Lykos Medical

office@lykosmedical.com
P: 719-434-8810 / F: 719-960-2909
7610 N.Union Blvd, #150, Colorado Springs CO 80920

Thank you for choosing Lykos Medical. We're happy to have you!

We started this organization with one thing in mind: helping the greatest generation of Americans by doing our best to give you world class treatment. From easy office communication to thorough evaluations with conscious decisions by your medical provider, we hope you find our care to be second to none.

Since opening our practice, we have progressively grown throughout the Colorado Springs and Pueblo area and now service patients in nearly every assisted living home in the region. We hope you find us to be well connected and versed in the various nuances of care within the assisted living world. We pride ourselves in our ability to coordinate with multiple echelons of care from the local staff, to home health agencies, and medical specialists.

Over the next week, our team will work diligently to get your loved one plugged in to our group. Be prepared to provide additional information if needed. Your designated medical provider will likely reach out soon as well. In this packet you will find all the necessary paperwork that we need to assume your loved one's care. You will also find some helpful forms/handouts that should help you organize their medical information for your reference.

From all of us here at Lykos Medical, thank you for choosing us to be your trusted partner in caring for your loved one. We look forward to working with you.

Sincerely,

The Lykos Team

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PATIENT REGISTRATION FORM

Patient's Full Name: _____

Patient's Date Of Birth: _____ Patient's SSN:_____

Patient's Current Mailing Address: _____

Insurance Information

Primary Insurance and policy number: _____

Secondary Insurance and policy number: _____

Insurance Cards Attached?: ____

Where should insurance billing be mailed? _____

Patient's Power of Attorney: _____ Relationship to Patient: _____

POA Email: _____ Phone Number: _____

POA Mailing Address: _____

Medical Information

Previous Primary Care Provider: _____

Specialty Providers Involved in Patient's Care: _____

_____

Medical Diagnoses: _____

Allergies: _____

Previous Surgeries with year: _____

Social History

Previous Employment:

Marital Status (Circle One): -Married -Widow(er) -Divorced -Single

Children:

Religious Preference: Language Preference:

Alcohol/Tobacco/Drug Use:

****Please attach copies of the following:** **-Face Sheet -Insurance Cards -Photo ID -Most Form**

-Current Medication List -Recent Provider visit notes -Completed Privacy Policy Form

ASSISTED LIVING FINANCIAL POLICY

Lykos Medical

Today's Date_____

Patient Name_____
Last First MI

Date of Birth _____SSN _____

We are committed to providing you with the best possible medical care. If you have medical insurance, we would like to help you receive the maximum allowable benefits. In order to achieve this goal, we will need your assistance and understanding of our financial policies. Please carefully review this information and sign/initial where indicated.

***** *Any changes to personal information must be given to the office immediately*****

ASSIGNMENT: I request that payment of authorized insurance, Medicare, and Medicaid benefits be made payable to Lykos Medical LLC on my behalf for services furnished to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. In the event that my account is turned over to a collection agency, I agree to pay all reasonable costs of collection and understand that I may no longer be a patient at this office.

_____ ***(Initial) I have read and agree to the above statement.***

CO-PAY/COINSURANCE/DEDUCTIBLE: I understand that my primary insurance will be billed; billing secondary insurance is a courtesy only and I am ultimately responsible for assigned co-payments, coinsurance and deductible amounts by primary and/or secondary insurance. Tertiary insurance billing remains my responsibility.

_____ ***(Initial) I have read and agree to the above statement.***

RELEASE OF INFORMATION: I authorize the holder of medical information about me to release any and all information to Centers for Medicare and Medicaid Services, its agents, my insurance carrier(s), or other entities as needed to determine these benefits or the benefits for my dependents or myself. If I have health insurance coverage under an HMO, I authorize Lykos Medical LLC to release information concerning my diagnosis and treatment to my primary care or referring physician after each visit.

_____ ***(Initial) I have read and agree to the above statement.***

REQUESTS FOR INFORMATION: Should I receive any requests from my insurance company in regards to my services at this office, I must respond to that correspondence immediately, in order to have the claim processed and paid.

