



ChiMontee Health Services

Location: 8310 South Valley Highway, 3rd Floor
Englewood, CO 80112. United States.

Email: chimonteeservices@gmail.com

Phone: (720) 900.9293

Website: www.chimonteehealthservices.com

Welcome to ChiMontee Health Services! Thank you for allowing us the honor of helping you with your behavioral and psychiatric needs. Patient care is an essential priority to us and your well-being is paramount. We hope to provide the best care possible and make your experience an exceptional one. At ChiMontee Health Services, we are interested in helping you through this journey, while staying committed to your goals and how best to achieve them.

We understand how overwhelming the effects of lack of proper care can be to you and the your loved ones and that is why, we are here, to help you through this journey; coping with your challenges in a healthy and comfortable way.

Our specialists are qualified to assist with all your questions and queries. We promise to promptly deal with any problems you may have in a professional and convenient manner.

You can call, text us at (720) 900-9293, or fill out the contact form on www.chimonteehealthservices.com.

Once again, thank you for trusting us. We look forward to seeing you.

Sincerely,

Chika Achebe. (Psychiatric Nurse Practitioner, MSN, PMHNP-BC)

Patient Information

Last Name: _____ First Name: _____ MI: _____

SSN: _____ DOB: _____ Height: _____ Weight: _____

Address: _____

State: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Preferred Contact: ☐ Email ☐ Cell Phone ☐ Home Phone Gender: ☐ Male ☐ Female

Marital Status

- ☐ Separated
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Partner

Ethnicity

- ☐ Latino or Hispanic
- ☐ Other

Race

- ☐ Asian
- ☐ White or Caucasian
- ☐ Hispanic or Latino
- ☐ American Indian or Alaskan Native
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Unreported/Refuse

Emergency Contact Information

Name _____

Relationship: _____

Phone: _____

How Did You Hear About Us?

- ☐ Insurance
- ☐ Hospital
- ☐ Physician Referral
- ☐ Online
- ☐ Other _____

Preferred Language

- ☐ English
- ☐ Spanish
- ☐ French

Responsible Party/Guarantor/Legal Guardian Contact

☐ Same As Patient

First Name: _____ Last Name: _____ MI: _____

Date of Birth: _____ Relationship: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Occupation: _____ Employer: _____

Driver's License#: _____ Issuing State: _____ Expiration: _____

Are you the legal Guardian? ☐ Yes ☐ No

Social, Education and Work History

Are you a current Smoker? ☐ Yes ☐ No

Do you drink Alcohol? ☐ Yes ☐ No

if yes, how often: _____

if yes, how much: _____

Do you use narcotics? ☐ Yes ☐ No

Do take prescription meds? ☐ Yes ☐ No

if yes, list: _____

if yes, how much: _____

Are you sexually active? ☐ Yes ☐ No

Do you have multiple partners? ☐ Yes ☐ No

Highest Level of Education: _____

School Attended: _____

Employer: _____ Current Occupation: _____

Any Work Related Stress?: _____

Employment Status

☐ Employed

☐ Unemployed

☐ Retired

☐ Current Student

☐ Disabled

Hobbies

☐ Biking ☐ Reading

☐ Bowling ☐ Swimming

☐ Hiking ☐ Computer/TV

Personal Medical History

Anaemia	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No
Anxiety	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis	<input type="radio"/> Yes <input type="radio"/> No
Arthritis	<input type="radio"/> Yes <input type="radio"/> No	Hypertension	<input type="radio"/> Yes <input type="radio"/> No
Atrial Fibrillation	<input type="radio"/> Yes <input type="radio"/> No	Irritable Bowel Disease	<input type="radio"/> Yes <input type="radio"/> No
Blood Clots	<input type="radio"/> Yes <input type="radio"/> No	Lactose Intolerance	<input type="radio"/> Yes <input type="radio"/> No
Bronchitis	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No
Cerebral Vascular Disease	<input type="radio"/> Yes <input type="radio"/> No	Pectic Ulcer	<input type="radio"/> Yes <input type="radio"/> No
COPD (Emphysema)	<input type="radio"/> Yes <input type="radio"/> No	Pneumonia	<input type="radio"/> Yes <input type="radio"/> No
Crohn's Disease	<input type="radio"/> Yes <input type="radio"/> No	Polycystic Ovarian Syndrome	<input type="radio"/> Yes <input type="radio"/> No
Frequent Infections	<input type="radio"/> Yes <input type="radio"/> No	Prostrate Disease	<input type="radio"/> Yes <input type="radio"/> No
Coronary Artery Disease	<input type="radio"/> Yes <input type="radio"/> No	Peripheral Vascular Disease	<input type="radio"/> Yes <input type="radio"/> No
Gall Bladder Disease	<input type="radio"/> Yes <input type="radio"/> No	Renal Kidney Disease	<input type="radio"/> Yes <input type="radio"/> No
GI Disorder	<input type="radio"/> Yes <input type="radio"/> No	STD	<input type="radio"/> Yes <input type="radio"/> No
Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Sexual Problems	<input type="radio"/> Yes <input type="radio"/> No

