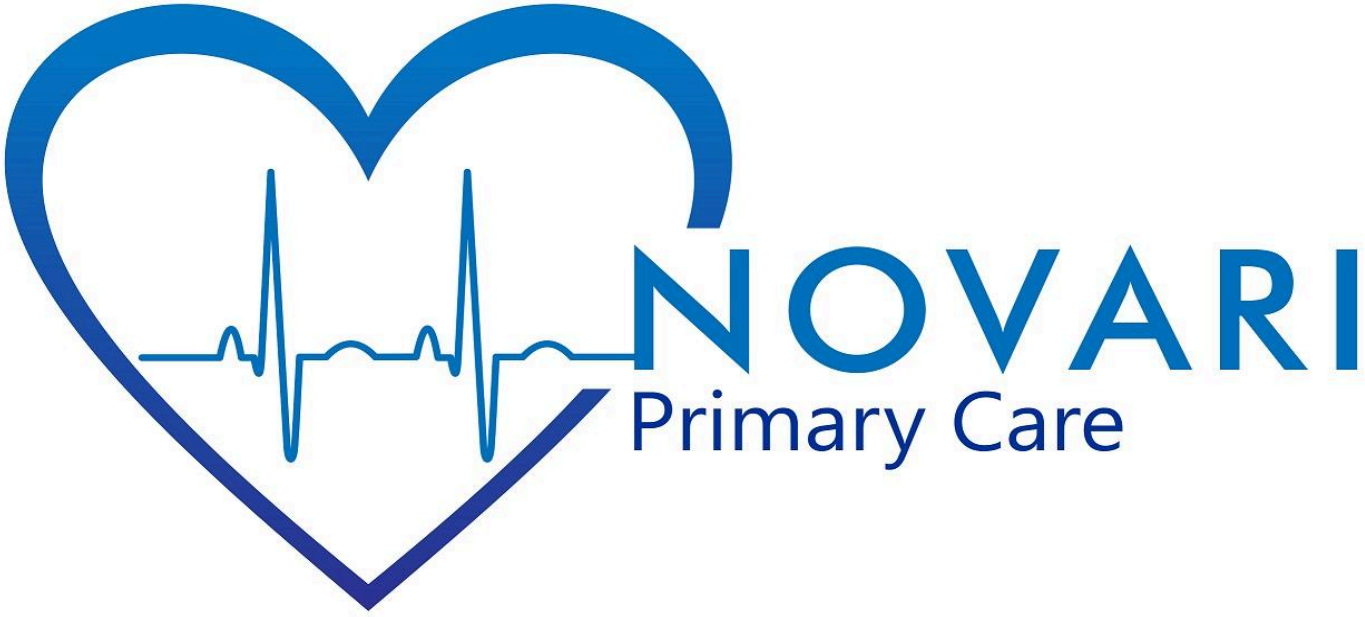
NOVARI
Primary Care

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



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Welcome To Novari Primary Care!

As the premier 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.

To ensure we can provide you with the best possible service right away, **we have recently updated our enrollment forms to gather more accurate information**. This improved form will be the standard documentation used moving forward.

We appreciate your time as you fill out these details. Please be as thorough and accurate as possible. To help you fully prepare to complete the enrollment, please use the checklist on the next page as your guide to confirm all items are included and that you have the following documentation ready:

- **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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REQUIRED DOCUMENTS CHECKLIST

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-Sustaining Treatment (POLST) form.**

Medicare · Medicaid · United Healthcare · Humana · aetna · AARP · MOLINA HEALTHCARE · TRICARE · BlueCross BlueShield · PREMERA BLUE CROSS · Regence · COMMUNITY HEALTH PLAN of Washington™ · wellcare · coordinated care · ambetter. FROM coordinated care · Cigna · Mutual of Omaha

*** We are not contracted with the following insurance providers:*
Kaiser, Wellpoint, Amerigroup, Tricare USFHP, Providence Health Plan, San Health Plan, and PEPS.

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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
Approximate height: _____ Approximate weight: _____
Government-Issued ID Upload:

Insurance Information
Please upload pictures of your insurance cards below.
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: _____

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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:_____Relationship:_____ Address: _____ City: _____ State: _____ Zip Code: _____ Phone: _____Fax: _____	

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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** Name of Recreational Drug/s used: _____

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

Respiratory Support Status		
Is the patient tracheostomy dependent?	**YES**	**NO**
Is the patient currently on a ventilator?	**YES**	**NO**
If YES, is there an established comprehensive care plan for tracheostomy and/or ventilator management?	**YES**	**NO**
Is Gastroenterology involved in G-tube management?	**YES**	**NO**

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*), with phone number _____ and fax number _____, 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:

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. 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

➔_____ 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 prohibit 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 where permitted by law.

TELEMEDICINE CONSENT

➔_____ I consent to telemedicine performed by a Novari Primary Care medical practitioner. This is described as real-time audio/visual or, when permitted, audio-only communication with my provider using a synchronous device and includesexaminations, 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 healthcare 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 4G8G 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: _____

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Advanced Primary Care Management
CONSENT FORM

Name: _____ DOB: _____

Date: _____

Novari Primary Care has chosen to participate in Medicare's newer Advanced Primary Care Management, or APCM, program. APCM is an updated Medicare care management program that allows Novari to support patients in newer and improved ways between regular doctor visits.

APCM may help with care needs between visits, including medication questions, coordination with caregivers or facilities, follow-up after hospital or ER visits, chronic condition support, preventive care reminders, and communication with other healthcare providers when needed.

By signing below, I understand that APCM is voluntary, that APCM may be billed to Medicare or my insurance once per calendar month when service requirements are met, that only one provider or practice can furnish and be paid for APCM services for me during the same calendar month, that Medicare cost sharing may apply depending on my insurance coverage, and that I may stop APCM services at any time by notifying Novari Primary Care verbally or in writing.

☐ **I consent to receive Advanced Primary Care Management (APCM) services from Novari Primary Care.**

Patient / Authorized Representative

Signature:_____

Printed Name: _____

Relationship:_____ Date: _____

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POLICIES AND PROCEDURES

Please initial the following policies and procedures in 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.

Hospice Clinical Oversight and Continued Care Policy

_____ In the event that a Novari Primary Care patient transitions to hospice care, Novari may continue to provide clinical oversight and care involvement as deemed appropriate by a Novari Primary Care provider. This may include primary care, mental health care, care coordination, medication review, family or facility communication, and other clinical support as appropriate. Novari's involvement does not replace the hospice agency, hospice medical director, or hospice plan of care, but is intended to support continuity of care and coordination for the patient's overall clinical needs.

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: _____

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 healthcare professional - or the main place I go to for routine medical care - is a NOVARI PROVIDER at Novari Primary Care

_____	_____
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. Opt-out

☐ I do not want to receive marketing activities, including voluntary alignment, at my home or at the place where I receive care.

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