Trask Mobile Medical

~ New Patient Information and Consent Forms ~

Patient Information				
Name:	Date of Birth:	SSN:	Gender: ☐ M ☐ F	Marital Status: ☐ S ☐ M ☐ D ☐ W

Community:	Primary Phone:	☐ Home ☐ Cell	Okay to leave message?:	☐ Y ☐ N
Patient Address:	Email:			
Previous Primary Care:	Phone:	Fax:		

MPOA/Emergency Contact Information				
Medical Power of Attorney (MPOA):	Relationship to Patient:		Active? ☐ Y ☐ N	
MPOA Address:	Phone:	☐ Home ☐ Cell	Okay to leave message?:	☐ Y ☐ N
Emergency Contact: (If same as MPOA write "Same")	Relationship to Patient:			
	Phone:	☐ Home ☐ Cell	Okay to leave message?	☐ Y ☐ N

Insurance Information		
Primary Insurance Company:	Member ID:	Group Number:
Secondary Insurance Company:	Member ID:	Group Number:

Preferred Pharmacy	
Pharmacy Name	Pharmacy Address

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By signing below, I _____ (patient or MPOA name) agree to the following information:

1. The information provided is true to the best of my knowledge

2. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any remaining balance. I authorize KMTRASKPLLC or the insurance company to release information as required to process my claims.

3. I authorize the release of patient medical records to KMTRASKPLLC. I will permit all secure electronic means of transmitting my medical records. A copy of this authorization may be used in place of the original. I understand that all of my medical records will be kept confidential.

4. I consent to photography for the purpose of medical care. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law. Images that identify me will be released and/or used outside the organization only upon written authorization from me or my legal representative.

5. I acknowledge that I received and read the Notice of Health Information Practices. I understand that my healthcare provider participates in Health Current, Arizona's health information exchange (HIE). I understand that my health information may be securely shared through the HIE, unless I complete and return an Opt Out Form to my healthcare provider.

6. I acknowledge that I have been made aware of the Privacy Agreement-HIPPA and have been provided a copy, or may obtain a copy upon request by contacting (480) 590-2123.

7. A representative of KMTRASKPLLC is required to explain and inquire of every potential patient whether or not they have or do not have an active POA making medical decisions on their behalf. No evaluation or treatment will be provided without a signed consent form from the patient or the MPOA.

8. This "agreement and consent" remains valid from this day forward to include all future services relating to the patient or until cancelled in writing by the patient of their MPOA. I understand and agree that KMTRASKPLLC reserves the right to make changes to this agreement and that I (patient or MPOA) will be notified in writing prior to any changes taking effect.

_____

Patient Name

_____

Patient or MPOA Signature Date

_____

If Patient is unable to sign, state reason

Trask Mobile Medical

~ Health History ~

Patient Name: _____
DOB: _____

Any known Allergies?
☐ No ☐ Yes (please specify): _____

Past Medical History: Check all that apply		
☐ COPD/Emphysema	☐ High Cholesterol	☐ Hypertension
☐ Stroke	☐ Rheumatoid Arthritis	☐ Alcoholism
☐ Dementia	☐ HIV	☐ Seizure Disorder
☐ Seasonal Allergies	☐ Depression	☐ Hepatitis
☐ Sleep Apnea	☐ Anemia	☐ Diabetes
☐ Irritable Bowel Syndrome	☐ Anxiety	☐ Diverticulitis
☐ Lupus	☐ Thyroid Disorder	☐ Arrhythmia (irregular heartbeat)
☐ DVT (blood clot)	☐ Liver Disease	☐ Ulcerative Colitis
☐ Arthritis	☐ GERD (acid reflux)	☐ Macular Degeneration
☐ Asthma	☐ Glaucoma	☐ Neuropathy
☐ Bipolar Disorder	☐ Heart Disease	☐ Osteopenia/Osteoporosis
☐ Bladder Problems/Incontinence	☐ Heart Attack (MI)	☐ Parkinson's Disease
☐ Bleeding Problems	☐ Hiatal Hernia	☐ Peripheral Vascular Disease
☐ Cancer (please specify): _____		☐ High Blood Pressure
☐ Peptic Ulcer	☐ Headaches	☐ Kidney Stones
☐ Psoriasis	☐ Crohn's Disease	☐ Kidney Disease
☐ Pulmonary Embolism (PE)	☐ Other (please specify): _____	

