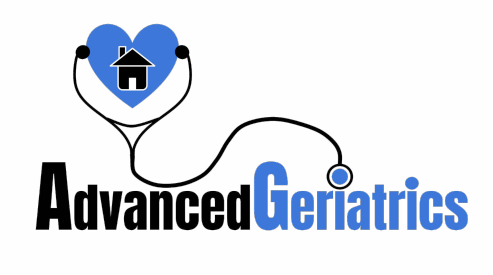

Agreement to Receive Chronic Care Management Services

As a patient with two or more chronic conditions, you may benefit from a program providing chronic care management services to Medicare patients. Chronic care management services include:

- Care management for chronic conditions, including systematic assessment of your health care needs, timely scheduling of preventive care services, and medication review and oversight;
- Access to your care team 24-hours-a-day, 7-days-a-week, including non-face-to-face access such as telephone, email, and secure messages;
- Successive routine appointments with a designated member of your care team;
- Creation of a comprehensive plan of care for your health issues;
- Management of care transitions among health care providers and settings, including referrals to other clinicians, follow -up after an emergency department visits, and follow - up after discharges from hospitals, skilled nursing facilities or other health care facilities;
- Coordination with home and community based clinical service providers

Your Rights

- As part of the chronic care management services, you will receive a copy of your comprehensive plan of care.
- You have the right to stop these chronic care management services at any time, effective at the end of the calendar month. Please contact our practice at **(315) 559-1965** to revoke your consent.

You agree and consent to the following by signing this agreement:

- You consent to **DESTA ANTHONY MOBILE NP ADULT HEALTH, PLLC** providing chronic care management services to you and billing for them.
- You acknowledge that only one provider can furnish and bill for chronic care management services for you during a calendar month. Please let us know if you have entered into a similar agreement with another practice.
- You consent to electronic communication of your health information w ith others involved in your care.
- **You understand that standard coinsurance, copays, and deductibles apply to chronic care management services, so you may be billed for these services up to once a month, whether or not you had a face-to-face meeting with your provider.**

Patient: _____

Guardian or Caregiver (if applicable): _____

Signature: _____ Date:_____

Consent to Treat and Health Care Agreement

1. Consent to Treat

I hereby consent and authorize Desta Anthony Mobile NP Adult Health to the evaluation, diagnostic procedures, testing, and treatment as directed my nurse practitioner. I understand that I may have some of these services provided under the direction of Desta Anthony, NP by nurse practitioner or nursing students affiliated with various educational programs.

2. Consent to Release Information

I acknowledge that Desta Anthony Mobile NP Adult Health, PLLC may release my protected health information as necessary for treatment, payment and health care operations and acknowledge that a Notice of Privacy Practice provides information on how my protected health information may be used and/or disclosed for these purposes. I understand that protected health information pertains to my diagnosis and/or treatment, and includes, but is not limited to, information related to my health history, diagnosis, treatment, prognosis, mental illness (excluding psychotherapy notes), use of alcohol or drugs, prescriptions and laboratory test results, including HIV.

3. Assignment of Insurance Benefits/Patient Financial Responsibility

I assign and transfer to Desta Anthony Mobile NP Adult Health, PLLC all rights, title and interest in payments from third-party payors. I understand that it is my responsibility to know my insurance benefits and whether or not the services I receive are a covered benefit. I understand and agree that I will be responsible for any deductible, co-pay or balance due that Desta Anthony Mobile NP Adult Health, PLLC are unable to collect from my third- party payor for whatever reason.

4. Medicare/Medicaid/Insurance Benefits

If I am eligible for health care benefits under any federal or state program, including, but not limited to Medicare or Medicaid, I certify that the information given by me in applying for payment under any such programs is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or Contractors any information needed for any federal or state program related claims. I request that payment or authorized benefits be made to Desta Anthony Mobile NP Adult Health, PLLC on my behalf. I understand that I am financially responsible for any deductible, co-pay or balance due under these programs.

5. Lab/X-ray/Diagnostic Services

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or diagnostic services that are not provided by Desta Anthony Mobile NP Adult Health, PLLC.

6. Consent to Photograph/Digital Imaging

I consent to photographs/digital images for treatment, and to verify identity for payment purposes. I understand that the Desta Anthony Mobile NP Adult Health, PLLC will retain the ownership rights to these photographs/digital images, but that I will be allowed access to view them or obtain copies.

7. Privacy Practices and Patient Bill of Rights

I acknowledge that I may receive a copy of the **Notice of Privacy Practices and Patients' Rights and Responsibilities** from www.mobilenp.com

Initial HERE:

→_____**Failure to provide complete insurance information may result in patient responsibility for the entire bill**.

→_____**If your insurance carrier pays you directly, you are responsible for payment and agree to forward the payment to us immediately**

Patient: _____

Guardian or Caregiver (if applicable): _____

Signature: _____ Date:_____

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth
Other Names Used (e.g., Maiden Name):	

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the Organization named above to obtain access to my medical records through the health information exchange organization called HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HealtheConnections is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HealtheConnections website at http://healtheconnections.org/ .

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for the Organization named above to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care).

☐ **2. I DENY CONSENT** for the Organization named above to access my electronic health information through HealtheConnections for any purpose, ***even*** *in a medical emergency*.

If I want to deny consent for all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections, I may do so by visiting HealtheConnections website at http://healtheconnections.org/ or calling HealtheConnections at 315.671.2241 x5.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

TELEHEALTH ACKNOWLEDGEMENT FORM

Patient's Name:_____ DOB: _____

1. I understand that my health care provider has recommended to me that I engage in a telehealth appointments when a house call is unable to be provided due to, but not limited to, isolation precautions, potential delay in care, inclement weather prohibiting travel to patient's home.

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 or Authorized Representative Signature Date

A. Notifier:
AdvancedGeriatrics

B. Patient Name: **C. DOB:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D. FEES** below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare will not pay for the **D. FEES** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
FEES PER DPC AGREEMENT	Not a covered service	$50-150

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D. Fees** listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D. Fees** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D. Fees** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D. Fees** listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.