IDEAL HEALTHCARE SOLUTIONS
50 Oliver St Suite 211, N Easton Ma 02356
Ph: 781-562-0468
Fax: 781-262-8218

Admission Packet Checklist

Please be sure to complete and include all the following

Registration Form	
Patient History	
List of Specialist	
Health Care Proxy	
MOLST	
Authorization for release of health information	
Chronic care management and Telehealth Agreements	
Claim Authorization	
Privacy Disclosure	
Privacy Policy	

Thank you

Please return completed packet via mail or fax 781-262-8218

IDEAL HEALTHCARE SOLUTIONS

Patient Registration Form

Patient Information

Patient Information

Last Name:	First Name:	M.I.:	Previous Name (if applicable)
Mailing Address:		Apt #	
City/State/Zip:			
Home Phone:	Cell Phone:		Work Phone:
Preferred Method of Contact for reminder calls and other electronically generated messages: (Please Select Only One Option) ☐ Voice ☐ Text			If Voice, Please Select Preferred Number : ☐ Home ☐ Cell ☐ Work
Date of Birth:	Sex: ☐ Male ☐ Female		HCP:
Marital Status:	Social Security #:		
Assisted Living	Emergency Contact Name:		
Emergency Contact Phone #:			Relationship to Patient:

Additional Information and Responsible Party

Responsible Party-

Last Name:	First Name:	
Date of Birth:		Phone:
Address of Person Responsible:		
City/State/Zip:	Relationship to Patient:	

Additional Information **(PLEASE FILL OUT ALL SECTIONS BELOW)**

Email Address:	**Can we leave a message regarding your medical care & test results?** ☐ Yes ☐ No
Race (please select): ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Decline	**Ethnicity (please select one):** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline
Preferred Language (please select one): ☐ English ☐ Bosnian ☐ Indian (including Hindi & Tamil) ☐ Sign Language ☐ Spanish ☐ Russian ☐ Other	
Preferred Pharmacy Name & Location:	

Insurance Information

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's ID #:	Policy Holder's ID #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

I have read and agree to Ideal Healthcare Solutions (IHS)payment policy. I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to IHS all money to which I am entitled for medical expenses related to the services performed from time to time by IHS, but not to exceed my indebtedness to IHS. I authorize IHS to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $15.00 returned check fee will be charged for checks returned due to insufficient funds. By choosing text messaging and/or email as a communication method, I acknowledge that Ideal Healthcare Solutions is not liable for any wireless charges I may incur and that unencrypted patient information may be sent to me via text message or email. MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to IHS. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

I have reviewed a copy of Ideal Healthcare Solution's Privacy Notice. ☐ **(Initials)**

Signature of Responsible Party: X _____ **Date:**

Printed Name of Responsible Party: X _____ **Date:**

IDEAL HEALTHCARE SOLUTIONS

PATIENT HISTORY FORM

Date: _____/_____/_____

NAME: _____ Birthdate: _____/_____/_____
Last First M. I.

Age:_____ Sex: ❑ F ❑ M

How did you hear about this practice?

Describe briefly your present symptoms:

Please list the names of other practitioners you have seen for this problem:

Hospitalizations (include where, when, & for what reason):

CURRENT MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what? _____

Pharmacy Name_____Address_____

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	**Dose (include strength & number of pills per day)**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	

Physician initials _____

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type) _____
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

Other medical conditions (please list):

PERSONAL HISTORY

What is your highest education? ❑High school ❑Some college ❑College graduate ❑Advanced degree

Marital status: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partnered/significant other

What is your current or past occupation?_____

Are you currently working? : ❑ Yes ❑ No Hours/week _____ If not, are you ❑ retired ❑ disabled ❑ sick leave?

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age (s)	Health & Psychiatric	Age(s) at death	Cause
Father				
Mother				
Siblings				
Children				

Physician initials _____

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD
- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

Women Only:
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Forgetful

OTHER PROBLEMS:

Smoking history_____

Alcohol Use_____

Immunization:

Flu Vaccine_____ Date_____

Pneumonia_____Date_____

Tetanus_____Date_____

Physician initials _____

MASSACHUSETTS HEALTH CARE PROXY

Information, Instructions, and Form

What does the Health Care Proxy Law allow?

