Patient Registration Form

Date: _____/_____/_____ Physician Name: _____ Account No:_____

Have you or any member of your family been seen by a Keystone provider before? ❑ Yes ❑ No

If yes, please list name of patient(s): _____

How did you hear about us? ❑ Friend/Family ❑ Radio ❑ TV ❑ Internet ❑ Newspaper/Magazine ❑ Other: _____

Patient's Name:_____ SSN: _____ Sex: ❑ M ❑ F

Date of Birth:_____/_____/_____ Age:_____ Former Names_____

Home Address: _____ Home Phone:(_____)_____

City_____ State_____ Zip_____ Work Phone: (_____)_____

Email: _____ Cell Phone: (_____)_____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Legally Separated ❑ Widowed ❑ Significant Other ❑ Life Partner ❑ Unknown

Preferred Language: _____ Race/Ethnicity_____

Primary Care Physician: _____

Employment status:

❑ Full-Time ❑ Part-Time ❑ Unemployed ❑ Retired ❑ Self Employed ❑ Full-Time Student ❑ Part-Time Student

Patient's Employer:_____ Work Phone: (_____)_____

Occupation: _____ Retirement Date: _____/_____/_____

Responsible Party: _____ Relationship: ❑ Self ❑ Spouse ❑ Parent ❑ Child

Address (if different than above): _____ Home Phone:(_____)_____

City:_____ State:_____ Zip:_____ Work Phone: (_____)_____

SSN: _____ DOB: _____/_____/_____ Cell Phone: (_____)_____

Employer:_____ If patient is a minor, are parents: ❑ Married ❑ Divorced ❑ Separated ❑ Never Married

Parent responsible for providing child's insurance:_____

Parent responsible for payment of medical expenses not covered by insurance: _____

Emergency Contact 1

Name:_____ Relationship to patient: _____

Address:_____ City_____ State_____ Zip_____

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____

Emergency Contact 2

Name:_____ Relationship to patient: _____

Address:_____ City_____ State_____ Zip_____

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____

Insurance information – Please present insurance cards and photo ID for copying and complete the following:

Primary Insurance Company: _____ Subscriber/Member No: _____

Subscriber Name: _____ Subscriber Date of Birth: _____/_____/_____

Group No: _____

Subscriber Address:_____ City_____ State_____ Zip_____

Patient relationship to subscriber: ❑ Self ❑ Spouse ❑ Domestic Partner ❑ Child ❑ Other: _____

Subscriber's Employer: _____ Policy Effective Date: _____/_____/_____

Secondary Insurance Company: _____ Subscriber/Member No: _____

Subscriber Name: _____ Subscriber Date of Birth: _____/_____/_____

Group No: _____

Subscriber Address:_____ City_____ State_____ Zip_____

Patient relationship to subscriber: ❑ Self ❑ Spouse ❑ Domestic Partner ❑ Child ❑ Other: _____

Subscriber's Employer: _____ Policy Effective Date: _____/_____/_____

Consent to Medical Care and Patient Services Agreement

Patient Name: _____ Date of Birth: _____/_____/_____

Provider: _____

1. **Consent to Medical Care.** I consent to and authorize the physicians, nurses and other health care providers at Keystone Health, and their respective affiliated entities (individually, as applicable, and collectively, "Keystone," and such providers, "Providers"), acting within the scope of their licenses, to perform such tests (including, without limitation, blood draws, lab tests, and x-rays), examinations, procedures and treatments as: (i) Patient's Providers deem necessary or advisable to determine Patient's health and/or to diagnose and treat Patient's disease, injury, pain, discomfort and/or dysfunction; and (ii) are routinely performed with respect to an initial or follow-up visit to an outpatient clinic or an admission to an acute care hospital, including, without limitation, responding to emergency medical conditions (collectively, "Routine Procedures"). With respect to Routine Procedures, and except in cases of emergency that prevent immediate discussion, I understand that Patient's Providers will discuss with me Patient's condition, the proposed treatment, alternative treatments and non-treatment, and the likelihood of success, risks, benefits, and side effects of the proposed treatment, alternative treatments and non-treatment (collectively, "Procedure Information"). I will immediately let Patient's Providers know if I have unanswered questions regarding the Procedure Information, if the Procedure Information was not presented in an understandable way, or if in light of the Procedure Information, I no longer consent to the test, examination, procedure or treatment in question. I further understand that prior to any test, examination, procedure or treatment being performed on Patient that goes beyond a Routine Procedure (a "Non-Routine Procedure"), I will be presented with an additional consent form to execute, and that I will have the right and opportunity to withhold my consent to such Non-Routine Procedure. Although I expect the care given Patient will meet customary standards, I understand that there are no guarantees concerning the result of Patient's care. I assume full risk and responsibility and release Keystone and Providers from responsibility for things that may go wrong if Patient does not receive the medical care and treatment recommended to me.

