NEW PATIENT ADMISSION CHECKLIST

************ATTENTION FACILITY HEALTH CARE PARTNERS***********

PATIENT **REQUIRED** MEDICAL INFORMATION

- Patient Health insurance - Please include an up to date copy of all insurance cards:
  - Medicare #
  - Medicaid #
  - Supplemental Insurance #
  - Veteran Status, Military Branch and VA insurance card
- Advance Directive/Living Will/DNR Documentation
- Face-Sheet
- Current Medication List
- Most recent history and physical and or discharge summary from last PCP visit or hospital visit
- List of most recent doctors/specialized care providers
- Sequoia New Patient Admission Packet - **FULLY COMPLETED**

Please note: All of the above listed documentation must be received and fully completed PRIOR to the initial face-to-face by a Sequoia practitioner. New patients WILL NOT be scheduled until all documentation has has been received and reviewed.

Admission Form Continued

DATE:	M F O
PATIENT NAME:	HOME PHONE:
DESIRED NAME:	EMAIL(required for portal):
ADDRESS:	CELL PHONE:
SOCIAL SECURITY #:	DATE OF BIRTH:
RESPONSIBLE PARTY (Minor/Guardian):	RELATIONSHIP:

PRIMARY INSURANCE

INSURANCE COMPANY NAME:	
INSURANCE COMPANY ADDRESS:	
POLICY HOLDER NAME:	DATE OF BIRTH:
POLICY #:	GROUP #:

SECONDARY INSURANCE

INSURANCE COMPANY NAME:	
INSURANCE COMPANY ADDRESS:	
POLICY HOLDER NAME:	DATE OF BIRTH:
POLICY #:	GROUP #:

CONSENT FOR MEDICAL CARE AND TREATMENT

CONSENT TO DIAGNOSE AND TREAT: I understand that my health condition may require diagnosis and treatment the Sequoia Integrative Medical Services, LLC and its affiliates including Sequoia Health Services ALF, LLC (collectively, "Sequoia") is a family medicine practice that provides evaluation and treatment services through primary care providers. I hereby voluntarily consent to such treatment., services and procedures as ordered by my physician and/or non-physician advanced practice provider who is associated with Sequoia. Such treatments and procedures may include, but are not limited to: examinations, blood draws, laboratory analysis, monitoring, medications, and other therapies. I understand that student nurses and others in professional training programs may be among the individuals, employee, and sub contractors.

NOTICE OF PRIVACY PRACTICES: I have received the Sequoia's Notice of Privacy Practices and authorize its associates and/or designees to discuss and provide documentation of my medical history, diagnosis, treatment and prognosis as described therein. It is the policy of Sequoia not to release confidential medical information to patient's family members without the patient;s written consent, which must be provided on a separately signed form.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its consent.

_____ _____

Signature of Patient Date

_____ _____

Signature of Legal Representative/Relationship Date

HIPAA Privacy Authorization

Authorization for Use or Disclosure of Protected health Information as required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164

1. Authorization
    a. I authorize Sequoia Integrative Medical Services, LLC and their providers, to use and disclose the protective health information described below to insurance companies, other medical providers, anyone involved in my care or billing company.

2. Effective Period
    a. This authorization for release of information covers the period of healthcare from
        i. _____ to _____

    OR

        ii. All past, present, and future periods.
        PREFERRED This allows Sequoia Integrative Medical Services, LLC to access all needed medical documents throughout the entire service period of the patient.

3. Extent of Authorization
    a. I authorize the release of my complete and health record, including records relating to medical healthcare,communicable diseases, HIV or AIDS, and treatment of alcohol and drug abuse, or any other treatments (please specify).

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or purposes as I may direct.
5. This authorization shall be in effect for duration of patients care.
6. I understand that I have the right to revoke this authorization, in writing, at anytime. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of Patient Date

_____ _____
Signature of Legally Authorized Representative/Relationship Date

Power of attorney (POA) Release of Information

Must indicate financial agent if patient does not manage finances independently

1) Name: _____

_____Health Care _____Financial _____Both Health Care/Financial

_____Mental Health Records _____Alcohol/Drug abuse treatment

_____Communicable diseases (including HIV and AIDS) _____Other

Relationship to Patient: _____

Phone Number: _____

Email Address: _____

Billing Address: _____

_____ I **hereby give consent, to the person named above, to receive information regarding my medical condition and allow access to my patient portal.**

_____ _____

Signature of Patient Date

_____ _____

Signature of Legally Authorized Representative/Relationship Date

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NEW PATIENT ADMISSION QUESTIONNAIRE

****REQUIRED FOR ALL PATIENTS****

PATIENT NAME _____ **DOB** _____

FACILITY NAME _____ **RM #** _____

PHARMACY _____

PHARMACY PHONE # _____ **PHARMACY FAX #** _____

DOES THIS PATIENT HAVE A WI DNR FORM? **YES** ☐ **NO** ☐
DOES THIS PATIENT HAVE WI DNR BRACELET? **YES** ☐ **NO** ☐
DOES THIS PATIENT HAVE CERT. OF INCAPACITY? **YES** ☐ **NO** ☐

FAMILY HEALTH HISTORY

Has a family member (parents, siblings, children) had any of the conditions listed?