The **Health Care Proxy** is a simple legal document that allows you to name someone you know and trust to make health care decisions for you if, for any reason and at any time, you become unable to make or communicate those decisions. It is an important document, however, because it concerns not only the choices you make about your health care, but also the relationships you have with your physician, family, and others who may be involved with your care. Read this and follow the instructions to ensure that your wishes are honored.

Under the Health Care Proxy Law (Massachusetts General Laws, Chapter 201D), any competent adult 18 years of age or over may use this form to appoint a Health Care Agent. You (known as the "Principal") can appoint any adult EXCEPT the administrator, operator, or employee of a health care facility such as a hospital or nursing home where you are a patient or resident UNLESS that person is also related to you by blood, marriage, or adoption. Whether or not you live in Massachusetts, you can use this form if you receive your health care in Massachusetts.

What can my Agent do?

Your Agent will make decisions about your health care *only* when you are, for some reason, unable to do that yourself. This means that your Agent can act for you if you are temporarily unconscious, in a coma, or have some other condition in which you cannot make or communicate health care decisions. Your Agent cannot act for you until your doctor determines, in writing, that you lack the ability to make health care decisions. Your doctor will tell you of this if there is any sign that you would understand it.

Acting with your authority, your Agent can make any health care decision that you could, if you were able. If you give your Agent full authority to act for you, he or she can consent to or refuse any medical treatment, including treatment that could keep you alive.

Your Agent will make decisions for you only after talking with your doctor or health care provider, and after fully considering all the options regarding diagnosis, prognosis, and treatment of your illness or condition. Your Agent has the legal right to get any information, including confidential medical information, necessary to make informed decisions for you.

Your Agent will make health care decisions for you according to your wishes or according to his/her assessment of your wishes, including your religious or moral beliefs. You may wish to talk first with your doctor, religious advisor, or other people before giving instructions to your Agent. It is very important that you talk with your Agent so that he or she knows what is important to you. If your Agent does not know what your wishes would be in a particular situation, your Agent will decide based on what he or she thinks would be in your best interests. After your doctor has determined that you lack the ability to make health care decisions, if you still object to any decision made by your Agent, your own decisions will be honored unless a Court determines that you lack capacity to make health care decisions.

Your Agent's decisions will have the same authority as yours would, if you were able, and will be honored over those of any other person, except for any limitation you yourself made, or except for a Court Order specifically overriding the Proxy.

How do I fill out the form?

1 At the top of the form, print your full name and address. Print the name, address, and phone number of the person you choose as your Health Care Agent. (**Optional:** If you think your Agent might not be available at any future time, you may name a second person as an Alternate Agent. Your Alternate Agent will be called if your Agent is unwilling or unable to serve.)

2 Setting limits on your Agent's authority might make it difficult for your Agent to act for you in an unexpected situation. If you want your Agent to have full authority to act for you, leave the limitations space blank. However, if you want to limit the kinds of decisions you would want your Agent or Alternate Agent to make for you, include them in the blank.

3 **BEFORE** you sign, be sure you have two adults present who will be witnesses and watch you sign the document. The only people who cannot serve as witnesses are your Agent and Alternate Agent. Then sign and date the document yourself. (Or, if you are physically unable, have someone other than either witness sign your name at your direction. The person who signs your name for you should put his/her own name and address in the spaces provided.)

4 Have your witnesses fill in the date, sign their names and print their names and addresses.

5 **OPTIONAL:** On the back of the form are statements to be signed by your Agent and any Alternate Agent. This is not required by law, but is recommended to ensure that you have talked with the person or persons who may have to make important decisions about your care and that each of them realizes the importance of the task they may have to do.

Who should have the original and copies?

