NOVARI

Primary Care

Novari Primary Care
4686 Pointes Drive Suite 219
Mukilteo, WA 98275
Phone: (425) 405-8089
Fax: (425) 426-2277

To Our Respected Patient,

Thank you for entrusting your health and comfort with Novari Primary Care. We appreciate the opportunity to provide you the best care possible and look forward to serving you. As part of your care, Medicare is offering a new benefit for beneficiaries with multiple chronic conditions. Medicare defines a chronic condition as a condition that is expected to last for at least 12 months and one that potentiates the risk for an acute exacerbation of the ailment, and can significantly affect an individual's decline in function. Such ailments include, but are not limited to: high blood pressure, depression, diabetes, Alzheimer's disease, chronic kidney disease, and other cardiovascular conditions.

The Benefits of Chronic Care Management (CCM)
By opting for CCM, you will be provided the most systematic approach to your care. Should you desire to receive CCM services through your Novari Primary Care health care provider, you will receive the following comprehensive care provision:

- 24/7 access to a care provider to help with your chronic healthcare needs
- Care coordination with both Novari Primary Care and your community-based services providers
- Transition management among health care providers, including referrals, and expeditious follow-up after discharges from hospital, skilled nursing facilities, or other health care facilities
- Medication oversight and management
- Use of a certified electronic health care record (EHR) and your option to have electronic access to your medical records

Before electing to sign up for CCM, please note that this benefit will be charged to Medicare and unpaid portions will be the responsibility of the patient. Furthermore, an agreement statement to receive chronic care management must be signed to commence services. A CCM Consent Agreement form has been provided in this enrollment packet for your convenience. Please review and sign if you wish to receive chronic care management from Novari Primary Care.

With All My Best,

K Ballew, ARNP

Karla Ballew, DNP, ARNP, AGNP-C
Chief Executive Officer | Medical Director
Novari Primary Care

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Patient Information

Name: _____
Social Security Number: _____ Gender:
Date of Birth: _____
Former | Current Occupation:_____
Marital Status:
Preferred Pharmacy: _____
Medicare Number: _____
Private Insurance | Carrier or Company:_____
ID Number: _____Group Number:_____
DSHS | ProviderONE | Medicaid Number: _____

Residential Care Facility (RCF) Information

Residential Care Facility Name:_____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: (_____)_____Fax: (_____)_____

Power of Attorney (POA) | Guardian | Responsible Party

Name:_____Relationship:_____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: (_____)_____Fax: (_____)_____
Email:_____
Does the above mentioned person have medical **Power of Attorney**?
Is the above mentioned person **financially responsible** for the patient?
If "No," provide the name and phone number of the individual representing as the patient's financial proxy:
Name:_____ Phone Number:_____

Allergies	**Social History**
_____ _____	Current Tobacco Use: _____pack(s) per day Alcohol Consumption: _____drinks per day Recreational Drug Use

Surgical History: *Please provide reason for the surgical procedure, approximate date, and hospital name*	**Hospitalizations**: *Please provide reason for hospitalization, approximate date, and hospital name*
_____ _____ _____	_____ _____ _____

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Patient Name: _____ **Date of Birth:** _____

MEDICAL HISTORY

Condition	Current	Past	Condition	Current	Past
Allergies			Hemorrhoids		
Alzheimer's Disease			High Blood Pressure		
Anemia			Kidney Problems		
Anxiety			Leg Swelling		
Arthritis			Liver Problems		
Asthma			Migraines		
Atrial Fibrillation			Multiple Sclerosis		
Cerebral Palsy			Pain: Location_____		
Congestive Heart Failure			Parkinson's Disease		
Constipation			Prostate Problems		
Cancer: _____			Skin Disease		
COPD			Stomach Problems		
Dementia (other)			Sleeping Problems (insomnia)		
Depression			Thyroid Disease		
Diabetes (Type 1 or 2)			Tuberculosis		
Diarrhea			Ulcer		
Emphysema			Vision Problems		
Epilepsy | Seizures			Weight Gain		
Fatigue (chronic)			Weight Loss		
Gallbladder Problems			Other:_____		
Hard of Hearing			Other:_____		

FAMILY HISTORY

	Family Members				
Illness	Father	Mother	Brother(s)	Sister(s)	Children
Alcohol or Drug Abuse					
Alzheimer's Disease					
Anxiety, Depression					
Cancer (please specify)					
Diabetes					
Heart Disease					
Heart Attack					
High Blood Pressure					
Stroke | TIA					
Other (please specify)					

⇒ **Please don't forget to attach a copy of the patient's most current medication list** ⇐

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Name: _____

Social Security Number: _____ Date of Birth:_____

I hereby authorize *(Health Care Provider)* _____, of _____ *(Organization)* to release:

___ The most recent 2 years of pertinent information (i.e. progress notes, labs/imaging)
___ All medical records
___ Other (please specify) _____

To the offices of Novari Primary Care. Please send the requested medical information to:

NOVARI PRIMARY CARE
4686 Pointes Drive Suite 219
Mukilteo, WA 98275
Or fax to: (425) 426-2277

Signature: _____ Date:_____

Relationship to Patient, if Representative Consenting: _____

Print Name: _____

*(*If signing as the patient's Power of Attorney, legally appointed guardian, or authorized representative, please provide legally-binding documentation to prove authority to sign on behalf of the patient)*

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CONSENT FOR TREATMENT, AUTHORIZATION FOR RELEASE OF INFORMATION, FINANCIAL AGREEMENT, TELEMEDICINE CONSENT

CONSENT FOR TREATMENT

_____ Permission is hereby fully granted to the physicians and staff of Novari Primary Care to provide ordinary and necessary medical examination, diagnoses, treatment, and the administering of such therapeutic treatment or services that the health care provider may order. I have chosen ordinary and necessary medical care, which may include preventive and prophylactic care, laboratory tests, diagnostics, and/or imaging. I also consent to routine immunizations during future office visits.