Diabetes_____ **Cancer**_____ **Heart Disease**_____ **High Blood Pressure** _____ **Tuberculosis** _____

Have you been hospitalized in the last 12 months? **Yes** _____ **No** _____
If yes, please list reason and date of hospitalization/s: _____
_____

PERSONAL HEALTH HISTORY

*****(PLEASE INCLUDE LIST OF DIAGNOSES)*****

	YES	NO		YES	NO		YES	NO
Heart Disease	☐	☐	Respiratory Disease	☐	☐	Difficulty Hearing	☐	☐
Thyroid	☐	☐	Mental Illness	☐	☐	ENT - Sinus/Colds	☐	☐
Seizures	☐	☐	Back Injury	☐	☐	Hepatitis/Jaundice	☐	☐
Stomach Ulcer	☐	☐	High Blood Pressure	☐	☐	Kidney Disease	☐	☐
Stomach/Gallbladder	☐	☐	Hernia	☐	☐	Chronic Pain	☐	☐
Seasonal Allergies	☐	☐	Arthritis/Gout/Joint Disease	☐	☐	Nervous Disorder	☐	☐
Vision/Eye Disorders	☐	☐	Diabetes I/II	☐	☐	Muscular Disease	☐	☐
Headaches	☐	☐	Cancer	☐	☐	Fainting/Dizziness	☐	☐

If 'yes' to any of the above, please specify _____
_____

Drug/Food Allergies: **YES** ☐ **NO** ☐

If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis):

Allergy	Reaction

Current Medications & Dosage	(If facility medication list is attached, please indicate)

SOCIAL HISTORY	YES	NO	
Do you currently smoke?	☐	☐	How long have/did you smoke? _____ Packs per day _____ If history of smoking, when did you quit? _____
Do you currently use drugs?	☐	☐	How long have/did you used drugs? _____ Quit Date? _____
Do you drink alcohol?	☐	☐	Number of drinks per week? _____ History of alcohol abuse? _____

DATE OF MOST RECENT LABORATORY RESULTS DATE: _____
PLEASE INCLUDE COPY OF RESULTS IF AVAILABLE

Bladder/Bowel Continent ☐ Incontinent ☐ Other _____

Vision Wears Glasses ☐ Does not wear glasses ☐

Hearing Hearing Aids/Devices ☐ Other _____

Mobility None ☐ Cane ☐ 4WW ☐ 2WW ☐ Manual W/C ☐ Broda W/C ☐
Transferring Device (Hoyer, EZ Stand, Etc.) _____

ADLs Independent ☐ 1 Assist with Cares ☐ 2 Assist with Cares ☐

Diet Regular ☐ Mechanical Soft ☐ Pureed ☐
Diabetic ☐ NAS/Cardiac ☐ Other _____

Current Therapy Services **Patient is receiving these services at time**

Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Skilled Nursing ☐

Service Provider/Company Name: _____

Chronic Care Management (CCM) Enrollment Informed Consent

What is CCM?

Chronic Care Management (CCM) services by a physician or non-physician practitioner (Physician Assistant [PA], Nurse Practitioner [NP], Clinical Nurse Specialist [CNS], Certified Nurse Midwife [CNM], and their clinical staff, per calendar month, for patients with multiple (two or more) chronic conditions in the last 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline. Only practitioner can bill CCM per service period (month).

- Use of a Certified Electronic Health Record (EHR)
- Continuity of Care with Designated Care Team Member
- Comprehensive Care Management and Care Planning
- Transitional Care Management
- Coordination with Home- and Community-Based Clinical Service Providers
- 24/7 Access to Address Urgent Needs
- Enhanced Communication (for example, email, or patient portal)
- Advanced Consent

Have you the patient or the acting health care agent, read the literature on CCM, agree to participate in CCM services and understands the following:

- There may be a possible copay (Refer to your insurance card for copay information)
- Patient can cancel the CCM program at any time
- Patient's Care Plan may be shared with other providers
- Only one practitioner per month can bill for the CCM service

Failure to enroll in CCM services prevents the Sequoia practitioners from managing chronic conditions "in-house" there-in leading to a greater chance of requiring out of facility appointments with specialists for appropriate management.

☐ **If Medicaid is your <u>primary</u> insurance, CCM services are an uncovered benefit. <u>Please check this box to op-out.</u>**

_____ _____

Signature of Patient Date

_____ _____

Signature of Legally Authorized Representative/Relationship Date

Patient Informed Consent for Telemedicine Services

Telemedicine involves the use of electronic communications to enable healthcare providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, sub specialists, employees, and subcontractors. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. Responsibility for the patient care will remain with the patient's medical record.

