuncture
- \_\_\_ Healing Touch, Reiki
- \_\_\_ Integrative Health Nurse Consult
- \_\_\_ Massage Therapy
- \_\_\_ Registered Dietitian / Nutrition Consult

I have read and I understand the description of the services I have requested (the “Services”) and the description of risks and benefits as provided on this consent form.

I understand that the Services are intended to be complementary to medical treatment of my health condition. I understand the Services may not be effective and are not a substitute for medical examination, diagnosis or treatment of my health condition. I also understand that I am responsible for obtaining any follow-up care from my healthcare that is recommended as a result of the Service.

I understand that I can discontinue the Services at any time. If I wish to discontinue the Services, I will immediately notify the person who is providing the Services to me. I also will notify the person providing the Services of any pain or discomfort I feel while the Services are being provided.

I understand that I am responsible for the payment of the Services. Unless prior arrangements have been made, I am responsible for payment at the time the Services are provided.

I understand that sexual intimacy is never appropriate in this or any other professional relationship. I understand that I should report any concerns regarding sexual intimacy to the management of the Center for Integrative Care at 404.440.2469 or 720.854.7026 and to:

Director of the Division of Registration  
Colorado Department of Regulatory Agencies:  
Office of Acupuncturists Registration  
1560 Broadway, Suite 1545  
Denver, CO 80202  
(303) 894-2464

I have had an opportunity to ask questions about the Services and the questions I have asked have been answered to my satisfaction. I believe that I have sufficient information to give informed consent to the Services.

I have read the above consent and understand and agree to what it says:

\_\_\_\_\_  
Patient Signature

The patient is unable to consent because \_\_\_\_\_  
I, therefore consent for the patient:

\_\_\_\_\_  
Relative/Guardian/Representative

\_\_\_\_\_  
Relationship to patient

## **DESCRIPTION OF SERVICES AND RELATED RISKS AND BENEFITS**

Please confirm that you have read and understand the following information by initialing the service(s) that you have requested.

### **ACUPUNCTURE**

I understand that acupuncture is performed by the insertion of sterilized, disposable needles through the skin or by application of heat to the skin or by both, at certain points on or near the surface of the body. I understand that certain adverse side effects may result from acupuncture treatment including but not limited to local bruising, bleeding, fainting, nausea, temporary pain or discomfort, and the possible aggravation of symptoms existing prior to the acupuncture treatment. In some cases, more serious side effects may occur. I understand that acupuncture has not been established by adequate scientific studies as an effective treatment method and is not a substitute for medical treatment of my health care condition. I understand that acupuncture may not achieve the desired purposes. I further understand that I should see a medical specialist for diagnosis and treatment of my health conditions.

### **HEALING TOUCH, REIKI**

I understand that during touch therapy, I may be gently touched in various places on his/her fully clothed body. At other times, the practitioner may be working within one or two inches of my body but will not touch me. The purposes of touch therapy include the promotion of relaxation, reduction of pain and anxiety and facilitation of the body's nature restorative processes. I understand that touch therapy is not a substitute for medical treatment, is not guaranteed to be effective, and may not achieve the desired purpose. I understand that I should see a medical specialist for diagnosis and treatment of my health concerns.

### **INTEGRATIVE HEALTH NURSE CONSULTATION**

I understand that the purpose of the integrative care nurse consultation is to provide information about complementary approaches to conventional medical care and may include lifestyle recommendations and interventions to promote relaxation. I understand that the recommendations and interventions discussed in this consultation are not a substitute for medical treatment, are not guaranteed to be effective, and may not achieve the desired purpose. I understand that I should see a medical specialist for diagnosis and treatment of my medical conditions.

### **MASSAGE THERAPY**

I understand that therapeutic massage involves the manipulation of the soft tissue structures of the body to prevent and alleviate pain, discomfort, muscle spasm, and stress; and, to promote health and wellness. The American Massage Therapy Association (AMTA) defines massage as, "a manual soft tissue manipulation that includes holding, causing movement, and/or applying pressure to the body."

I understand that certain adverse side effects may result from massage therapy including but not limited to local bruising, muscle soreness, temporary pain or discomfort, and the possible aggravation of symptoms existing prior to the massage therapy treatment. In some cases, more serious side effects may occur. I understand that massage therapy is not a substitute for medical treatment of my health care condition. I understand that I should see a medical specialist for diagnosis and treatment of my health concerns.

**REGISTERED DIETITIAN / NUTRITION CONSULTATION**

I understand that the goals of a nutrition consult involve preventing and reducing nutrient deficiencies, preserving lean body mass, improving tolerance to treatment, minimizing the effect of nutrition-related side effects and complications, maintaining strength and energy, enhancing immune function by decreasing risk of infection, aiding in recovery and healing from cancer therapy, and maximizing quality of life. I understand that the recommendations and interventions discussed in this consultation are not a substitute for medical treatment, are not guaranteed to be effective, and may not achieve the desired purpose. I understand that I should see a medical specialist for diagnosis and treatment of my medical conditions.

Boulder Community Hospital  
Center for Integrative Care  
Patient Information

Name: \_\_\_\_\_ M \_\_\_ F \_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number: \_\_\_\_\_ Alternate phone: \_\_\_\_\_

Email address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Relationship \_\_\_\_\_

Physician: \_\_\_\_\_

- Service requested:     \_\_\_\_\_ Acupuncture  
                              \_\_\_\_\_ Dietitian/Nutrition Consult  
                              \_\_\_\_\_ Massage Therapy  
                              \_\_\_\_\_ Wellness/Integrative Care Nurse Consult  
                              \_\_\_\_\_ Healing/Therapeutic Touch and Reiki

When were you first diagnosed with cancer? \_\_\_\_\_

What type of cancer? \_\_\_\_\_

Where was/is it located? \_\_\_\_\_

Any recurrences/metastases? \_\_\_\_\_

Are you being treated now? \_\_\_ Yes \_\_\_ No

When was the date of your last treatment? \_\_\_\_\_

What treatments have you undergone? \_\_\_\_\_

Did your treatment include radiation therapy? \_\_\_ Yes \_\_\_ No

Location of radiation field: \_\_\_\_\_

Did your treatment include any removal of lymph nodes? \_\_\_ Yes \_\_\_ No Please describe: \_\_\_\_\_

Please list your current medications & conditions they are prescribed for (if known):  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any of the following:

- |                          |  |
|--------------------------|--|
| _____ easy bruising      | _____ fatigue                            |
| _____ low platelet count | _____ low white count                    |
| _____ osteoporosis       | _____ recent history of blood clots      |
| _____ weight loss        | _____ diarrhea _____ nausea              |
| _____ skin problems      | _____ neuropathy in hands or feet        |
| _____ incisions          | _____ medical devices                    |
| _____ depression         | _____ anxiety _____ difficulty breathing |
| _____ pain or discomfort |  |

Specific Medical Conditions:

Known allergies or sensitivities \_\_\_\_\_

Cardiovascular conditions (e.g. heart conditions, high/low blood pressure, etc.) \_\_\_\_\_

Liver or Kidney conditions \_\_\_\_\_

Respiratory or Lung conditions \_\_\_\_\_

Diabetes \_\_\_\_\_ Arthritis \_\_\_\_\_

Injuries (e.g. disc problems, fractures, etc) \_\_\_\_\_

Other surgeries \_\_\_\_\_

Major complaints/Other information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_

Thank you!