Neurological History

- | | | | |
|-----------------------|--|-----------|--|
| Peripheral Neuropathy | <input type="radio"/> Yes <input type="radio"/> No | Tremors | <input type="radio"/> Yes <input type="radio"/> No |
| Difficulty Speaking | <input type="radio"/> Yes <input type="radio"/> No | Dizziness | <input type="radio"/> Yes <input type="radio"/> No |
| Weakness/Fainting | <input type="radio"/> Yes <input type="radio"/> No | Nausea | <input type="radio"/> Yes <input type="radio"/> No |
| Light Sensitivity | <input type="radio"/> Yes <input type="radio"/> No | Migraines | <input type="radio"/> Yes <input type="radio"/> No |
| Pain | <input type="radio"/> Yes <input type="radio"/> No | Seizures | <input type="radio"/> Yes <input type="radio"/> No |
| Spinal Injury | <input type="radio"/> Yes <input type="radio"/> No | Epilepsy | <input type="radio"/> Yes <input type="radio"/> No |
| Numbness/Tingling | <input type="radio"/> Yes <input type="radio"/> No | | |

Dermatology History

- | | | | |
|---------------|--|----------|--|
| Rashes | <input type="radio"/> Yes <input type="radio"/> No | Lesion | <input type="radio"/> Yes <input type="radio"/> No |
| Skin Cancer | <input type="radio"/> Yes <input type="radio"/> No | Acne | <input type="radio"/> Yes <input type="radio"/> No |
| Skin Melanoma | <input type="radio"/> Yes <input type="radio"/> No | Wrinkles | <input type="radio"/> Yes <input type="radio"/> No |
| Age Spots | <input type="radio"/> Yes <input type="radio"/> No | Eczema | <input type="radio"/> Yes <input type="radio"/> No |
| Dryness | <input type="radio"/> Yes <input type="radio"/> No | | |

Behavioral History

- | | | | |
|------------------------|--|---------------------------|--|
| Depression | <input type="radio"/> Yes <input type="radio"/> No | Memory Loss | <input type="radio"/> Yes <input type="radio"/> No |
| Hallucination | <input type="radio"/> Yes <input type="radio"/> No | Insomnia | <input type="radio"/> Yes <input type="radio"/> No |
| Weight Loss/Gain | <input type="radio"/> Yes <input type="radio"/> No | Anxiety | <input type="radio"/> Yes <input type="radio"/> No |
| Alcohol Abuse | <input type="radio"/> Yes <input type="radio"/> No | Attention Problems | <input type="radio"/> Yes <input type="radio"/> No |
| Loss Of Energy/Fatigue | <input type="radio"/> Yes <input type="radio"/> No | Loss of Interest/Pleasure | <input type="radio"/> Yes <input type="radio"/> No |
| Drug Use | <input type="radio"/> Yes <input type="radio"/> No | | |

Health Maintenance History

Flu Vaccine ☐ Yes ☐ No

Pneumonia Vaccine ☐ Yes ☐ No

Tetanus Vaccine ☐ Yes ☐ No

Physical Examination ☐ Yes ☐ No

Hepatitis Vaccine ☐ Yes ☐ No

STD Examination ☐ Yes ☐ No

Shingles Vaccine ☐ Yes ☐ No

Gardasil Vaccine ☐ Yes ☐ No

Mammogram ☐ Yes ☐ No

Colonoscopy ☐ Yes ☐ No

Pap Test ☐ Yes ☐ No

EKG ☐ Yes ☐ No

Family History

	N/A	Father	Mother	Sibling	Children
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy / Convulsion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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AUTHORIZATION FOR TREATMENT

I hereby authorize treatment by Chimontee Health Services and have agreed to voluntarily receive such treatment. I consent to treatment and services deemed advisable by Chimontee Health Services staff including urine/saliva drug testing. I acknowledge that any questions I have regarding this treatment may be directed towards Chimontee Health Services staff.

