PLEASE ONLY USE BLUE OR BLACK INK

Dear Patient,

Welcome to Rocky Mountain Movement Disorders Center, P.C. and thank you for scheduling your appointment with us. Our mission is to provide the highest quality, most state-of-the-art care for all patients and families affected by movement disorders. The road to improving your quality of life begins here.

Please fill out the forms provided in this packet and bring them with you to your first appointment. Along with these forms, please plan to bring the following items with you to your appointment:

- Insurance card(s) - Including your Medicare and Medicaid cards, if applicable
- Driver's license or state photo ID card
- Payment for your visit co-pay, if applicable
- All original medication bottles for medications currently prescribed*
- If available, Power of Attorney (POA) and/or Advanced Directive forms

If you have not already sent the following items or provided the information to our office, please plan to do so at the time of your appointment:

- Primary care physician's full name, address, telephone, and fax numbers
- Referring physician's full name, address, telephone, and fax numbers
- MRI reports and films/CD's; CT reports and film/CD's
- Any other reports pertaining to your care

***Very Important:** Do **NOT** bring your own medication list. Please fill out the medication list our office has provided for you in this new patient packet. This form is specifically designed to aid our providers in providing you the best possible care.

If you have questions or concerns regarding any of the requested documents, anything pertaining to your new patient packet, or if you have general questions regarding our practice, please do not hesitate to call our office prior to your appointment. You may also visit our website at www.movementdisorderscenter.org to learn more about our clinic and our staff.

Sincerely,

RMMDC Providers, Management, & Staff

ROCKY MOUNTAIN
MOVEMENT DISORDERS CENTER

Rajeev Kumar, M.D.
Medical Director

Victoria Segro, MSN, C-ANP
Nurse Practitioner

Sarah Robbins, MSN, ACNP-C
Nurse Practitioner

Josette Pressler, LPN
Clinical Nurse Supervisor

Peyton Mills, BSN, RN
Clinical Nurse

Jessica Jaynes, BS, CCRC
Karen Ortiz, CCRC
Research Supervisors

Janell DeGiorgio, MA, CCRC
Liza Heap, BS, BA, CCRC
Scott Rubinstein, MSc, CCRC
Beth Capozzi, CCRC
Research Coordinators

Kate Greenly, MS
Junior Research Coordinator
Genetic Counselor

Melanie Patton, BS
Junior Research Coordinator

Huntington's Disease Society of America
Center of Excellence

Huntington's Disease Society of America

701 East Hampden Avenue
Suite 510
Englewood CO 80113-2759
(303) 357-5455 Phone
(303) 357-5459 Fax
www.movementdisorderscenter.org

Rocky Mountain Movement Disorders Center, P.C.

701 E. Hampden Ave Ste 510 Englewood CO 80113
Phone (303) 357-5455 Fax (303) 357-5459

Patient Demographic Information

Patient Name: _____ DOB: _____ Gender: M F

Social Security #: _____ - _____ - _____ Marital Status: _____

Mailing Address: _____

City: _____ State:_____ Zip Code: _____-_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

(We do not sell or advertise your email address to any other firm – this is for our Patient Portal purposes.)

Primary Care Physician (PCP): _____

Address: _____

PCP Phone #: _____ PCP fax #: _____

Referring Physician: _____

Address: _____

Ref Phys Phone #: _____ Ref Phys fax #: _____

Pharmacy: _____ Phone: _____ Fax: _____

Address: _____

Employment Status: FT PT Student Retired Unemployed Employer: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____ Cell: _____ Work: _____

Insurance Information

Primary Insurance Co: _____ ID #: _____

Group #: _____ Primary Insured's Name: __ _____

Primary Insured's DOB: _____

Secondary Insurance Co: _____ ID#: _____

Group #: _____ Secondary Insured's Name: __ _____

Secondary Insured's DOB: _____

Please read and sign the following Consent for Treatment

I hereby give my consent for health care treatment and diagnostic procedures by the physicians and other providers of RMMDC.

Signature: _____ Date: _____

Rocky Mountain Movement Disorders Center, P.C.

701 E. Hampden Ave Ste 510 Englewood CO 80113
Phone (303) 357-5455 Fax (303) 357-5459

Patient Authorization for the Use and Disclosure of Protected Health Information

I hereby give my consent to Rocky Mountain Movement Disorders Center, P.C. (RMMDC) to use and disclose protected healthcare information (PHI) about me to carry out treatment, payment, and healthcare operations consistent with RMMDC's Notice of Privacy Practices.