AUTHORIZATION FOR RELEASE OF INFORMATION

_____ I acknowledge that my health information, including information regarding diagnosis or treatment of mental illness, drug or alcohol abuse, and/or HIV-related information, may be disclosed in accordance with current law. I also understand that my health information may be maintained in an electronic health information exchange network or other electronic databases, released to and accessible to all providers involved in my care regardless of their location, hospital-affiliation or specialty, and that my Novari Primary Care health care provider may have access to this information from other providers. I understand that this information may include my prescription history. Finally, I understand that I may be contacted by Novari Primary Care or its business associates, at the primary phone number I have provided, for purposes of treatment, appointment reminders and/or payment of my bills.

_____ I specifically authorize the release of pertinent medical information regarding diagnosis or treatment of mental illness, drug or alcohol abuse and/or HIV related information to individuals or organizations directly involved in my care or treatment and/or to any organization responsible for payment of services furnished to me. In the event that any of the foregoing information is released, I understand that state and federal law prohibits further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by state and federal law. Withdrawal of this authorization shall be addressed in writing to the Medical Director of Novari Primary Care. I understand that neither Novari Primary Care nor any of its related entities or providers will condition treatment, payment, enrollment or eligibility for benefits on this authorization to release information

FINANCIAL AGREEMENT

_____ I accept full financial responsibility for the medical house call services rendered by my Novari Primary Care. I understand that I will be required to pay for any outstanding balances in the event that my insurance coverage does not fully cover the services received. Balances that are left unpaid may be referred to a collections agency or the disruption of the patient's care.

TELEMEDICINE CONSENT

_____ I consent to telemedicine performed by a Novari Primary Care medical practitioner. This is described as real-time audio/visual communication with my provider using a synchronous device and includes examinations, diagnostic testing, treatment, and other health care services deemed medically necessary. I can withdraw my consent at any time, and I understand that phenomena such as COVID-19 can make telehealth visits the only viable option to ensure that my medical needs are met in a timely manner.

By way of my signature, I authorize and give full permission to Novari Primary Care to utilize and disclose my protected health information for the purpose of treatment, payment, and coordination of my care.

Signature: _____ Date:_____
Relationship to Patient, if Representative Consenting:_____
Print Name: _____

*(*If signing as the patient's Power of Attorney, legally appointed guardian or authorized representative, please provide legally-binding documentation to prove authority to sign on behalf of the patient)*

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CHRONIC CARE MANAGEMENT CONSENT AGREEMENT

By signing this Agreement, you consent to Novari Primary Care (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 healthcare 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 you a written or electronic copy of your care plan.
- If you revoke this Agreement, the Provider will administer 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 (425) 405-8089 or in writing to 4686 Pointes Drive Suite 219, Attention: NOVARI PRIMARY CARE. Upon receipt of your revocation, the Provider will give you written confirmation (including the effective date) of revocation.

Beneficiary	**Beneficiary's Power of Attorney, Guardian, Representative (if applicable)**
Signature: _____	Signature: _____
Print Name: _____	Print Name: _____
Date: _____	Date: _____

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ENROLLMENT FORM COMPLETION CHECKLIST

To finalize your enrollment and initiate care with Novari Primary Care, please kindly use the following checklist to ensure that this enrollment packet is completed:

- ❑ Completed patient demographic information and summation of medical and family history [pages 2 and 3]
- ❑ Authorization for disclosure of health information page filled out and signed by the patient's Power of Attorney or legally appointed guardian [page 4]
- ❑ Consent for treatment, authorization for release of information, and financial agreement form, reviewed, initialed, and signed by the patient's Power of Attorney or legally appointed guardian *and* decision to elect for Chronic Care Management [page 5 and 6]
- ❑ Provide a copy of **insurance card(s)**
- ❑ Supply a copy of the patient's most recent **medication list**
- ❑ Enclose a copy of the **Durable Power of Attorney for Health Care** forms, and a copy of a signed **Physician Order for Life-Sustain Treatment** (POLST) form.

HOW TO SUBMIT YOUR COMPLETED ENROLLMENT PACKET

- ❑ **Email:** In compliance with HIPAA laws and regulations, emails containing completed enrollment packets *must* be encrypted before being sent to Novari Primary Care. To do this, download the Virtru Extension and activate your account. When attaching your completed enrollment form, toggle the Virtru encryption to "on" before sending.
- ❑ **Fax:** Please fax the completed enrollment packet, checklist, and supporting documents to **(425) 426-2277**.
- ❑ **Mail:** You may mail the enrollment packet, checklist and additional forms listed above to:

NOVARI PRIMARY CARE
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Once received and reviewed for completion, a Novari Primary Care representative will contact you and schedule your initial appointment to establish care. Please note that receiving this completed packet in a timely manner is imperative, as we are unable to fill medications, address medical concerns, order labs, diagnostics, imaging, durable medical equipment or provide referrals until care is established through the initial visit.

If you have any questions, please contact our office and we will be glad to answer your queries: (425) 405-8089 or by email at Quality@NovariPrimaryCare.com. We look forward to caring for you.

Welcome to Novari Primary Care!