Health Screening History:			
Colonoscopy	Date:	Facility/Provider:	Abnormal Result? ☐ Y ☐ N
Mammogram	Date:	Facility/Provider:	Abnormal Result? ☐ Y ☐ N
Dexa (Bone Density)	Date:	Facility/Provider:	Abnormal Result? ☐ Y ☐ N
Pap Smear	Date:	Facility/Provider:	Abnormal Result? ☐ Y ☐ N

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~ Health History ~

Patient Name: _____

List **all medications** you take, including over the counter (OTC) medications and vitamins. Include specific doses and when taken. If you do not know, please call your pharmacist to confirm.

Medication Name:	Dosage:	When Taken:

List **all prior surgeries** and approximate dates performed.

Surgery:	Date Performed:

Social / Cultural History:

Education Level: ☐ Elementary ☐ High School ☐ Vocational ☐ College

Are there any vision problems that affect ability to communicate? ☐ No ☐ Yes

Are there any hearing problems that affect ability to communicate? ☐ No ☐ Yes

Are there any limitations to understanding or following instructions (written or verbal)?

☐ Yes Written ☐ Yes Verbal ☐ Both Written and Verbal ☐ Neither

Smoking/Tobacco Use: ☐ Current ☐ Past ☐ Never

Type: _____ Amount/day: _____ Number of Years: _____

Alcohol: ☐ Current ☐ Past ☐ Never Drinks/week: _____

Recreational Drug Use: ☐ Current ☐ Past ☐ Never

Are there any cultural or religious concerns you have related to our delivery of care?

☐ No ☐ Yes (please specify): _____

Trask Mobile Medical

~ Health History ~

Family Medical History: Check all that apply

Mother: ☐ Living, Age: _____ ☐ Deceased, Age: _____

☐ COPD/Emphysema ☐ Diabetes ☐ High Blood Pressure

☐ Stroke ☐ Asthma ☐ Kidney Disease

☐ Dementia ☐ Heart Disease ☐ Migraines

☐ Cancer (type): _____

Father: ☐ Living, Age: _____ ☐ Deceased, Age: _____

☐ COPD/Emphysema ☐ Diabetes ☐ High Blood Pressure

☐ Stroke ☐ Asthma ☐ Kidney Disease

☐ Dementia ☐ Heart Disease ☐ Migraines

☐ Cancer (type): _____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

Medical Provider:	**Phone Number:**

_____

Patient Name

_____

Patient/POA Signature Date

_____

If patient unable to sign, state reason

Trask Mobile Medical

~ Chronic Care Management Program ~

Trask Mobile Medical (TMM) is participating in the Chronic Care Management Program (CCM), this is available to all Medicare beneficiaries with two or more chronic conditions.

This program will provide you with a care coordinator who will work closely with all parties involved to ensure you receive the highest level of care possible. We will work to reduce hospitalizations/associated costs and eliminate any gaps in care. By participating in this program, you are allowing TMM CCM Team to monitor your conditions, provide care oversight and update the medical provider as needed should there be any changes of condition.

While Medicare does cover the CCM Program, if you do not have a supplemental/secondary insurance, they may be responsible for a co-pay for the service. We will submit a claim to Medicare once we have provided 20 minutes of non-face-to-face care per month.

Only one provider can bill Medicare for this service, please notify us if there is another provider that is providing you with this service. You can opt-out of the CCM Program at anytime with verbal notice. By signing below, you are agreeing to enroll in the Chronic Care Management Program, thus giving TMM permission to bill Medicare for the services provided.

_____

Patient Name

_____

Patient/POA Signature Date

_____

If patient unable to sign, state reason

☐ Check this box if you have chosen to Opt-Out of the CCM Program

Trask Mobile Medical

~ HIPPA Compliance and Notice of Privacy Practices ~

HIPPA Compliance Patient Consent Form Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such revocation will not be retroactive.