2. **Assignment of Payments from Insurance for Services.** I hereby assign to Keystone the right to receive directly all payments otherwise payable to me or for my benefit in connection with all medical treatment and/or services provided by Keystone. I authorize all payors to make all payments directly to Keystone. This is only a limited assignment of any right to payment I may have. By making such assignment, I in no way obligate or require Keystone to perform any contractual obligations I may have in connection with such payment. This assignment is the only assignment I am making to Keystone and, in the event of a conflict from any other document, is the controlling assignment between Keystone and me, including, but not necessarily limited to, any assignment of benefits contained on my insurance benefits card. Notwithstanding this assignment of payment and any other plan or benefits card provision to the contrary, I specifically acknowledge and agree that I am personally liable for the medical treatment and/or services provided by Keystone, its employees, agents, independent contractors, or physicians as detailed below. If a Third Party Payor, including but not limited to, an insurer or ERISA plan, does not fully reimburse Keystone for the care I receive, I specifically acknowledge and independently agree that I am liable for any balance owing, including any costs and attorney fees.

3. **Financial Policy.** I agree to abide by the financial policies relating to my payment obligations for medical care received by Patient. I further understand and agree that I am financially responsible for payment of all charges incurred which are not paid by any Third-Party Payors. Non-covered services may also include those services Patient's Providers determine to be medically necessary, but are determined unnecessary by the applicable Third-Party Payors.

4. **Trainees.** I understand that certain individuals at Keystone are in training to become Providers and that such individuals may observe, and within the bounds of applicable law, may assist in Patient's care as part of their education, and I consent to such observation and assistance.

5. **Filming and Observers.** I consent to Keystone taking photographs, recording video, and preparing drawings and other graphic materials of Patient and any of Patient's treatments and procedures for scientific, educational, and training purposes; provided, Patient's identity is not revealed by such media or by any descriptive text accompanying them. I further consent to Keystone taking photographs, recording video, and preparing drawings and other graphic materials of Patient for diagnostic, treatment, and identifying purposes. In addition, I consent to the presence (whether actual or through closed-circuit television) of observers during Patient's treatments and/or procedures at Keystone, including representatives of medical equipment and device manufacturers; provided, such observers' presence is solely for scientific, educational or training purposes.

6. **Blood-Borne Pathogens Testing.** I consent to Keystone testing Patient's blood for HIV and other blood-borne pathogens in the event: (i) a Keystone employee or Provider, is exposed to Patient's bodily fluids and such exposure could result in transmission of a blood-borne disease; or (ii) any of Patient's Providers determines such testing is medically advisable.

7. **Communications.** Subject to any limitations set forth by separate document regarding disclosure of Patient's PHI, I agree that with respect to Patient's appointments, medical care, and payment for such care, Keystone and its assignees and designees, including, third-party collection agents (collectively, "Keystone Parties"), are authorized to communicate with me, through either a live person or an automated dialing system with artificial or pre-recorded voice and through a variety of media, including, through telephone calls (both to my landline and wireless phone numbers), mail, emails, and text messaging, even when I say I may incur third-party service charges for such communications.

8. **Use and Disclosure of Health Care Information.** I understand that Keystone may collaborate with or be contacted by other health care providers to coordinate, manage and provide health care to Patient, and I consent to Keystone sharing Patient's health information and records electronically or otherwise for the purposes of treatment, payment or operations, including improving the overall quality of health care services provided to Patient and other patients (e.g., avoiding unnecessary or duplicate testing, etc).

   I consent to the inclusion in Patient's electronic health records ("EHR") of sensitive diagnoses and related information such as HIV/AIDS, sexually transmitted diseases, genetic information, and mental health and substance abuse, etc. The EHR will be accessible by Keystone credentialed Providers as well as other individuals approved to access the EHR or obtain EHR information via data exchanges with the EHR for purposes related to treatment, payment, health care operations and/or other purposes permitted by the Health Insurance Portability and Accountability Act (as amended, supplemented or otherwise modified from time to time, "HIPAA"). As required by HIPAA, Keystone has implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality and integrity of Patient's information while under the control of Keystone.