Patient Name: _____

Signature: _____ Date: _____

Medicare Patients and Commercial Insurance Agreement

Name of Beneficiary: _____ Medicare Number: _____

Health Insurance: _____

I request that payment of authorized Medicare benefits be made to Chimontee Health Services for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine benefits payable for related services.

This authorization is in effect until I choose to revoke it.

I request that the payment for services rendered to me and my dependents by Chimontee Health Services be made to Chimontee Health Services for the year(s) that I received said treatment(s).

Patient Signature: _____ Date: _____



ChiMontee Health Services

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby request and authorize the release of my personal health information to:

Company: _____

Phone: _____

Fax: _____

Email: _____

TREATMENT DATES: From the date of _____ to the present.

Treatment Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Type of information to be requested or disclosed is as follows:

To Be Released

- ☐ Treatment Plans
- ☐ Psychiatric Progress Notes
- ☐ Health/Medical Records
- ☐ Education Reports
- ☐ Discharge Summaries
- ☐ Psychology/Psychiatric Evaluation
- ☐ Social/Development History
- ☐ Verbal Communication
- ☐ Other

To Be Requested

- ☐ Treatment Plans
- ☐ Psychiatric Progress Notes
- ☐ Health/Medical Records
- ☐ Education Reports
- ☐ Discharge Summaries
- ☐ Psychology/Psychiatric Evaluation
- ☐ Social/Development History
- ☐ Verbal Communication
- ☐ Other

AUTHORIZATION: I _____ hereby give my permissions to ChiMontee Health Services to release information contained in my medical records. I certify that this request is made voluntarily, and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by sending a letter to the facility Privacy Officer or their designee. I understand my revocation will not be effective to the extent that action has already been taken in reliance on it. This authorization expires: _____ If not otherwise specified this authorization will expire in 365 days. I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected. Other Condition: A copy or facsimile of this Authorization with my signature may be used with the same validity as the original.

Patient: _____

Birth Date: _____

SSN#: _____ Treatment Date: _____

Patient Signature: _____ Date: _____



Chimontee Health Services

Notice of Privacy Practices

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS AND DESCRIBES HOW INFORMATION ABOUT YOU MAY BE DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Confidentiality

As a rule, I will disclose no information about you, or the fact that you are my patient, without your written consent. My formal Mental Health Record describes the services provided to you and contains the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress, and any psychological testing reports. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes.

However, I do not routinely disclose information in such circumstances, so I will require your permission in advance, either through your consent at the onset of our relationship (by signing the attached general consent form), or through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing, at any time, by contacting me.

II. Limits of Confidentiality

Possible Uses and Disclosures of Mental Health Records without Consent or Authorization There are some important exceptions to this rule of confidentiality - some exceptions created voluntarily by my own choice, [some because of policies in this office/agency], and some required by law. If you wish to receive mental health services from me, you must sign the attached form indicating that you understand and accept my policies about confidentiality and its limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together. I may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

- **Emergency:** If you are involved in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.
- **Child Abuse Reporting:** If I have reason to suspect that a child is abused or neglected, I am required by Colorado law to report the matter immediately to the Colorado Department of Social Services.
- **Adult Abuse Reporting:** If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by Colorado law to immediately make a report and provide relevant information to the Colorado Department of Welfare or Social Services.
- **Court Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information unless you provide written authorization or a judge issues a court order. If I receive a subpoena for records or testimony, I will notify you so you can file a motion to quash (block) the subpoena. However, while awaiting the judge's decision, I am required to place said records in a sealed envelope and provide them to the Clerk of Court. In civil court cases, therapy information is not protected by patient-therapist privilege in child abuse cases, in cases in which your mental health is an issue, or in any case in which the judge deems the information to be "necessary for the proper administration of justice." Protections of privilege may not apply if I do an evaluation for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** Under Colorado law, if I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. By my own policy, I may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety. If you become a party in a civil commitment hearing, I can be required to provide your records to the magistrate, your attorney or guardian ad litem, a CSB evaluator, or a law enforcement officer, whether you are a minor or an adult.
- **Workers Compensation:** If you file a worker's compensation claim, I am required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.
- **Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission.**