_____ ***(Initial) I have read and agree to the above statement.***

PAYMENTS: Self-pay and previous balance amounts are due when billed. Insurance co-payments are mandated by your insurance company and will be billed **after** each visit. Patients with insurance claims pending will be sent statements for the full amount due until the account is satisfied. I agree that if the insurance company denies benefits for any reason, I am responsible for the full amount owed for services provided. If I have questions, I understand to contact the office first.

_____ ***(Initial) I have read and agree to the above statement.***

RETURNED CHECKS: I understand and agree to pay a returned check charge of $35.00 for each check that is returned for any reason. I agree to pay the amount of the check plus the service charge within 30 days of receipt of notification.

_____ ***(Initial) I have read and agree to the above statement.***

PRIVACY POLICY: I have been made aware of the privacy policy of Lykos Medical LLC and have received (or reviewed or been given the option to receive and review) a copy of the Notice of Privacy Practices.

_____ **(Initial) I have read and agree to the above statement.**

I have read and agree to the above information and I, the undersigned (patient or POA), am ultimately responsible for the fees. By signing below, I consent to be contacted by regular mail, by email or by telephone (including a cell phone number) regarding any matter related to the above referenced account by the creditor, its successors or assigns. This consent includes any updated or additional contact information that I may provide and includes contact that employs auto-dialer technology and/or prerecorded messages.

PRINT NAME_____

SIGNATURE _____ DATE _____

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Colorado Medical Orders for Scope of Treatment (*MOST*)

- **FIRST follow these orders, THEN contact Physician, Advanced Practice Nurse (APN), or Physician Assistant (PA), for further orders if indicated.**
- These Medical Orders are based on the person's medical condition & wishes.
- Any section not completed implies full treatment for that section.
- May only be completed by, or on behalf of, a person 18 years of age or older.
- **Everyone shall be treated with dignity and respect.**

Last Name		
First Name/Middle Name		
Date of Birth		Sex
Hair Color	Eye Color	Race/Ethnicity

A — Check One Box Only

CARDIOPULMONARY RESUSCITATION (CPR) **Person has no pulse and is not breathing.**

☐ **No CPR** Do Not Resuscitate/DNR/Allow Natural Death

☐ **Yes CPR** Attempt Resuscitation/ CPR

*When not in Cardiopulmonary arrest, follow orders **B**, **C**, and **D***

B — Check One Box Only

MEDICAL INTERVENTIONS **Person has pulse and/or is breathing.**

☐ **Comfort Measures Only:** Use medication by any route, positioning, and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort.
Do not transfer to hospital for life-sustaining treatment.
Transfer only if comfort needs cannot be met in current location; **EMS**-Contact medical control.

☐ **Limited Additional Interventions:** Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. ***Transfer*** *to hospital if indicated. Avoid intensive care;* **EMS**-Contact medical control.

☐ **Full Treatment:** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
Transfer *to hospital if indicated. Includes intensive care.* **EMS**-Contact medical control.

Additional Orders: _____ (**EMS=*Emergency Medical Services***)

C — Check One Box Only

ANTIBIOTICS

☐ No antibiotics. Use other measures to relieve symptoms.

☐ Use antibiotics when comfort is the goal.

☐ Use antibiotics.

Additional Orders: _____

D — Check One Box Only

ARTIFICIALLY ADMINISTERED NUTRITION AND HYDRATION

*******Always offer food & water by mouth if feasible********

☐ No artificial nutrition/hydration by tube. **(NOTE: Special rules for *proxy by statute* on page 2)**

☐ Patient has executed a "Living Will" ☐ Patient has not executed a "Living Will"

☐ Defined trial period of artificial nutrition/hydration by tube.
(Length of trial: _____ Goal:_____)

☐ Long-term artificial nutrition/hydration by tube.