Expected Benefits:

- Improved access to medical care by enabling a patient to remain in his/her local healthcare site (i.e. home) while the physician consults and obtains test results at distant/ other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a specialist.

Possible risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, the consultant may determine that the transmitted information is of inadequate quality, thus necessitating a face to face meeting with the patient, or at least a rescheduled video consult.

Patient Informed Consent for Telemedicine Services (Continued)

By signing below, you acknowledge that you understand and agree with the following explanation of "Informed Consent"

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine, which identifies me, will be disclosed to researchers or other entities without my written consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time , without affecting my right to future care or treatment.
3. I understand the alternatives to telemedicine consultation as they have been explained to me, and I'm choosing to participate in a telemedicine consultation, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location, or at a testing facility, at the direction of the consulting healthcare provider.
4. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
5. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed assured.
6. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my healthcare provider and consulting healthcare providers order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in 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 telemedicine examination room; and/or (3) terminate the consultation at any time.

Patient Consent to The Use of Telemedicine:
I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits of the teleconferencing consultation and a telemedicine visit under the terms described herein.
By signing below, I hereby state that I have read, understood, and agree to the terms of this document.

☐ If Medicaid is your primary insurance, Telemedicine Services are an uncovered benefit please check box to op-out.

_____ _____
Signature of Patient Date

_____ _____
Signature of Legacy Authorized Representative/Relationship Date

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Remote Patient Monitoring (RPM) Consent Form

If you do not understand or agree to any or all of the information below, do not sign this agreement.

Risks & Benefits of RPM

RPM services allow your medical provider to monitor your health in between visits. This does not mean your provider will be monitoring your status 24/7. RPM may help your medical provider identify issues that require attention sooner than without RPM and allows you to communicate information to your provider without having to travel to the provider office. RPM devices rely on good cellular or bluetooth connection to transmit data, any deficiencies in connection may result in failure to transmit information.

I agree to allow Sequoia Integrative Medical Services to provide Remote Patient Monitoring (RPM) services. These services include using remote health monitoring technology to wirelessly transfer health data, including, but not limited to blood pressure, weight, blood glucose, etc. RPM also includes consultation and guidance from my medical provider, who will have access to view this data and who may communicate with my or members of my care team, including family, caregivers, guardians, etc.

I understand that:

- I am the only person who should be using the remote monitoring equipment as instructed.
- I will not use the device for reasons other than this Remote Patient Monitoring program.
- I can only participate in this program with one medical provider at a time.
- I will take my readings daily or as instructed by my medical provider as part of my participation in the program.
- My data will be electronically transmitted from the device(s) to my provider in a safe and secure manner, but that information security can never be 100% guaranteed.
- My provider will securely and confidentially store my collected data into my electronic medical record to the best of their ability, but information security can never be 100% guaranteed.

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I acknowledge that:

- RPM is NOT AN EMERGENCY RESPONSE UNIT AND IS NOT MONITORING 24/7. Call 911 for immediate medical emergencies.
- By providing my phone and email information below, i agree to opt into automated and personalized text messages and phone calls. I understand that i can opt out of the automated reminders to take readings at any time.

Financial Consent:

- My insurance will be charged monthly for this service. Co-payments may apply.
- My medical provider owns the equipment and I am responsible for returning the equipment when my participation in the RPM program has ended.
- I will not tamper with the equipment and understand that I may be responsible for any fees associated with misuse or loss of the equipment.
- I can withdraw my consent to participate in this program at any time by contacting my medical provider and returning the equipment provided to me.

I, _____, have read and understand the information and consent to participate in the Remote Patient Monitoring (RPM) program, as stated above. I am aware that this consent is valid until I withdraw it.

Date: _____ (dd/mm/yyyy)

Patient Name (Print) _____

Patient DOB (dd/mm/yyyy) _____

Authorized Person (Print) _____

Signature of Patient of Authorized Person _____

Relationship of Authorized Person _____

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Remote Patient Monitoring (RPM) Contact Information

Your Remote Patient Monitoring program includes reminders to take health measurements. Automated reminders are only sent if you do not take a reading according to your physician's instructions. You can opt out of automated reminders at any time, but still be contacted about your individual treatment plan from your medical provider.

Patient Name _____

DOB (dd/mm/yyyy) _____

Mobile Phone # _____

⬜ I do not have a mobile phone

⬜ I would like to opt out of automated text messages

⬜ I would like to opt out of automated voicemail reminders

Home Phone # _____

⬜ I do not have a home phone

⬜ I would like to opt out of automated voicemail reminders

Email Address _____

⬜ I do not have a email address