After you have filled in the form, remove this information page and make at least four photocopies of the form. Keep the original yourself where it can be found easily (*not* in your safe deposit box). Give copies to your doctor and/or health plan to put into your medical record. Give copies to your Agent and any Alternate Agent. You can give additional copies to family members, your clergy and/or lawyer, and other people who may be involved in your health care decisionmaking.

How can I revoke or cancel the document?

Your Health Care Proxy is revoked when any of the following four things happens:

1. You sign another Health Care Proxy later on.
2. You legally separate from or divorce your spouse who is named in the Proxy as your Agent.
3. You notify your Agent, your doctor, or other health care provider, orally or in writing, that you want to revoke your Health Care Proxy.
4. You do anything else that clearly shows you want to revoke the Proxy, for example, tearing up or destroying the Proxy, crossing it out, telling other people, etc.

AFTER FILLING IN THE FORM, REMOVE THIS INSTRUCTION PAGE. BE SURE TO TALK WITH YOUR AGENT.

YOUR BIRTH DATE (m/d/y)
____/____/____

MASSACHUSETTS HEALTH CARE PROXY

1 I, _____, residing at
(Principal: PRINT your name)

_____
(Street) (City/town) (State/ZIP)

appoint as my **Health Care Agent**: _____
(Name of person you choose as Agent)

of _____
(Street) (City/town) (State/ZIP)

Agent's tel (h) _____ (w) _____ E-mail _____

OPTIONAL: If my agent is unwilling or unable to serve, then I appoint as my **Alternate Agent**:

_____
(Name of person you choose as Alternate Agent)

of _____
(Street) (City/town) (State/ZIP) (Phone)

2 My Agent shall have the authority to make all health care decisions for me, including decisions about life-sustaining treatment, subject to any limitations I state below, if I am unable to make health care decisions myself. My Agent's authority becomes effective if my attending physician determines in writing that I lack the capacity to make or to communicate health care decisions. My Agent is then to have the same authority to make health care decisions as I would if I had the capacity to make them **EXCEPT** (here list the limitations, *if any*, you wish to place on your Agent's authority):

I direct my Agent to make health care decisions based on my Agent's assessment of my personal wishes. If my personal wishes are unknown, my Agent is to make health care decisions based on my Agent's assessment of my best interests. Photocopies of this Health Care Proxy shall have the same force and effect as the original and may be given to other health care providers.

3 **Signed**:_____ **Date:** ___/___/___ (mo/day/yr)

Complete only if Principal is physically unable to sign: I have signed the Principal's name above at his/her direction in the presence of the Principal and two witnesses.

_____ _____
(Name) (Street)

_____
(City/town) (State/ZIP)

4 **WITNESS STATEMENT:** We, the undersigned, each witnessed the signing of this Health Care Proxy by the Principal or at the direction of the Principal and state that the Principal appears to be at least 18 years of age, of sound mind and under no constraint or undue influence. Neither of us is named as the Health Care Agent or Alternate Agent in this document.
In our presence, on this day ____/____/____ (mo / day / yr).

Witness #1 _____ Witness #2 _____
(Signature) (Signature)

Name (print) _____ Name (print) _____

Address _____ Address _____

_____ _____

5

Statements of Health Care Agent and Alternate Agent (OPTIONAL)

Health Care Agent: I have been named by the Principal as the Principal's **Health Care Agent** by this Health Care Proxy. I have read this document carefully, and have personally discussed with the Principal his/her health care wishes at a time of possible incapacity. I know the Principal and accept this appointment freely. I am not an operator, administrator or employee of a hospital, clinic, nursing home, rest home, Soldiers Home or other health facility where the Principal is presently a patient or resident or has applied for admission. But if I am a person so described, I am also related to the Principal by blood, marriage, or adoption. If called upon and to the best of my ability, I will try to carry out the Principal's wishes.

