Primary Care NPs

12081 W. Alameda Parkway #438

Lakewood, CO 80228

Phone: 303-551-3643 **Fax:** 720-523-1512

Admin@stonemountainprimarycare.org

Primary Care New Client Packet

Patient Name:

____

____

Facility:____

____

Date of Birth:_____________________________________SS#___________________

Male ___ **Female**___

1) Please provide a front and back copy of Insurance cards. Please include all primary and supplemental insurances.
2) Please provide Medicare number________________________________
3) Please attach facility face sheet
4) Please attach medication records
5) Please attach any current labs or medical records.

Consent for Treatment

I, ______________________________________ so hereby voluntarily consent to treatment and care provided by Primary Care NPs . This care may encompass nursing, routine diagnostics and routine medical care. This form has been explained to me and I understand the contents.

Signature of Patient or Power of Attorney ___________________________________

Date:_____________________________________

HIPPA

This notice of Privacy Practices describes how we my use and disclose your protected health information to carry out your treatment, payment or health care operations, and only for other purposes that are permitted or required by law. This includes coordination of your health care with a third party. Your protected health information will be used as needed to obtain payment for your health care services. These rights became effective April 14, 2013. We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to thi form, please ask to speak with our HIPAA compliance officer by phone. Your signature below is only acknowledgement that you have receive this notice of our Privacy practices.

Print Name: ____

Signature:

____Date:___________________

Chronic Care Management Consent

Medicare is offering a new benefit for beneficiaries with multiple chronic conditions, and by consenting to this agreement, you allow **Primary Care NPs** to provide chronic care management services to you. CCM services are only available to patients with two or more chronic conditions. Medicare defines a chronic condition as a condition that is expected to last for at least 12 months, and that increases the risk of death, acute exacerbation of disease, or a decline in function.

Benefits of CCM Services include: • 24/7 access to a care provider to help with your chronic healthcare needs • A comprehensive plan of care for health needs, available on paper or electronically • Coordination with both home and community-based service providers • Transition management among health care providers, including referrals, and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities • Medication oversight and management • Use of a certified electronic health record (EHR) as mandated by Medicare Should you desire to receive CCM services through your provider, he/she agrees to only bill Medicare for CCM services once per 30-day billing cycle. Furthermore, your provider agrees only to bill Medicare for CCM services if you have more than one chronic condition. Beneficiary Acknowledgment and Agreement By signing this agreement, you agree to the following terms: • You consent to your provider providing CCM services to you. • You certify that your provider has fully explained the scope of CCM services to you. • You acknowledge that only one practitioner can furnish and be paid for CCM services during a calendar month. • You authorize electronic communication of your medical information between treating providers as part of your care. • You understand that CCM services are subject to Medicare Co-Insurance, and so you may be billed for a portion of the CCM services. • You understand that you have the right to terminate CCM services at any time by revoking this agreement effective at the end of the then-current month. You may revoke this agreement verbally by notifying Stone Mountain Primary Care by telephone at (303-551-3643), or by emailing your written revocation to Admin @stonemountainprimarycare.org.

Beneficiary/Responsible Party Signature: ________________________________

Print Name: ____ **Date:** ___________________

TELEMEDICINE CONSENT

1. I understand that my health care provider, Primary Care NPs has recommended to me that I engage in a telehealth appointment with a provider.

2. My health care provider has explained to me how the telehealth technology will be used to connect me with a provider. Telehealth appointments may be conducted by videoconferencing, video images, still (high quality photo) images, or by telephone conference. I understand that this appointment will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider. I understand that the health care provider may use devices such as a stethoscope or otoscope or other peripheral devices to assist in the examination.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telehealth appointment if it is felt that the videoconferencing connections are not adequate for the situation. I understand that I can discontinue the telehealth appointment at any time

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the appointment other than my healthcare provider and specialty health care provider in order to operate the equipment. The above mentioned people will all maintain confidentiality of the information obtained.

I further understand that I will be informed of their presence during the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telehealth examination room; and/or (3) terminate the telehealth appointment at any time. 5. I have had the alternatives to a telehealth appointment explained to me, and in choosing to participate in a telehealth appointment, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the specialty health care provider or the primary care provider. 6. In an emergency situation, I understand that the responsibility of the telehealth specialist or provider may be to direct me to emergency medical services, such as emergency room. Or the telehealth provider may discuss with and advise my local provider. The telehealth specialist's or provider's responsibility will end upon the termination of the telehealth connection. 7. I understand that billing for the telehealth consultation may occur from 1) the primary care provider and 2) telehealth provider, and 3) as a facility fee from the site from which I am presented. Billing is at the discretion of the provider. Billing procedures will be explained to me. 8. I have read this document carefully, and understand the risks and benefits of the telehealth appointment and have had my questions regarding the procedure explained and I hereby consent to participate in a telehealth appointment visit under the terms described herein.

Patient/Guardian signature Date:____