CARE ALLIANCE

Patient Checklist for Podiatry Enrollment

Step 1:

- Complete Patient Consent for Services (including all initials)
- Complete Patient Information
- Complete HIPPA form
- Include Community Facesheet
- Include Insurance Cards copied front & back
- **Medicare # and/or Medicaid # are required before first podiatry service**
- Include most recent H&P
- Include medication list

Step 2:

- Give all documents above to nursing office in your community.

  OR

- **Fax ALL documents: 866-991-7241**

Step 3:

- Podiatry Clinics occur every 9 weeks.
- Patient list will be sent to community 2 weeks prior to clinic date, call number below to verify you're on the list or ask to be added.

Questions or concerns, please contact our business office:

952-283-3169

Leave a message and we will return your call!

7801 East Bush Lake Rd. Suite 400 | Bloomington MN | 55439

|Care Alliance Patient Consent for Podiatry Services |

*****Circle Housing Type:** Assisted Memory Care Independent Skilled/LTC

Patient Name: _____ Phone: _____

DOB: _____ Building: _____

Release of Information: *I authorize the release of any information from any agencies or carriers, including pharmacy to AHI Care Alliance for purpose of administering the medical claims and medical care. I also authorize AHI Care Alliance to release any required information to any agencies, insurance carriers or other health care providers as needed*. **(initials)_____**

Notice of Privacy Practices: *I have read and understand the facilities and/or AHI Care Alliance privacy policies regarding the handling of my protected health information. I can contact AHI Care Alliance with any questions regarding Privacy Practices, request a copy be mailed to me or find a copy on their website.* **(initials)_____**

I certify that I have not had podiatry services in the past 62 days, *and I acknowledge that I will be financially responsible if denied by my insurance.* ***(Initials)_____***

Treatment Authorization (Wound Care): *I hereby authorize AHI Care Alliance or their designee(s) to treat my or the patient's condition as they deem appropriate, including wound photographs and statistical wound measurements.* **(Initials_____)**

I understand that AHI Providers are experienced in providing health care services including exams, routine care, treatment of diagnosed conditions and preventative measures.

I understand that AHI Care Alliance will bill Medicare and other insurance carriers including Medical Assistance when possible.

I understand that I am responsible for the deductible and co-insurance amounts as set forth by my insurance carrier.

I authorize Medicare and any other insurance carriers to send payments directly to AHI Care Alliance as they will take assignments for payments.

Advanced Health Institute is committed to providing high-quality Podiatry care to the patients we serve. As such, we practice good time management activities to ensure prompt service for all. Your privacy is a priority and we will not share confidential health information with those who are not entitled to receive it. Our providers intention is to provide Podiatry care services in the privacy of your home but on occasion, you may be seen in a common area. If this occurs, the provider will do their best to provide discretion and as much privacy as possible.

Signature of Patient, Guardian, Power of Attorney or Responsible Party:
Printed Name & Relationship to Patient:
Date:

A COPY OF THIS FORM SHALL BE AS VALID AS THE ORIGINAL.

Advanced Health Institute

| Patient Information for Podiatry Services |

Patient Name:		
First	Middle	Last
Address:		Room #:
City/State/Zip:		Phone:

DOB: _____ **Sex:** (*circle one*) Male or Female or Other

Diabetic: (*circle one*) Yes or No **Primary Care Physician:** _____

Physician Ph: _____ Clinic Name: _____

Date Last Seen: _____ Pharmacy: _____

Code Status: (circle one) Full Code Do Not Resuscitate (DNR) Undecided

Billing information: Please attach copy of insurance cards

Social Security #: _____

Medicare #: _____ Medicaid #: _____

Primary Insurance: _____ ID#: _____ Group #: _____

Secondary Insurance: _____ ID #: _____ Group #: _____

Financial Responsible Party Name: _____

Phone: _____

Address:_____

City: _____State: _____ Zip Code:_____

Email: _____

HIPAA NOTICE OF PRIVACY PRACTICES FOR ADVANCED HEALTH INSTITUTE & CARE ALLIANCE

The privacy of your medical information is important to us. We understand that your medical information is personal, and we are committed to protecting it. We create a record of your care at AHI Care Alliance. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information. We make every effort to ensure that your privacy and personal medical information is protected as regulated under both HIPAA and Minnesota state laws.

YOUR RIGHTS

You have the right to request restrictions. You can request in writing restrictions on the way we handle your personal health information for treatment, payment, or health care operations. The law does not require us to agree with these restrictions. A written determination will be sent to you.

You have the right to confidential communications. We will make every effort to accommodate reasonable requests to communicate with you about your health information at an alternative location. We must have a current address and telephone number on file. It is important that you understand that bills will be sent to you at the address in your records.

You have the right to access. You have the right to receive, by written request, a copy of your personal health information that is contained in a "designated record set", with some specified exceptions. For example, if your doctor determines that your records are sensitive, we may not give you access to your records. A "designated record set" includes insurance and payment information and case or medical management records.

You have the right to amendment your health information. The Doctor will review this request with you and amend your file accordingly. Records that cannot be amended are records we did not create, records that are accurate and complete, and records complied in anticipation of a civil, criminal or administrative action or proceeding. If we deny your request to amend your records you do have the right to file a written statement of disagreement with us, and we have the right to rebut that statement.

You have the right to share information. With you written approval we will share your personal health information with other people, facilities, or companies.

You have the right to information about certain disclosures. You have the right to request in writing information about the times we have disclosed your personal health information for any purpose other than the following exceptions:

- Treatment, payment, or health care operations.
- Disclosures that you or your personal representative have authorized.
- Certain other disclosures, such as disclosures for national security purposes.

Personal Health Information includes all medical data and any information that could lead to a member's identity such as name, address, telephone number, and identification number.

OUR OFFICE POLICY AND PROCEDURE

We will not share any personal health information in your file with any person, facility, or company unless you have given your written permission. If you need a form completed, we will only mail it to you, unless you have given your written permission to have it sent or faxed elsewhere. Nothing in your file will ever be transmitted via internet or computer to any person, facility, or company. Information will only be faxed with your written permission.

- Information can be shared with health care providers (doctors, dentists, pharmacies, hospitals and other caregivers) who request it to aid in your treatment.
- Information can be shared to obtain payment. We must use and disclose your health information to determine eligibility, claims payment, utilization and management of your benefits and other services, and to respond to any complaints, appeals and external reviews.
- Information may be shared with law enforcement officers under certain conditions, or by subpoena.
- Information must be shared with Workers' Compensation insurers or their representatives.
- There are a few exceptions to disclosure of personal health information. If you would like more information on what these are you may contact:

U.S. Department of Health and Human Services
200 Independence Ave SW
Room 509F, HHH Building
Washington, DC 20201
HHS Voice Hotline1-800-368-1019

If you feel your privacy rights have been violated, you may file a written complaint with our privacy officer. Every effort will be made to ensure that your complaint is addressed promptly. A written complaint should be mailed to: **AHI Care Alliance 7801 E Bush Lake Rd. Bloomington, MN 55439.**

Signature: _____ Date: _____
Print Name:_____
Witness:_____