(Signature of **Health Care Agent**)_____

Alternate Agent: I have been named by the Principal as the Principal's **Alternate Agent** by this Health Care Proxy. I have read this document carefully, and have personally discussed with the Principal his/her health care wishes at a time of possible incapacity. I know the Principal and accept this appointment freely. I am not an operator, administrator or employee of a hospital, clinic, nursing home, rest home, Soldiers Home or other health facility where the Principal is presently a patient or resident or has applied for admission. But if I am a person so described, I am also related to the Principal by blood, marriage, or adoption. If called upon and to the best of my ability, I will try to carry out the Principal's wishes.

(Signature of **Alternate Agent**)_____

* * * * *

Health Care Proxy developed by Massachusetts Health Decisions in association with the following member organizations of the Massachusetts Health Care Proxy Task Force:

Boston University Schools of Medicine and Public Health: Law, Medicine, and Ethics Program
Deaconess ElderCare Program
Hospice Federation of Massachusetts
Massachusetts Bar Association
Massachusetts Department of Public Health
Massachusetts Executive Office of Elder Affairs
Massachusetts Federation of Nursing Homes
Massachusetts Health Decisions
Massachusetts Hospital Association
Massachusetts Medical Society
Massachusetts Nurses Association
Medical Center of Central Massachusetts
Suffolk University Law School: Elder Law Clinic
University of Massachusetts at Boston: The Gerontology Institute
Visiting Nurse Associations of Massachusetts

For prices and information on quantity orders, or for non-English language licensing, please contact non-profit

Massachusetts Health Decisions

Email: proxy@masshealthdecisions.org

rev. 1/15

MASSACHUSETTS MEDICAL ORDERS for LIFE-SUSTAINING TREATMENT (MOLST) www.molst-ma.org

Patient's Name _____

Date of Birth _____

Medical Record Number if applicable: _____

INSTRUCTIONS: *Every patient should receive full attention to comfort.*

→ This form should be signed based on goals of care discussions between the patient (or patient's representative signing below) and the signing clinician.
→ Sections A–C are valid orders only if Sections D and E are complete. Section F is valid only if Sections G and H are complete.
→ If any section is not completed, there is no limitation on the treatment indicated in that section.
→ The form is effective immediately upon signature. Photocopy, fax or electronic copies of properly signed MOLST forms are valid.

A

Mark one circle ➔

CARDIOPULMONARY RESUSCITATION: for a patient in cardiac or respiratory arrest

O Do Not Resuscitate O Attempt Resuscitation

B

Mark one circle ➔

VENTILATION: for a patient in respiratory distress

O Do Not Intubate and Ventilate O Intubate and Ventilate

Mark one circle ➔

O Do Not Use Non-invasive Ventilation (e.g. CPAP) O Use Non-invasive Ventilation (e.g. CPAP)

C

Mark one circle ➔

TRANSFER TO HOSPITAL

O Do Not Transfer to Hospital (*unless needed for comfort*) O Transfer to Hospital

D

PATIENT or patient's representative signature

Required

Mark one circle and fill in every line for valid Page 1.

Mark one circle below to indicate who is signing Section D:
o Patient o Health Care Agent o Guardian* o Parent/Guardian* of minor

Signature of patient confirms this form was signed of patient's own free will and reflects his/her wishes and goals of care as expressed to the Section E signer. Signature by the patient's representative (indicated above) confirms that this form reflects his/her assessment of the patient's wishes and goals of care, or if those wishes are unknown, his/her assessment of the patient's best interests. ***A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.***

X _____ _____
Signature of Patient (or Person Representing the Patient) **Date of Signature**

_____ _____
Legible Printed Name of Signer **Telephone Number of Signer**

E

CLINICIAN signature

Required

Fill in every line for valid Page 1.

Signature of physician, nurse practitioner or physician assistant confirms that this form accurately reflects his/her discussion(s) with the signer in Section D.

X _____ _____
Signature of Physician, Nurse Practitioner, or Physician Assistant **Date and Time of Signature**

_____ _____
Legible Printed Name of Signer **Telephone Number of Signer**

Optional

Expiration date (if any) and other information

This form does not expire unless expressly stated. *Expiration date (if any) of this form:* _____

Health Care Agent Printed Name _____ Telephone Number _____

Primary Care Provider Printed Name _____ Telephone Number _____

SEND THIS FORM WITH THE PATIENT AT ALL TIMES.
HIPAA permits disclosure of MOLST to health care providers as necessary for treatment.

