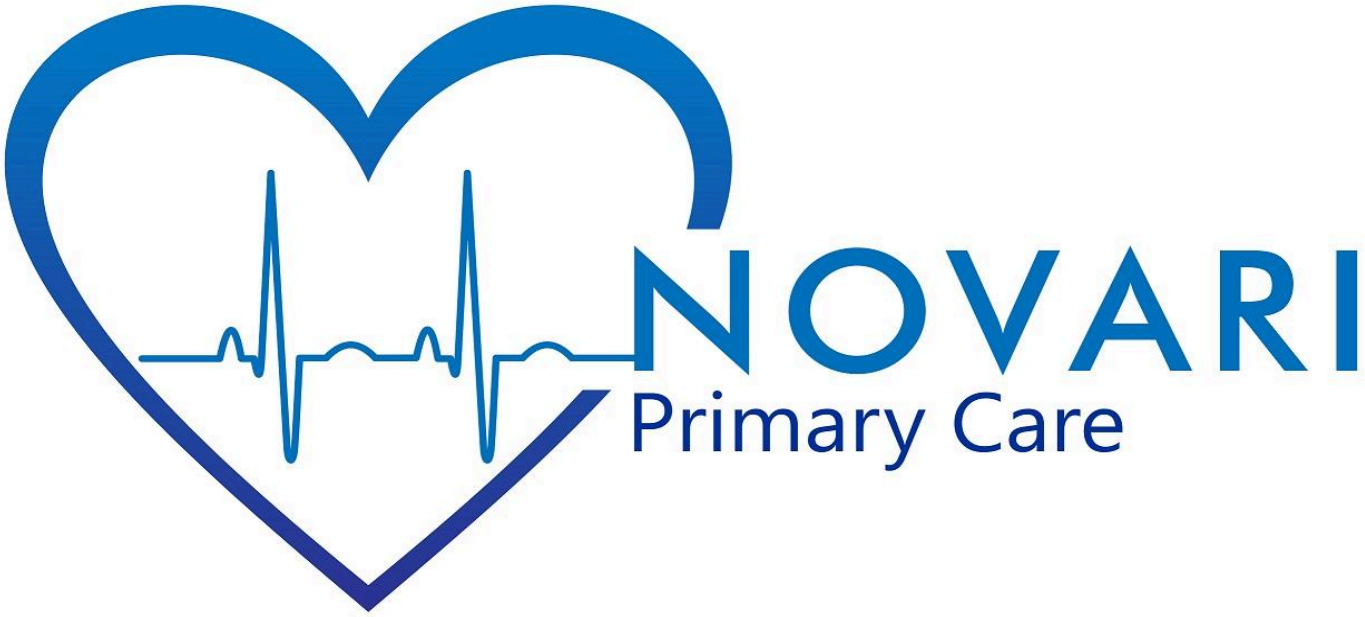
NOVARI
Primary Care

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

Welcome To Online Enrollment!

Welcome to Novari Primary Care, the premiere in-home healthcare practice in Washington State. We are thankful for your interest in our organization and we look forward to taking care of you or your loved one.

We appreciate your time as you fill out our enrollment forms. Please be as thorough and accurate as possible so we can provide you with the best service right away. To ensure you are fully prepared to complete our enrollment form, please see that you have the following documentation:

- **Insurance Cards, such as Medicare, Medicaid, or private insurance cards**
- **Your most recent medication list (if possible)**
- **A government-issued ID**

Thank you for your time and attention, and we look forward to serving you!

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Patient Information

Name: _____

Social Security Number: _____ Gender: M F

Date of Birth: _____

Former | Current Occupation:_____

Marital Status: Married Divorced Single Widowed

Government-Issued ID Upload:

Insurance Information

Please upload pictures of your insurance cards below.

I have Medicare	I have Private Insurance	I have Medicaid

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			Kidney Disease: Stage ____		
Allergies			Leg Swelling		
Alzheimer's Disease			Liver Problems		
Anemia			Migraines		
Anxiety			Mood Disorders		
Arthritis			Multiple Sclerosis		
Asthma			Neurodevelopmental Disorder		
Atrial Fibrillation			Nightmare Disorder		
Behavioral Disturbances			Obsessive-Compulsive Disorder		
Bipolar			Pain: Location_____		
Cerebral Palsy			Panic Disorder		
Congestive Heart Failure			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 or 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)			Other:_____		
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 send the requested medical information to:

NOVARI PRIMARY CARE
4686 Pointes Drive
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 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.

