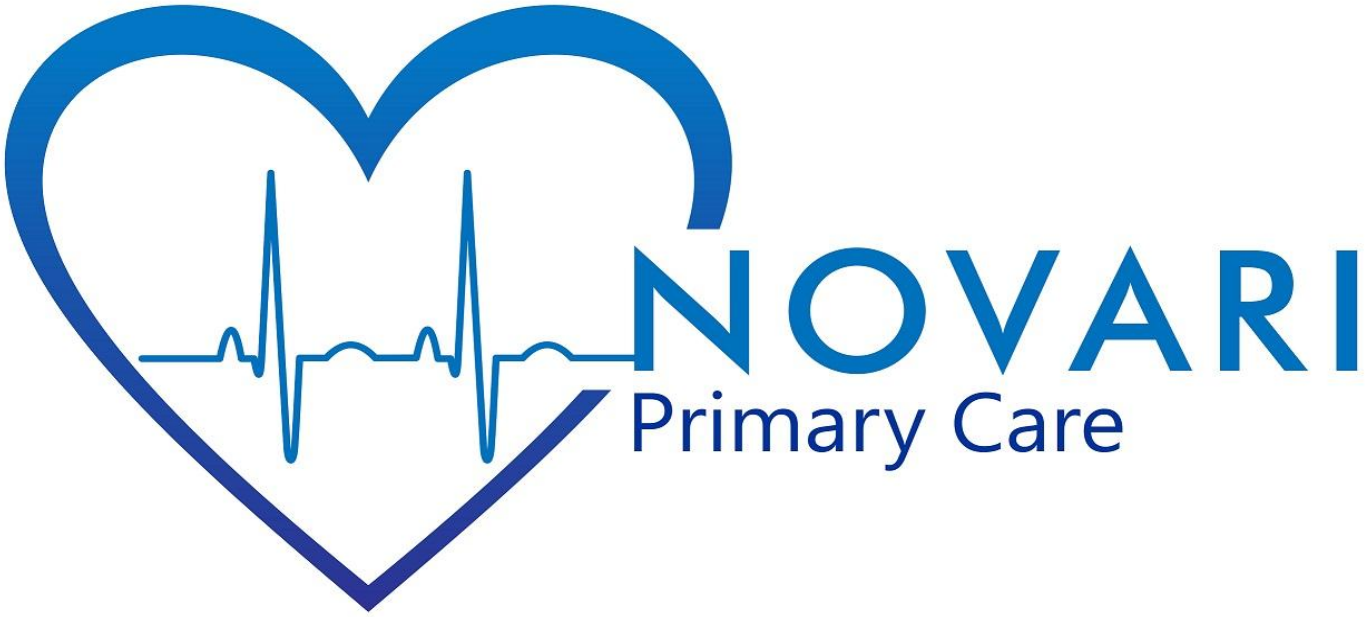
NOVARI
Primary Care

NOVARI Primary Care

(425) 405-8089 | Fax: (425) 426-2277
4686 Pointes Drive, Mukilteo, WA, 98275

Patient Information

Name: _____

Social Security Number: _____ Gender: M F

Date of Birth: _____

Former | Current Occupation:_____

Marital Status: Married Divorced Single Widowed

Approximate height: _____ Approximate weight: _____

Insurance Information

Please also scan pictures of your insurance cards, front and back.

Medicare	Private Insurance	Medicaid
Policy #:_____	Policy #:_____	Policy #:_____

Residential Care Facility (RCF) Information

Residential Care Facility Name:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____Fax: _____

Preferred Pharmacy: _____

Power of Attorney (POA) | Guardian | Responsible Party

Name:_____Relationship:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____Fax: _____

Email:_____

Do you consent to receive SMS messages to the phone number above? YES NO

Would you like to receive access to our patient portal/receive notifications through email? YES NO

Does the above-mentioned person have medical **Power of Attorney**? YES NO

Is the above-mentioned person **financially responsible** for the patient? YES NO

If **NO**, who is financially responsible for the patient? Name: _____ Phone: _____

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MEDICAL HISTORY

Condition	Current	Past	Condition	Current	Past
Addictions			High Blood Pressure		
ADHD			Chronic Kidney Disease: Stage ____		
Allergies			Leg Swelling		
Alzheimer's Disease			Liver Problems		
Anemia			Migraines		
Anxiety			Mood Disorders		
Arthritis, Location:			Multiple Sclerosis		
Asthma			Neurodevelopmental Disorder		
Atrial Fibrillation			Nightmare Disorder		
Behavioral Disturbances			Obsessive-Compulsive Disorder		
Bipolar			Pain: Location		
Cerebral Palsy			Panic Disorder		
Congestive Heart Failure __ Systolic __ Diastolic __ Mixed			Parkinson's Disease		
Constipation			Phobias		
Cancer:			Post-Traumatic Stress Disorder		
COPD			Prostate Problems		
Dementia (other)			Schizophrenia		
Depression			Skin Disease		
Dissociative Identity Disorder			Stomach Problems		
Diabetes Type 1 Type 2			Sleeping Problems (insomnia)		
Diarrhea			Traumatic Brain Injury		
Eating Disorders			Thyroid Disease		
Emotional Lability			Tuberculosis		
Emphysema			Ulcer		
Epilepsy | Seizures			Vision Problems		
Fatigue (chronic)			Weight Gain		
Gallbladder Problems			Weight Loss		
Hallucinations (Auditory)			Morbid Obesity		
Hallucinations (Visual)			Other:		
Hard of Hearing			Other:		
Hemorrhoids			Other:		