Patient's Name: _____ **Patient's DOB** _____ **Medical Record # if applicable**_____

F — Statement of Patient Preferences for Other Medically-Indicated Treatments

INTUBATION AND VENTILATION

Mark one circle ➔

○ Refer to Section B on Page 1	○ Use intubation and ventilation as marked in Section B, but short term only	○ Undecided ○ Did not discuss

NON-INVASIVE VENTILATION (e.g. Continuous Positive Airway Pressure - CPAP)

Mark one circle ➔

○ Refer to Section B on Page 1	○ Use non-invasive ventilation as marked in Section B, but short term only	○ Undecided ○ Did not discuss

DIALYSIS

Mark one circle ➔

○ No dialysis	○ Use dialysis ○ Use dialysis, but short term only	○ Undecided ○ Did not discuss

ARTIFICIAL NUTRITION

Mark one circle ➔

○ No artificial nutrition	○ Use artificial nutrition ○ Use artificial nutrition, but short term only	○ Undecided ○ Did not discuss

ARTIFICIAL HYDRATION

Mark one circle ➔

○ No artificial hydration	○ Use artificial hydration ○ Use artificial hydration, but short term only	○ Undecided ○ Did not discuss

Other treatment preferences specific to the patient's medical condition and care _____

_____

_____

PATIENT or patient's representative signature

G

Required

Mark one circle and fill in every line for valid Page 2.

Mark one circle below to indicate who is signing Section G:

o Patient **o Health Care Agent** **o Guardian*** **o Parent/Guardian* of minor**

Signature of patient confirms this form was signed of patient's own free will and reflects his/her wishes and goals of care as expressed to the Section H signer. Signature by the patient's representative (indicated above) confirms that this form reflects his/her assessment of the patient's wishes and goals of care, or if those wishes are unknown, his/her assessment of the patient's best interests. ***A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.***

X _____ _____

Signature of Patient (or Person Representing the Patient) **Date of Signature**

_____ _____

Legible Printed Name of Signer **Telephone Number of Signer**

CLINICIAN signature

H

Required

Fill in every line for valid Page 2.

Signature of physician, nurse practitioner or physician assistant confirms that this form accurately reflects his/her discussion(s) with the signer in Section G.

X _____ _____

Signature of Physician, Nurse Practitioner, or Physician Assistant **Date and Time of Signature**

_____ _____

Legible Printed Name of Signer **Telephone Number of Signer**

Additional Instructions For Health Care Professionals

→ Follow orders listed in A, B and C and honor preferences listed in F until there is an opportunity for a clinician to review as described below.

→ Any change to this form requires the form to be voided and a new form to be signed. To void the form, write VOID in large letters across both sides of the form. *If no new form is completed, no limitations on treatment are documented and full treatment may be provided.*

→ Re-discuss the patient's goals for care and treatment preferences as clinically appropriate to disease progression, at transfer to a new care setting or level of care, or if preferences change. Revise the form when needed to accurately reflect treatment preferences.

→ The patient or health care agent (if the patient lacks capacity), guardian*, or parent/guardian* of a minor can revoke the MOLST form at any time and/or request and receive previously refused medically-indicated treatment. ***A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.***

IDEAL HEALTHCARE SOLUTIONS
50 Oliver Street, North Easton, MA 02356
Ph: 781-562-0468 • Fax: 781-262-8218

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

Patient Address: _____ SS#: _____

_____

Patient Telephone: ( ) _____

I authorize the person(s) or organization(s) listed below, to release health information, including copies of my medical record of care, to Ideal Healthcare Solutions for the purpose(s) described below:

NAME: _____ Purpose (check appropriate box(s)

ADDRESS: _____ □ Medical Care

_____

□ Other (please specify)