III. Patient's Rights and Provider's Duties:

- **Right to Request Restrictions-** You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me: 1) what information you want to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.
 - **Right to an Accounting of Disclosures -** You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice). On your written request, I will discuss with you the details of the accounting process.
 - **Right to Inspect and Copy -** In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, I may charge a fee for costs of copying and mailing.
 - **Right to Amend -** If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and submitted to me. In addition, you must provide a reason that supports your request. I may deny your request if you ask me to amend information that: 1) was not created by me; I will add your request to the information record; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.
 - **Right to a copy of this notice -** You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time. Changes to this notice: I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information I already have about you as well as any information I receive in the future. The notice will contain the effective date I will have copies of the current notice available on request.
- Complaints:** If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services.



Chimontee Health Services

Chimontee Health Services' Financial Policy and Responsibilities

FINANCIAL POLICY AND PATIENT RESPONSIBILITIES By initialing, you understand your responsibilities and agree to this policy.

1. Co-pays are due at the time of your appointment. If you are not able to pay your required co-pay, please reschedule your appointment for another time. Please do not ask us to make an exception to this policy. _____
2. You are responsible for any payments including deductibles. We reserve the right to suspend scheduling appointments for non-payment. It is your responsibility to update your insurance information for timely filing. **NO FURTHER SERVICES WILL BE PROVIDED UNTIL YOUR ACCOUNT IS UP-TO-DATE.** _____
3. Initial visits with Chika Achebe PMHNP is 60 -minute appointments and follow-up visit is 30-minute appointments. If you extend beyond this time, your insurance will be billed for an extended appointment and you may be responsible for extra deductibles or coinsurance _____
4. Please be on time for your appointment. If you will be 15 or more minutes late, your appointment will be rescheduled and you will be charged a no-show fee of \$50.00. _____
5. We strictly enforce a no-show policy. A missed appointment fee will be charged for missed follow-up appointments and for missed initial appointments. You will be charged if you do not attend your scheduled appointment or you cancel with less than 24 hours. This fee is your responsibility and will not be charged to your insurance. It will be due prior to scheduling your next appointment. Failure to pay this fee may result in suspension of appointment scheduling privileges. We will keep your credit card on file to charge this fee.

Fees are as follows:

Chika Achebe - No Show New Patient: \$100.00. No Show Existing Patient: \$50.00 _____

Three (3) missed and or last-minute cancelled appointments will result in discharge from our practice. If you have questions, please speak with your provider. _____

6. Due to being a mental health facility, possession of firearms or weapons of any kind are strictly prohibited. _____
7. Referrals and prior authorizations for services received are the responsibility of the patient (or patient's guardian if patient is a minor). Services that are not covered because of failure to obtain referral or prior authorization are the patient's responsibility. _____
8. Fee-for-service, cash, or uninsured patients will be required to pay the entire fee prior to seeing the provider. _____
9. If patient is a minor, patient must be present at every appointment in order to bill your insurance. If you wish to schedule an appointment without the patient present, the out-of-pocket fee will be \$130 per half an hour. _____
10. We require a notice of 7 business days for any refill requests. It is not our responsibility to keep track of how many days you have left of your medication. _____
11. If you require a provider to complete disability paperwork, you will be required to schedule a separate appointment or will be charged an out-of-pocket rate of \$250 which is due prior to the receipt of the paperwork. _____
12. Direct Payments to Clients.

If your insurance company reimburses you directly, you are required to investigate these payments

and turn them over to your health care provider immediately, or you will be required to pay for all services in full and terminated as a patient. Keeping payments meant for your health care provider is a serious offense and can lead to legal proceedings.

FINANCIAL POLICY AND PATIENT RESPONSIBILITIES 2020

_____ I WISH TO RECEIVE A COPY OF THIS FINANCIAL POLICY or

_____ A COPY OF THE FINANCIAL POLICY WAS OFFERED AND I DECLINE AT THIS TIME

I, the undersigned, have received/declined (please circle one) a copy of the Financial Policy of Chimontee Health Services LLC and understand that I am responsible for following the policy guidelines. I also understand that failure of payment as outlined in the policy may suspend my ability to schedule appointments with my provider until payment arrangements have been made. Chimontee Health Services' Financial Policy and Responsibilities.

Patient/Responsible Party Signature: _____ Date: _____