With this consent, RMMDC may do the following:
(Please select YES or NO for each statement)

- May call Home and leave a message containing personal health information: YES NO
- May call Cell and leave a message containing personal health information: YES NO
- May call Work and leave a message containing personal health information: YES NO

I give authorization for review of my medical records to all appropriate RMMDC personnel regarding clinical research trials. (For more information, please see our receptionist for a copy of our Notice of Privacy Practices.)

Please list the individuals with whom we may communicate regarding your treatment at RMMDC (i.e. family members, caregivers, etc.). Please list alternative phone numbers for family members if necessary.

_____	_____	_____	_____
(Name)	(Mobile Phone)	(Home Phone)	(Relationship to Patient)
_____	_____	_____	_____
(Name)	(Mobile Phone)	(Home Phone)	(Relationship to Patient)
_____	_____	_____	_____
(Name)	(Mobile Phone)	(Home Phone)	(Relationship to Patient)
_____	_____	_____	_____
(Name)	(Mobile Phone)	(Home Phone)	(Relationship to Patient)

_____ _____
Patient Name (please print) Patient (or responsible party) Signature

_____ _____
Responsible Party Name & Relationship to Patient (please print) Date

Rocky Mountain Movement Disorders Center, P.C.

Notice of Privacy Practices

Effective Date: August 13, 2020

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

If you have any questions about this notice, please contact our Privacy Officer, Rocky Mountain Movement Disorders Center, P.C., 701 E. Hampden Avenue, Suite 510, Englewood CO 80113, phone: (303) 357-5455, Fax: (303) 357-5459 e-mail: info@kumarneuro.com.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research. For example, our research coordinators may review your personal health information to help them identify patients who might be suitable candidates for a research study. You may also be contacted by our office to inquire if you wish to participate in a research study.

We may also disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official

- With health oversight agencies for activities authorized by law
- For special government functions, such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Rocky Mountain Movement Disorders Center, P.C.

701 E. Hampden Ave Ste 510 Englewood CO 80113
Phone (303) 357-5455 Fax (303) 357-5459

Acknowledgment of Receipt of this Notice

Rocky Mountain Movement Disorders Center, P.C. is committed to treating and using your protected health information in a responsible manner and in accordance with applicable law. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgment, we will continue to provide your treatment and will use and disclose your protected health information as permitted by law.

I acknowledge that I have received the Notice of Privacy Practices for Rocky Mountain Movement Disorders Center, P.C.

_____

Patient Name (please print)

_____

Patient (or Authorized Representative) Signature

_____

Authorized Representative & Relationship to Patient (please print)

_____

Date

Rocky Mountain Movement Disorders Center, P.C.

701 E. Hampden Ave., Suite 510 Englewood, CO 80113

Financial Policy/Consent for Payment

Rocky Mountain Movement Disorders Center ("RMMDC") is committed to providing you with quality neurological care. Your clear understanding of our Financial Policy/Consent for Payment is important to our professional relationship.

It is your responsibility to provide our office with current insurance information. Your insurance policy is a contract between you and the insurance carrier. Your coverage, the requirements for co-payments, co-insurance, and any deductibles, are all defined in your policy. Because insurance plans vary considerably, we cannot predict which services will or will not be covered by your policy. RMMDC will file claims with your insurance carrier for services that we provide to you. You will be responsible for any remaining unpaid portions of our invoices**. <u>You are ultimately responsible for the timely payment of your account.</u>**

You are responsible for co-payments, co-insurance amounts, and any in/out-of-network deductibles that you may owe under the terms of your insurance policy. You are also responsible for any referrals and pre-authorizations required by your insurance carrier(s). An authorization, pre-certification, or verification of eligibility is not a guarantee of payment.

It is the policy of RMMDC to hold a valid credit card number on file to cover the unpaid patient responsibility portion of your account. RMMDC may automatically bill your credit card for unpaid account balances over ninety (90) days old. If you fail to comply with this policy, you may be denied treatment or care by RMMDC.

RMMDC accepts payments by cash, check, Visa, Mastercard, Discover, and American Express.

Hospice Patients

If you are currently under hospice care, please be advised that unless you have pre-arranged the visit to our clinic with your hospice provider, your visit will not be covered by your insurance policy and you will be personally responsible for all charges incurred.

Payment Arrangements and Expectations

Co-payments must be paid at the time you check in for your appointment. If you are self-paying for your visit, RMMDC will collect payment in full at the time you check out for all services provided to you during your visit.