PH: ( ) _____ _____

FAX: ( ) _____ _____

DESCRIPTION OF INFORMATION TO BE RELEASED (Please check all that apply):

□ Last Physical Exam □ Immunizations □ Lab Reports x 6 months □ Imaging reports x 6 months

□ Last Discharge Summary □ Consultation Reports x 3months □ Other (please specify)

_____
_____
_____

Release of Specifically Protected Health Information

I request and authorize the release of the specific categories of information that I have INITIALED below:
____ HIV test results (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST)
____ HIV/AIDS medical treatment information
____ Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHUR DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED OR WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR Part 2.)
____ Other(s): Please list _____

Please Continue Completing Form on Page 2

I understand that:

I may revoke my authorization at any time by submitting a written request to the Operations Manager or the Medical Records Supervisor in my Doctor's Office.

I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected.

I understand that this authorization will automatically expire 1 year from the date of signature.

I have carefully read and understand the above, have had any questions explained to my satisfaction, and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed.

Patient's Signature: _____ Date: _____

When the patient is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Signature of Legal Representative: _____ Date: _____

Print Name: _____ Relationship of representative to patient: _____

CONSENT AGREEMENT
FOR PROVISION OF CHRONIC CARE MANAGEMENT

By signing this Agreement, you consent to Ideal Healthcare Solutions (referred to as "Provider"), providing chronic care management services (referred to as "CCM Services") to you as more fully described below.

CCM Services are available to you because you have been diagnosed with two (2) or more chronic conditions which are expected to last at least twelve (12) months and which place you at significant risk of further decline.

CCM Services include 24-hours-a-day, 7-days-a-week access to a health care provider in Provider's practice to address acute chronic care needs; systematic assessment of your health care needs; processes to assure that you timely receive preventative care services; medication reviews and oversight; a plan of care covering your health issues; and management of care transitions among health care providers and settings. The Provider will discuss with you the specific services that will be available to you and how to access those services.

Provider's Obligations.
When providing CCM Services, the Provider must:

- Explain to you (and your caregiver, if applicable), and offer to you, all the CCM Services that are applicable to your conditions.
- Provide to you a written or electronic copy of your care plan.
- If you revoke this Agreement, provide you with a written confirmation of the revocation, stating the effective date of the revocation.

Beneficiary Acknowledgment and Authorization.
By signing this Agreement, you agree to the following:

- You consent to the Provider providing CCM Services to you.
- You authorize electronic communication of your medical information with other treating providers as part of coordination of your care.
- You acknowledge that only one practitioner can furnish CCM Services to you during a calendar month.
- You understand that cost-sharing will apply to CCM Services, so you may be billed for a portion of CCM Services even though CCM Services will not involve a face-to-face meeting with the Provider.

Beneficiary Rights.
You have the following rights with respect to CCM Services:

- The Provider will provide you with a written or electronic copy of your care plan.
- You have the right to stop CCM Services at any time by revoking this Agreement effective at the end of the then-current month. You may revoke this agreement verbally (by calling 781-562-0468) or in writing (to Ideal Healthcare Solutions, 50 Oliver St, Suite 211, N. Easton MA 02356). Upon receipt of your revocation, the Provider will give you written confirmation (including the effective date) of revocation.

Beneficiary
Signature: _____
Print Name: _____
Date: _____

Beneficiary's Representative and/or Caregiver (if applicable)
Signature: _____
Print Name: _____
Date: _____

Authorization for Claims Payment and Reviews

1. **Assignment and Coordination of Insurance Benefits** - I agree to provide information regarding all group hospitalization, health maintenance organization, Workers' Compensation, automobile, and other health care benefits ("Insurance Plan(s)") to which I may be entitled. I hereby assign payment(s), if any, from my Insurance Plan(s) to Ideal Healthcare Solutions (or its affiliate) and each of the independent contractor physicians and/or professional corporations for services rendered to me. The direct payment hereby assigned and authorized includes any Insurance Plan(s) benefits to which I am otherwise entitled, including any major medical benefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to the Ideal Healthcare Solutions (or its affiliate), the independent contractor physicians and/or professional corporations for services rendered to me during the applicable periods of medical care.