By signing this form, I understand that:

1. Protected health information may be disclosed or used for treatment, payment, or healthcare operations. The practice reserves the right to change the privacy policy as allowed by law.
2. I understand that my healthcare provider participates in Health Current, Arizona's health information exchange (HIE). I understand that my health information may be securely shared through the HIE unless I complete and return an Opt Out Form to my healthcare provider.
3. The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
4. The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
5. The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? ☐ **Yes** ☐ **No**

May we leave a message on your answering machine at home or on your cell phone? ☐ **Yes** ☐ **No**

May we discuss your medical conditions with any member of your family? ☐ **Yes** ☐ **No**

If YES, please name the members allowed:

Name:	Relationship:	Phone Number:

Patient Name

Patient/POA Signature Date

If patient unable to sign, state reason

Trask Mobile Medical

~ Notice of Health Information Practices ~

You are receiving this notice because your healthcare provider participates in a non-profit, non-governmental health information exchange (HIE) called Health Current. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinate your care by securely sharing your health information. This Notice explains how the HIE works and will help you understand your rights regarding the HIE under state and federal law.

How does Health Current help you to get better care?
In a paper-based record system, your health information is mailed or faxed to your doctor, but sometimes these records are lost or don't arrive in time for your appointment. If you allow your health information to be shared through the HIE, your doctors are able to access it electronically in a secure and timely manner.

What health information is available through Health Current?
The following types of health information may be available:

- Hospital records
- Medical history
- Medications
- Allergies
- Lab test results
- Radiology reports
- Clinic and doctor visit information
- Health plan enrollment and eligibility
- Other information helpful for your treatment

Who can view your health information through Health Current and when can it be shared?
People involved in your care will have access to your health information. This may include your doctors, nurses, other healthcare providers, health plan and any organization or person who is working on behalf of your healthcare providers and health plan. They may access your information for treatment, care coordination, care or case management, transition of care planning and population health services.

You may permit others to access your health information by signing an authorization form. They may only access the health information described in the authorization form for the purposes stated on that form. Health Current may also use your health information as required by law and as necessary to perform services for healthcare providers, health plans and others participating with Health Current.

The Health Current Board of Directors can expand the reasons why healthcare providers and others may access your health information in the future as long as the access is permitted by law. That information is on the Health Current website at healthcurrent.org/permitted-use.

Does Health Current receive behavioral health information and if so, who can access it?
Health Current does receive behavioral health information, including substance abuse treatment records. Federal law gives special confidentiality protection to substance abuse treatment records from federally assisted substance abuse treatment programs. Health Current keeps these protected substance abuse treatment records separate from the rest of your health information. Health Current will only share the substance abuse treatment records it receives from these programs in two cases.

One, medical personnel may access this information in a medical emergency. Two, you may sign a consent form giving your healthcare provider or others access to this information.

Trask Mobile Medical

~ Notice of Health Information Practices ~

How is your health information protected?
Federal and state laws, such as HIPPA, protect the confidentiality of your health information. Your information is shared using secure transmission. Health Current has security measures in place to prevent someone who is not authorized from having access. Each person has a username and password, and the system records all access to your information.

Your Rights Regarding Secure Electronic Information Sharing

You have the right to:

1. Ask for a copy of your health information that is available through Health Current. Contact your healthcare provider and you can get a copy within 30 days.

2. Request to have any information in the HIE corrected. If any information in the HIE is incorrect, you can ask your healthcare provider to correct the information.

3. Ask for a list of people who have viewed your information through Health Current. Contact your healthcare provider and you can get a copy within 30 days. Please let your healthcare provider know if you think someone has viewed your information who should not have.

You have the right under article 27, section 2 of the Arizona Constitution and Arizona Revised Statutes title 36, section 3802 to keep your health information from being shared electronically through Health Current:

1. You may "opt out" of having your information available for sharing through Health Current. To opt out, ask your healthcare provider for the Opt Out Form. After you submit the form, your information will not be available for sharing through Health Current.
   Caution: If you opt out, your health information will NOT be available to your healthcare providers even in an emergency.

2. You may explode some information from being shared. For example, if you see a doctor and you do not want that information shared with others, you can prevent it. On the Opt Out Form, fill in the name of the healthcare provider for the information that you do not want shared with others. **Caution:** If that healthcare provider works for an organization (like a hospital or a group of physicians), all your information from that hospital or group of physicians may be blocked from view.

3. If you opt out today, you can change your mind at any time by completing an Opt Back In Form that you can obtain from your healthcare provider.

4. If you do nothing today and allow your health information to be shared through Health Current, you may opt out in the future.

IF YOU DO NOTHING, YOUR INFORMATION MAY BE SECURELY SHARED THROUGH HEALTH CURRENT.