Additional Orders: _____

E — Check All That Apply

DISCUSSED WITH:

☐ Patient

☐ Agent under Medical Durable Power of Attorney

☐ Proxy (per statute C.R.S. 15-18.5-103(6))

☐ Guardian

☐ Other:_____

(SECTION RESERVED FOR FUTURE USE)

SUMMARY OF MEDICAL CONDITION(S):

Physician/APN /PA Signature (mandatory)	**Print Physician/APN/PA** ***Name, Address and Phone Number***	**Date**
Colorado License #:		

HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

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Record Release Form

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Name of Patient: _____

Date of Birth: _____ SSN: _____

I authorize the following party (previous medical provider):

_____

to disclose:

- All of my health information
- My health information relating to the following treatment or condition:

  _____

to the folllowing party:

Lykos Medical LLC, 7610 N Union Blvd, #150, Colorado Springs CO 80920

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The purpose of this authorization is (check all that apply):

- At my request
- Other: _____

This authorization ends: _____

My Rights:

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature : _____ Date: _____

Printed Name: _____

Relationship to Patient: _____

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Personal Health Tracker

Facility Nurse _____ Provider: _____
Lab Day: _____ Provider Visit Day: _____
Significant Events:

_____
_____
_____
_____
_____
_____
_____
_____

Allergies: _____

Current Medications:

Name:	Dose:

Past Medications:

Name:	Dose:

Chronic Medical Conditions:

_____
_____
_____
_____

Medical Equipment Needs:

_____
_____
_____
_____

Surgeries:

_____
_____
_____

Other Notes:

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Lykos Medical, LLC HIPAA Compliance Policy

Lykos Medical, LLC has adopted this General HIPAA Compliance Policy in order to recognize the requirement to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the Health Information Technology for Economic and Clinical Health ("HITECH") Act of 2009 (Title XIII of division A and Title IV of division B of the American Recovery and Reinvestment Act ("ARRA") and the HIPAA Omnibus Final Rule (Effective Date: March 26, 2013). We acknowledge that full compliance with the HIPAA Final Rule is required by or before September 23, 2013.

Lykos Medical, LLC hereby acknowledges our duty and responsibility to protect the privacy and security of Individually Identifiable Health Information ("IIHI") generally, and Protected Health Information ("PHI") as defined in the HIPAA Regulations, under the regulations implementing HIPAA, other federal and state laws protecting the confidentiality of personal information, and under principles of general and professional ethics. We also acknowledge our duty and responsibility to support and facilitate the timely and unimpeded flow of health information for lawful and appropriate purposes.

Scope of Policy

This policy governs overall HIPAA compliance for Lykos Medical, LLC. All personnel of Lykos Medical, LLC must comply with this policy. Demonstrated competence in the requirements of this policy is an important part of the responsibilities of every member of the workforce.

Officers, agents, employees, contractors, temporary workers, and volunteers must read, understand, and comply with this policy.

Assumptions

Lykos Medical, LLC hereby recognizes its status as a Covered Entity under the definitions contained in the HIPAA regulation.
Lykos Medical, LLC must comply with HIPAA and the HIPAA implementing regulations, in accordance with the requirements at 45 CFR Parts 160 and 164, as amended.
Full compliance with HIPAA is mandatory and failure to comply can bring severe sanctions and penalties. Possible sanctions and penalties include, but are not limited to: civil monetary penalties, criminal penalties including prison sentences, and loss of revenue and reputation from negative publicity.
Full compliance with HIPAA strengthens our ability to meet other compliance obligations, and will support and strengthen our non-HIPAA compliance requirements and efforts.
Full compliance with HIPAA reduces the overall risk of inappropriate uses and disclosures of Protected Health Information (PHI), and reduces the risk of breaches of confidential health data.
The requirements of the HIPAA Administrative Simplification Regulations (including the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules) implement sections 1171-1180 of the Social Security Act (the Act), sections 262 and 264 of the Public Law 111-5, and section 1104 of Public Law 111-148.

Notice of Change in Healthcare Provider

To: _____ (provider name)

This letter serves as a notice of change in healthcare providers.

I, _____ , have chosen to move to a new healthcare provider and would like to discontinue services with the provider named above.

Thank you for your care and respect in this decision. Please see the attached record request, if applicable.

_____
Printed Name

_____ _____
Signature Date

_____
Name of individual, if other than the patient

_____
Relationship to patient