2. **Unauthorized, Non-Covered, or Out of Plan Services** - I understand if my Insurance Plan(s) does not consider this admission or any service rendered during this admission a covered service or has not authorized this service, they will not pay for this admission or the service rendered during this admission or outpatient visit. I agree to be fully responsible for payment to Ideal Healthcare Solutions for this admission or any service if determined by my Insurance Plan(s) to be a non-covered service. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, co-insurance or other charge In the event my Insurance Plan(s) does not reimburse these services provided to me, I acknowledge I will be responsible for any remaining balance.

3. **For Medicare Recipients Only** - I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to the Hospital and/or independent contractors for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related services. In the case of Medicare Part B benefits, I request payment either to myself or to the party who accepts assignment.

4. **Residents, Interns or Medical Students-** I understand residents, interns, medical students and other health care professional students may participate, under the supervision of an attending physician or other health care professional, in my care as part of the Ideal Healthcare Solutions' education programs.

By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered and accept the above conditions and terms and I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered. I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by Ideal Healthcare Solutions. *I understand and agree this document will remain in effect for all future outpatient or physician office visits to Ideal Healthcare Solutions, unless specifically rescinded in writing by me.*

Patient Signature: _____ Date: _____

Relationship to Patient: _____

CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION

By signing this form, you are granting consent to Ideal Healthcare Solutions to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting Ideal Healthcare Solutions at (781) 562-0468. You have a right to request that we restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Signature	Date

I certify that I have been made aware of Ideal Healthcare Solutions' **Notice of Privacy Practices** and that I have a right to receive a copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Ideal Healthcare Solutions' health care operations. The Notice also describes my rights and Ideal Healthcare Solutions' duties with respect to my protected health information. I understand that copies of the **Notice of Privacy Practices** are available in the registration areas of each facility and on Ideal Healthcare Solutions' web site at www. i d e a l h e a l t h c a r e s o l u t i o n s . c o m I may request that a copy be mailed to me by calling **781-562-0468**

Ideal Healthcare Solutions reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices**. I may obtain a revised **Notice of Privacy Practices** by calling the above number and requesting a revised copy be mailed to me, by asking for one at the time of my next appointment, or by accessing Ideal Healthcare Solutions' web site listed above to view the most current version.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

NAME OF PATIENT OR PERSONAL REPRESENTATIVE

DATE

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY

PATIENT IDENTIFICATION

Ideal Healthcare Solutions

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

CONSENT AGREEMENT

FOR TELEHEALTH SERVICES

By signing this Agreement, you consent to Ideal Healthcare Solutions (referred to as "Provider"), providing telehealth services.

Prior to telehealth services, please read and sign the following consent for telehealth treatment:

1. You retain the right to withhold or withdraw consent to telehealth services at any time for any reason, without affecting your right to care and treatment, future or present.
2. Your confidentiality of your medical information "HIPPA" applies to telehealth services. The information disclosure to you or by you during the duration of treatment is generally confidential. Exceptions to this includes: protection for you or the public from serious harm, to report abuse or neglect or children, the elderly or people with disabilities, and response to an order from a court or other valid legal order such as a subpoena.
3. Telehealth services occur on a variety of platforms, including but not limited to: Zoom and Doximity, both of which had encryption capabilities to protect your personally identifiable information. Despite all efforts there are risks associated with telehealth, including but not limited to, the possibility that transmission of information could be disrupted or distorted by technical failures; transmission of your information could be interrupted by unauthorized persons, and/or misunderstanding between you and your provider.
4. All existing laws regarding your medical information and medical records apply.
5. You agree not to record or share the content of your telehealth visit.
6. You agree to conduct the visit in a private space unless an arrangement has been agreed to by you and your provider.

Beneficiary

Signature:
_____

Print Name:
_____

Date: _____

Beneficiary's Representative and/or Caregiver (if applicable)

Signature:
_____

Print Name
_____

Date: _____