   I agree that Keystone may use and disclose Patient's health information for a range of purposes, such as: treatment, eligibility verification, and/or payment to healthcare providers, regulators, Third-Party Payors or their agents, including insurance companies, managed care organizations, state and federal government programs, Workers' Compensation programs, obtaining pre-admission or continued length of stay certification, quality of care assessment and improvement activities, evaluating the performance and qualifications of Providers, conducting medical and nursing training and education programs, conducting or arranging for medical review, audit services, ensuring compliance with legal, regulatory and accreditation requirements, and public health and health oversight services.

   I consent to Keystones request for Patient's health information from Third Party Payors and other providers of care to Patient, receipt of and release of Patient's health information to or from Third Party Payors, providers of care and social service agencies, whether written, verbal, or electronic, for the uses described above. I also consent to Keystones participation in health information exchanges and other data exchanges or treatment, payment and operations, including the sharing of Patient's information electronically.

   I acknowledge that a copy of the current Keystone Notice of Privacy Practices (the "Privacy Notice") was offered to me and is available upon request. I understand that the Privacy Notice provides additional information about how Keystone may use and disclose protected health information ("PHI") and that I have certain rights to request to restrict the use of Patient's PHI.
   _____ (initials)

9. **Patient Rights and Responsibilities.** I acknowledge that the Patient Rights and Responsibilities form was offered to me and is available online and upon request. I understand this includes information about visitation rights, Advance Directives, as well as information regarding other patient rights and responsibilities. _____(initials)

10. **Duration of Consent.** For outpatient visits, this written consent shall remain valid during the duration of care from the date of Patient's/ Patient Representative's signature, unless revoked in writing.

Patient or Representative Signature:_____ Date: _____/_____/_____

Release to Obtain Medical Information

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ SSN #: _____

I request and authorize:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

to release healthcare information of the patient named above to:

Name: KEYSTONE HOUSE CALL
Address: 21 N FISHER PARK WAY
City: EAGLE State: ID Zip Code: 83616
Phone: 208.514.0670 Fax: 208.549.7880

This request and authorization applies to:

❑ Healthcare information relating to the following treatment, condition, or dates:

❑ All healthcare information

❑ Other: _____

❑ Yes ❑ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

❑ Yes ❑ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

_____ _____
Patient Name (Please Print) Relationship to Patient (if not self)

_____ _____
Patient Signature (or Responsible Party) Date

THIS AUTHORIZATION IS IN EFFECT FOR THE DURATION OF YOUR TREATMENT.

CCM Informed Consent Form

Dear Patient,

You are eligible for a new Medicare program that enables us to provide you with around-theclock service to oversee your chronic conditions and improve your overall wellness. Chronic conditions are ongoing medical problems like diabetes, high blood pressure, dementia, heart disease, depression, osteoporosis, and many others. These conditions must be managed effectively in partnership between the healthcare team and patient to maintain the best possible overall health and wellness.

What are the benefits of signing up for Chronic Care Management Services?

- Coordinate visits with your doctors, facilities, labs, radiology, or others
- Provide access to around-the-clock (24/7) services from your care team
- Assist with management of medications
- Provide a personalized and comprehensive care plan management
- Assist with scheduling preventive care services, many of which are covered by Medicare

NOTE: You must sign an agreement to receive this type of chronic care management services.

What do you need to know before signing up?

Medicare will allow us to bill approximately $42 for these services during any month that we have provided at least 20 minutes of non-face-to-face chronic care management services.

Medicare will reimburse us approximately $32 and requires you to pay approximately $8 to $9 (your Medicare co-insurance amount, may be covered by your secondary insurance) each month that you receive at least 20 minutes of chronic care management. Our office will have the record of when and how the 20 minutes were spent and you will have 24/7 access to your electronic medical record if you ever have questions.

Our practice is compliant with HIPAA and all laws related to the privacy and security of Protected Health Information (PHI). As a part of this program, your PHI may be shared between care givers directly involved with your health.

You have a right to:

Discontinue this service at any time for any reason. Because your signature is required to end your chronic care management services, please ask any of our staff members for the CCM termination form. The provider will continue providing CCM services until the end of the month and may bill Medicare for those services. After the end of the month, the provider will discontinue CCM services and no longer bill for those services to Medicare.

NOTE: Only one physician can bill for this service for you. Please let your physician or our staff know if you have entered into a similar agreement with another physician/ practice.

The goal of Keystone Medical House is to make sure you get the best care possible from everyone that is involved with your health.

I agree to participate in the Chronic Care Management program. ❑ Yes ❑ No

Print Name_____ Date_____/_____/_____

Signature _____