Patient Checklist for Primary Care/Wound Care Enrollment to AHI Care Alliance

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 primary care visit**
- Include Most Recent Health History Information
- Include Most Recent Medication List
- Include Power of Attorney and/or Health Care Directive

Step 2:

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

  OR

- **Fax ALL documents to: 866-691-8423**

Step 3:

- You will be added to the rounds list to be seen when the provider is at your building.
- Please ask your nursing office for the date of your provider visit.

If you have any further questions or concerns, please contact our business office:

952-479-4261

Leave a message and we will return your call!

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

|Care Alliance Patient Consent for Primary Care Services & Wound Care |

Circle Housing Type: Assisted Independent Skilled/LTC **Circle:** Primary Care or Wound Care (or both)

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 healthcare 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)__________**

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. I understand wound photographs without patient identifiers may be used for training, education & other purposes by AHI.* **(Initials_______)**

Patient Portal: *I authorize my healthcare representative to access my healthcare information in the Patient Portal Access in E Clinical Works and communicate with the AHI Care Team to obtain information from the Patient Portal. I understand the risks associated with online communications between my physician, myself and those authorized to communicate on my behalf.* **(Initials_______)**

Advanced Health Institute is committed to providing high-quality primary 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 health 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.

I understand that AHI Providers are experienced in providing health care services including exams, routine care, treatment of diagnosed conditions and preventative measures. I have had a chance to ask any questions and receive answers from my provider.

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.

Email Address for Patient Portal Access:
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.

Patient Information for ***Primary Care** or ***Wound Care** (*Circle One)

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: ____

|Release of Information|

Patient Name:		
First	Middle	Last
Date of Birth:	Address:	

This form Authorizes Release of Patient Information to:
AHI Care Alliance Fax 866-691-8423 Phone 952-479-4261
Mailing Address: 7801 E. Bush Lake Rd. Suite 400 Bloomington, MN 55439

Release Information from:	
Provider Name:	
Clinic:	
Phone:	**Fax:**

Information to Release:
CHECK ALL THAT APPLY

Dates/years to include: ______________________
OR

- ○ **ALL HEALTH INFORMATION**
- ○ HISTORY & PHYSICAL
- ○ LAB REPORTS
- ○ PROGRESS NOTES
- ○ MEDICATION LIST/PHARMACY DATA
- ○ SURGICAL REPORT
- ○ RADIOLOGY REPORTS
- ○ RADIOLOGY IMAGING
- ○ ER VISIT NOTES
- ○ CARE PLANS
- ○ DISCHARGE SUMMARY
- ○ IMMUNIZATIONS
- ○ BILLING RECORDS
- ○ CHEMICAL/SUBSTANCE ABUSE PROGRAM SUMMARY
- ○ MENTAL HEALTH DOCUMENTATION

OTHER: ________________________________
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I authorize & voluntarily release my health information as noted above. I understand that the disclosed information may be redisclosed and may no longer be protected by state & federal law. I understand that this authorization may be revoked by me in writing and sent to AHI Care Alliance. I understand that enrollment, payment & eligibility will not be determined or impacted by whether I consent to release of my health information or not.

Date:	**Signature of Patient or Legal Responsible Party:**

Printed Name of Patient or Legal Responsible Party: (Please include POA or Health Care Directive Documents)

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 PO Box 23175, Richfield, MN 55423.**

Signature: ______________________________ Date: ______________

Print Name:____

Witness:____