In the event you need to make special payment arrangements, our policy is to collect payment in full within ninety (90) days. If you have a question about your account balance or would like to discuss a payment plan arrangement, please contact our billing department at 303-867-5475. If your account becomes delinquent and we are unable to collect your debt, we may transfer your account to an outside collection agency. Should your account be transferred to a collection agency, you will be responsible for any associated collection fees, and you may also be discharged from treatment and care from RMMDC.

No-Show, Cancellation and Administrative Fees

Please help us serve you better by keeping scheduled appointments. In the event you are unable to keep your appointment, please call and cancel at least forty-eight (48) hours before your scheduled appointment. Patients who give less than forty-eight (48) hours' notice will be charged a $100.00 missed appointment fee. Patients who fail to show up at their scheduled appointment time and do not notify us ahead of time will be charged $150.00 no show fee. This charge is the responsibility of the patient and is not covered by any insurance carrier. We realize that it is not always possible to give us the requisite notice and will consider individual cases.

Our office also charges the following Administrative Fees:

- Returned Checks: $30.00
- Completion of Disability or other Forms: $75.00
    - Additional Form Requests: $50.00
- Copies of Medical Records: Fees provided upon request

Patient Agreement and Signature

By my signature below, I acknowledge that that I have read and fully understand and agree to the Financial Policy/Consent for Payment above. To the best of my knowledge, the financial and insurance information provided by me to RMMDC is true and correct. I understand that I am responsible to pay in full for all services rendered by RMMDC, including reasonable attorney fees and cost of collection in the event of account default. I also authorize RMMDC to furnish or obtain any/all personal health or insurance information to/from insurance carriers, Social Security Administration (Medicare), and other third-party payers for purposes of processing my insurance claims and collecting payment. I hereby assign all benefits to RMMDC for all of my insurance claims related to services provided to me by RMMDC and authorize my insurance carrier(s) to send claim payments directly to RMMDC. I agree that a photocopy of this agreement shall be as valid as the original.

_____ _____

Patient Name (Please Print) Patient (or responsible party) Signature

_____ _____

Responsible Party Name/Relationship to Patient (Please Print) Date

Rocky Mountain Movement Disorders Center, P.C.
701 E Hampden Ave, Ste 510
Englewood CO 80113

MEDICATION LIST

Please write the quantity of tablets taken at each time frame

(i.e. 2 tablets taken at 8:00 AM - note the number 2 in the 8 AM box)

Rajeev Kumar, M.D.
Vicki Segro, MSN, C-ANP
Sarah Robbins, MSN, ACNP-C
Phone (303)357-5455
Fax (303)357-5459

Patient Name_______________________________________

Date of Birth______________________________

Date__________________________________

Please fill out all *non-prescription* drugs and supplements on the back of this form.

Pharmacy Information	**Local:**							**Mail Order:**																		
Prescription Medication	**Strength**	**Form**	**12AM**	**1AM**	**2AM**	**3AM**	**4AM**	**5AM**	**6AM**	**7AM**	**8AM**	**9AM**	**10AM**	**11AM**	**NOON**	**1PM**	**2PM**	**3PM**	**4PM**	**5PM**	**6PM**	**7PM**	**8PM**	**9PM**	**10PM**	**11PM**
Example	40mg	capsule									2				1								1			
List all medications prescribed by our office first																										

Rocky Mountain Movement Disorders Center, P.C.
701 E Hampden Ave Ste 510
Englewood CO 80113

Rajeev Kumar, M.D.
Vicki Segro, MSN C-ANP
Sarah Robbins, MSN, ACNP-C
Phone (303)357-5455
Fax (303)357-5459

Non-Prescription Drugs and Vitamins/Supplements

Vitamins/Supplements	**Strength**	**Form**	12AM	1AM	2AM	3AM	4AM	5AM	6AM	7AM	8AM	9AM	10AM	11AM	NOON	1PM	2PM	3PM	4PM	5PM	6PM	7PM	8PM	9PM	10PM	11PM

Rocky Mountain Movement Disorders Center, P.C.
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(303) 357-5455 Phone (303) 357-5459 Fax

Patient Medical History

Name: _____ DOB: ____/____/_____

Occupation: _____ Retired (***Y/N***): _____

Have you left your job due to Disability? (***Y/N***): _____ Date of Disability: ___/___/___

Dominant Hand (*please check one*): Right _____ Left _____

Reason for today's visit: _____

_____

_____

Allergies to Medications (*describe reaction*): _____

_____

---

*Please check any of the following **medical diagnoses** you have or have had in the past:*

Medical Diagnosis	**√**	**Date of Diagnosis**	**Medical Diagnosis**	**√**	**Date of Diagnosis**
Diabetes			High Blood Pressure		
Liver Disease			Heart Attack		
Kidney Disease			Other Heart Disease		
Asthma			Stroke		
Other Lung Disease			Seizure		
Sleep Apnea			Head injury with loss of consciousness		
Encephalitis/Meningitis			Other not listed:		