CONSENT FOR BEHAVIORAL AND MENTAL HEALTH TREATMENT

⇒ _____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.

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.

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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.

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

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ADDITIONAL DOCUMENTS

Please use this section to upload additional documents, <u>if you have them.</u>

- A copy of the patient's most recent medication list:

- A copy of the Durable Power of Attorney for Health Care form:

- A copy of a signed Physician Order for Life-Sustain Treatment (POLST) form:

Once received and reviewed for completion, a Novari Primary Care representative will contact you and schedule your initial appointment to establish care. We may reach out to you if additional documentation is required. Please note that completing this 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 all applicable forms are received and 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.

Certification of Truth
I certify that the above information in this form is true and correct to the best of my knowledge. If signing on behalf of another, I attest that I am legally authorized to sign on their behalf. Signature: _____ Print Name: _____ Relationship to Patient: _____ Sign Date: _____

Dear Patient:

Medicare has started an initiative where health care providers who share a common set of goals aimed at improving patient care can work together more effectively. This initiative brings together health care professionals in an Accountable Care Organization (ACO), to work together with Medicare to give you more coordinated care and services.

Novari Primary Care is voluntarily taking part in this new initiative by joining Advanced Illness Partners because we think it will help us provide better quality care for our patients.

You are receiving this letter and form because your doctor or other health care professional thinks that you might benefit from care coordination and preventive services offered by Advanced Illness Partners.

You can use this form to confirm that a **Novari Primary Care provider** is the main doctor or other health care professional you see or is the main place you go for routine care, to help determine if Advanced Illness Partners should help coordinate your care. Routine care can include regular care and check-ups you get from a doctor or other health care professional and care for other chronic health problems, such as asthma, diabetes, and hypertension. Please complete and return the enclosed form.

Alternatively, instead of returning this form, you can also log into Medicare.gov and select your main doctor or other health care professional to determine whether ACO, Inc. should help with coordinating your care. If you make a selection on this form and make a different selection through Medicare.gov, Medicare will prioritize the most recently submitted selection.

Your benefits will NOT change, and you can visit any doctor, other health care professional, or hospital.

Whether or not you complete this form or select a doctor or other health care professional through Medicare.gov, you remain eligible to receive the same Medicare benefits and you still have the right to use any doctor, other health care professional, or hospital that accepts Medicare, at any time. If you have questions, feel free to ask your doctor or other health care professional, call Advanced Illness Partners at 1-800-569-2998 or call Medicare at 1-800-MEDICARE (1-800-633-4227) to ask about ACOs. TTY users should call 1-877-486-2048.

Completing this form or selecting a doctor or other health care professional through Medicare.gov is your choice AND you can change your mind.

If you choose to complete this form or select a doctor or other health care professional through Medicare.gov you should do so yourself. No one else should complete this for you.

No one is allowed to attempt to influence your choice to complete this form or select a doctor or other health care professional through Medicare.gov by offering or withholding anything in exchange for you to complete or not complete the form or to make a selection online. If you feel pressured to sign or not sign this form or to make a selection online, please call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Please call 1-800-922-7022 or update your online selection if you change your mind later about whether you consider NOVARI PROVIDER to be the main doctor or other health care professional you see or the main place you go for routine care.

Sincerely,
Novari Primary Care

Get more information about ACOs.

CMS Website: https://innovation.cms.gov/innovation-models/aco-reach

ACO Website: https://advancedillnesspartners.org

Confirmation of Main Doctor or Other Healthcare Professional Form

1. Confirm ✔

By signing below, I am confirming that my main doctor or other healthcare professional – or the main place I go to for routine medical care – is a NOVARI PROVIDER at Novari Primary Care.

PATIENT NAME

_____ _____

Signature **Print Name**

___ / __ /_____ _____

Date **Date of Birth**

Medicare Number _____

Note: If the names listed above and in the attached letter are incorrect do not sign this form. If you would like to receive a new form with a different doctor, other healthcare professional, or practice listed, please call Advanced Illness Partners at 1-800-569-2998 to request a new form.

2. Return ✉

Electronic submission of your enrollment form will also submit this form.

Note: Completing and returning this form is voluntary. It won't affect your Medicare benefits.