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MEDICAL HISTORY

Allergies	Social History
_____ _____ _____	Current Tobacco Use: _____pack(s) per day Alcohol Consumption: _____drinks per day Recreational Drug Use (circle one) YES NO

Surgical History: Previous surgical procedures, approximate dates, and hospital names	Hospitalizations: The reason for hospitalization, approximate date, and hospital name
_____ _____ _____ _____	_____ _____ _____ _____

FAMILY HISTORY

Illness	Family Members				
	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)					

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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 fax the requested medical information 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 SERVICES

CONSENT FOR PRIMARY CARE SERVICES

⇒ _____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. This may include preventive and prophylactic care, laboratory tests, diagnostics, and/or imaging. I also consent to routine immunizations during future office visits. By consenting to Primary Care, I also agree to telehealth visits if deemed medically appropriate due to COVID status, illnesses present, or patient acuity. 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

CONSENT FOR BEHAVIORAL AND MENTAL HEALTH TREATMENT

YES **NO** Permission is hereby fully granted to the Novari Primary Care Psychiatric and Mental Health Specialist 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, *if such specialty care is needed*. (1) If medically necessary and appropriate to the patient's condition, psychiatric medications may be discussed and considered by the PMHNP. The medical provider will discuss risks, benefits, potential side effects, government-mandated warnings, and alternative treatment options with you. (2) Psychotherapy or talk therapy may be integrated into your care. During psychotherapy, unpleasant feelings may arise. Such feelings are generally temporary and encouraged to be shared and expressed with your mental health practitioner. By acknowledging Novari Primary Care's Psychiatric and Mental Health Services, you acknowledge that the outcome of psychiatric care may vary from one individual to the next.

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. 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.

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.

PALLIATIVE CONSENT

YES **NO** I consent to receive Palliative Care services. This includes being seen by a palliative care provider who specializes in creating and implementing care plans that consider patients on a holistic level. This includes medication reconciliations, form reviews, care optimization, working with families, and considering patient emotional and spiritual support.

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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 when 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 healthcare 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.

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 with 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 the electronic communication of your medical information with other treating providers as part of the 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, Attention: NOVARI PRIMARY CARE. Upon receipt of your revocation, the Provider will give you written confirmation (including the effective date) of revocation.

☐ I consent to this Medicare benefit ☐ I decline this Medicare benefit

Signature: _____

Print Name: _____

Sign Date: _____

NOVARI Primary Care

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4686 Pointes Drive, Mukilteo, WA, 98275

Policies and Procedures

Please initial the following policies and procedures in the the provided spaces below.

Appointment Timeframes

_____ We want all patients to receive the proper time they need from their provider. No patient or facility should feel rushed, and we are committed to remaining with you until all patient needs have been met. For these reasons, we schedule facilities within a general timeframe, instead of a specific time.

Voicemails and Callbacks

_____ We have an expansive support team ready to receive your calls. If we miss your call, you will have an opportunity to leave a detailed voicemail describing the nature of your call. Voicemails will be returned the same business day when possible. Missed calls without a voicemail will not be returned. Detailed voicemails allow us to assist you more efficiently.

24-Hour Policy, Third Parties

_____ We believe timely communication is imperative to patient wellness, and Novari prides itself on one of the fastest response times in the industry. We sometimes require up to 24 hours to complete a request. Requests from third-party organizations, such as pharmacies, home health entities, specialists, prior providers, hospice entities, laboratories, and others, may result in delays that are out of our control.

By signing below, I hereby acknowledge that I have fully read and understood the Novari Primary Care protocols regarding patient care.

Signature: _____ Sign Date: _____

Printed Name: _____

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REQUIRED DOCUMENTS

Please provide a copy of the following:

- ❑ **Insurance card(s),** front and back
- ❑ Patient's most recent **medication list**
- ❑ A copy of the **Durable Power of Attorney for Health Care** forms
- ❑ 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 patient information must be encrypted before being sent to Novari Primary Care. To do this, scan your document, visit www.novariprimarycare.com/contact-us and select the option to send us a "Secure Email" and attach your scanned enrollment form.
- ❑ **Fax:** Please fax the completed enrollment packet, checklist, and supporting documents to **(425) 426-2277**.
- ❑ **Mail:** You can mail the enrollment packet and additional forms listed above to:

NOVARI PRIMARY CARE
4686 Pointes Drive
Mukilteo, WA 98275

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!