*Please complete below section if you have or have had a **diagnosis of cancer**:*

Date of Diagnosis: ____/____/____ Type: _____

Details of Treatment: (e.g. Surgery/chemotherapy/radiation)

_____

_____

Is the cancer cured with no current evidence of residual cancer? **Yes/No** (*please circle one)*

---

*Please check any of the following **psychiatric history** diagnoses you have or have had in the past:*

Psychiatric Diagnosis	**√**	**Date of Diagnosis**
Depression		
Bipolar Disorder		
Anxiety Disorder		
Schizophrenia		
Psychogenic Movement Disorder		
Suicide Attempt		

Any psychiatric hospitalization? **Yes/No** (*please circle one*)

Other: _____

_____

_____

Please use blue/black pen to fill out

Rocky Mountain Movement Disorders Center, P.C.
701 East Hampden Avenue Suite 510 Englewood CO 80113
(303) 357-5455 Phone (303) 357-5459 Fax

*Please check all **prior surgeries** and include dates:*

Medical Procedures	**√**	**Date of Surgery**	**Medical Procedures**	**√**	**Date of Surgery**
Gall Bladder Removal			Knee Surgery [Right or Left]		
Appendix Removal			Hip Surgery [Right or Left]		
Tonsil Removal			Shoulder Surgery [Right or Left]		
Cataract Surgery			Cervical spine (neck)		
Heart Surgery			Lumbar Spine (low back)		
Bladder Surgery			Brain Surgery		
Hysterectomy			Other Surgeries:		
Prostate Surgery					

*If there is anything else you want to tell us about your medical history, please do so here:*_____

_____

_____

Family History

Please list all family medical conditions – If the family member is deceased, please state age of death and cause of death:

Father	_____ _____
Mother	_____ _____
Sisters	_____ _____
Brothers	_____ _____
Children	Do you have any children? **Yes/No** (*please circle one)* *List names and ages of children:* _____ _____

Please list details if there is anyone in your immediate family with neurologic conditions such as Huntington's Disease, Parkinson's disease, ALS (Lou Gehrig's Disease), cerebellar ataxia, dementia, tremor, dystonia, tics, Tourette syndrome, restless legs syndrome, or other movement disorders? **Yes/No** (please circle one): _____

_____

_____

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Social History

Marital Status: _____

Do you smoke? Yes: ___ No: ___ Quit: ___ Packs per day: _____ How long? _____

Do you drink alcohol? Yes: ___ No: ___ Quit: ___ Amount and frequency: _____

Do you use marijuana? Yes: ___ No: ___ Quit: ___ Amount and frequency: _____

Do you currently or have you in the past used other drugs such as cocaine, amphetamines, methamphetamines, LSD, barbiturates? _____

Provide the name, phone # and fax # for each provider to whom you would like us to send the report:

_____

_____

_____

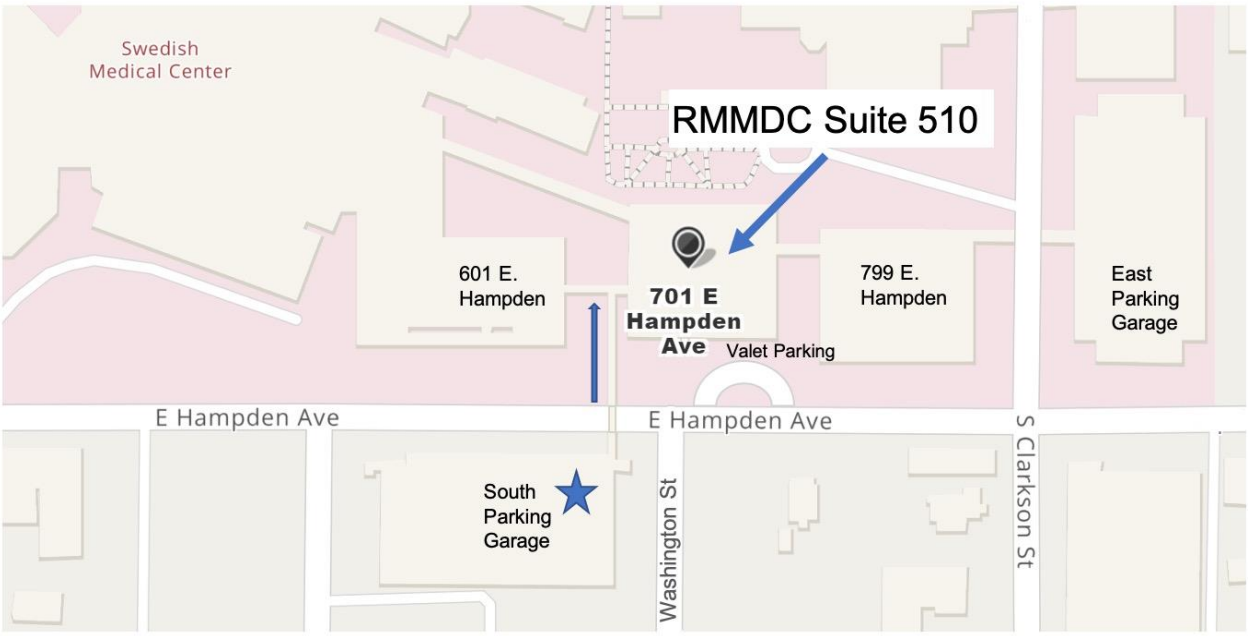
_____

Rocky Mountain Movement Disorders Center, P.C.
701 East Hampden Avenue Suite 510 Englewood CO 80113
(303) 357-5455 Phone (303) 357-5459 Fax

Review of Symptoms Form

1. Eyes, Ears, Nose
    a. Change in vision **Yes No**
    b. Double vision **Yes No**
    c. Runny nose **Yes No**
    d. Nose bleeds **Yes No**
    e. Hearing problems **Yes No**
    f. Change in voice **Yes No**
2. Cardiovascular
    a. Chest pain **Yes No**
    b. Shortness of breath **Yes No**
    c. Fainting/blackout spell **Yes No**
    d. Palpitations **Yes No**
    e. Leg swelling **Yes No**
3. Gastrointestinal
    a. Abdominal pain **Yes No**
    b. Heartburn **Yes No**
    c. Difficulty swallowing **Yes No**
    d. Vomiting/nausea **Yes No**
    e. Constipation/diarrhea **Yes No**
    f. Blood in stool **Yes No**
4. Genito-urinary
    a. Urgency of urination **Yes No**
    b. Frequency of urination **Yes No**
    c. Urinary incontinence **Yes No**
    d. Erectile dysfunction **Yes No**
5. Musculoskeletal
    a. Joint pain **Yes No**
    b. Joint swelling **Yes No**
    c. Muscle pain **Yes No**
6. Hematologic/lymphatic
    a. Swollen glands **Yes No**
    b. Bleeding **Yes No**
7. Neurologic
    a. Headaches **Yes No**
    b. Seizures **Yes No**
    c. Numbness/tingling **Yes No**
    d. Weakness **Yes No**
    e. Balance problems **Yes No**
    f. Tremor **Yes No**
    g. Abnormal gait **Yes No**
8. Skin/hair
    a. Rashes **Yes No**
    b. Hair loss **Yes No**
    c. Itching **Yes No**
    d. Change in skin spots **Yes No**
9. Psychiatric
    a. Anxiety **Yes No**
    b. Depression **Yes No**
    c. Other psychiatric illness _____ **Yes No**
10. Endocrine
    a. Fatigue **Yes No**
    b. Weight loss/gain **Yes No**
11. Sleep
    a. Snoring **Yes No**
    b. Daytime sleepiness **Yes No**
    c. Morning headache **Yes No**
    d. Insomnia **Yes No**
12. Pulmonary
    a. Shortness of breath **Yes No**
    b. Cough **Yes No**
    c. Wheezing **Yes No**
13. Mental Health
    a. Alcohol abuse **Yes No**
    b. Substance abuse **Yes No**
    c. Memory problems **Yes No**
    d. Confusion **Yes No**
14. General
    a. Change in weight **Yes No**
    b. Fever/chills **Yes No**
    c. Night sweats **Yes No**
    d. Fatigue **Yes No**

Parking Information



** <u>Complimentary Valet Parking at:</u>

701 E. Hampden Avenue
Englewood, CO 80113

- Available Monday Through Friday
- 7:00 AM – 5:00 PM

** <u>Complimentary Self-Parking at:</u>

<u>South Parking Garage:</u>

(Across from the Main Hospital Entrance)

The South garage is located on Old Hampden Avenue and South Washington Street, with the entrance on Washington. It offers a covered walkway from the second floor of the structure, over the street, and into the 701 E. Hampden Medical Office Building.

To get to our office:

- Walk across the bridge (2nd floor of parking garage)
- Turn right into building 701
- Take the elevator up to the 5th floor
- We are in **Suite 510**