Address: PO BOX 18752
TUCSON, AZ 85731

Phone: 520-245-7869
Fax: 520-844-3422
Email: GSA@geriatricservicesofaz.com

Checklist

- ○ Please sign and date all pages included in this packet
- ○ Please include a copy of your insurance information front and back
- ○ Please include a copy of your immunizations if available
- ○ Please include a copy of your medication list if available
- ○ Medical and or financial power of attorney paperwork

Please return all information to Geriatric services of Arizona prior to your first meeting

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Welcome

Thank you so much for choosing Geriatric Services of Arizona as your primary care provider. Our team works hard to deliver the highest quality, compassionate care to the residents we serve.

We do accept most insurance plans. If you have any questions about insurance acceptance, please contact our office at the number above.

Included in the packet, you will find helpful information regarding our policies and procedures. Prior to your first visit, we ask you to complete this packet.

If you do have a medical or financial power of attorney, please include a copy along with this packet.

We thank you for choosing geriatric services and were excited to partner with you in your health and wellness journey.

Sincerely

Bari Orozco AGNP-BC
Nurse practitioner/OWNER
Geriatric Services of Arizona
PHONE: 520-651-3329
FAX : 520-844-3422
EMAIL: GSA@geriatricservicesofaz.com

WE TREAT THEM LIKE FAMILY

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Registration information

Today's date_______________

Assisted living name and address

____

Client Legal name_________________________________

Date of birth______________________

E-mail address_______________________________________ **Phone #**________________________

POA/Family member name, address, and phone number____

____

Social Security number (needed to verify insurance) ____________________________

Insurance information
Please attach a copy of your insurance card with this packet. Please make sure to make a copy of the front and the back of the card

Primary insurance____________________________ ID#____________________________

Group#_____________________________________

Secondary insurance_________________________ ID#______________________________

Group#____________________________________

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the nurse practitioner. I understand that I am financially responsible for any balance. I also authorize geriatric services of Arizona or agents or insurance company to release any information required to process the claim

I authorize Geriatric Services of Arizona to be my primary medical practitioner and to treat any acute and chronic medical issues

I authorize my photo to be used in the EMR, on social media and on our website

____

Client/Medical Power of attorney

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Financial policy

The following is a statement of our financial policy which we ask you to read and sign prior to your first appointment. Additionally, we may require you to present your insurance cards at your first appointment

Medicare- we are Medicare providers we do accept assignment

HMO and PPO

It is your responsibility to know your benefits regarding covered services, deductibles and co-pays including coinsurance and referrals. You may call the member services phone number on your insurance card for assistance

Contracted insurance carriers

We will submit a claim to your insurance company for medical visits. If payment is not received within 60 days, the balance of becoming a responsibility. It will be your responsibility to recover the reimbursement from your insurance carrier

Private insurance carriers

We can supply you with a necessary paperwork for you to submit the claims to your insurance company for reimbursement. Full payment is required at the time of services are rendered

I have read this policy and understand the that regardless of insurance, I am financially responsible for payment of services

____

Signature

____

Printed name

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Authorization for release of information

Assisted Living Facility____

Client name____

I___________________________________ consented to the release of my medical information to

Geriatric services of Arizona

Previous primary care provider___________________ **phone number**__________________

The information I wish to release is-**circle what applies**

Pertinent information laboratory/pathology entire chart

Potential for redisclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure that you are right to the protection of privacy of this information once geriatric services of Arizona discloses it to another party.

Rights of the individual

You may inspect a copy of the information use to disclose under the authorization

You may refuse to sign this authorization

Signature of the Client________________________________

Printed name____

Signature of Client representative_______________________________

Relationship of the resident's representative to this Client_______________________

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Notice of privacy Practices and HIPAA compliance statement.

Understanding your health information.

Geriatric services of Arizona will create and maintain a record of each client's treatment that contains protected personal health information. Typically, this record contains history, assessment, medical information, diagnosis, and a treatment plan for future treatments.

This notice describes some medical information about you may be used and disclosed in how you can get access to the information. Our intent is an organization is to be fully compliant with the health insurance and portability and accountability act (HIPAA) of 1996

1. **OUR PLEDGE REGARDING MEDICAL INFORMATION**
   The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you received at our organization. This notice will tell you about the ways you may use and share the information about you. We also described your rights and certain duties we have regarding the use and disclosure of medical information.

2. **OUR LEGAL DUTY**
   The law requires us to keep your medical information private. The law also requires that we give you this notice describing her legal duties, privacy practices and your rights regarding your medical information. Will have to wait to change our privacy practices in the terms of this notice at any time, provided that the changes are permitted by law. We have the right to make the changes to her privacy practices and the new terms of her notice effective for all medical information including information previously created a received prior to the changes. Before we make a change to our practices, we will amend this notice and make the changes available upon request.

3. **USE AND DISCLOSUREOF YOUR MEDICAL INFORMATION**
   The following section describes different ways that we use and disclose medical information. Not every use for disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose her medical information for any purpose not listed below without your specific written authorization. Any specific medical information use or disclosure may be revoked at any time upon providing us with receipt of your written intent not to disclose any further medical information.

   Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, nurse practitioner students or other people who are taking care of you.

Healthcare operations: We may use a disclosure of medical information for healthcare operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses, and credentials we need to serve you

Payment: We may use a disclosure of medical information for payment purposes
Additional uses on disclosures: In addition to using and disclosing her medical information for treatment, payment, and healthcare operations, we may use and disclose medical information for the following purposes
Notification of family member or personal representative
Disaster relief and law enforcement
Research and limited circumstances
Funeral director, corner medical examiner
Specialized government functions
Court orders or judicial and administrative proceedings
Public health activities/health oversight activities
Victims of abuse, neglect, or domestic violence

4. YOUR INDIVIDUAL RIGHTS

You have the right copies of your medical information
You must make a request in writing with a medical record release of information
If you request copies of your medical record for your personal files, abdominal charge will apply to cover your costs
You have the right to receive a list of all the times we or our business Associates shared your medical information for purposes other than treatment, payment, and healthcare operations
You have the right to request that additional restrictions be placed on her use or disclosure of her medical information. We will attempt to abide, though we are not required to the restrictions except a case of an emergency.
You have the right to request that we communicate with you about your medical information by different means. The request may be made in writing
You have the right to request that we change her medical information. We may deny your request of we did not create the information you wanted changed or for certain other reasons. You may respond with this statement of disagreement that we will add to the medical record.

RIGHT TO REVISE PRIVACY PRACTICES

As permitted by LOC, we reserve the right to amend or modifier privacy policies and practices. The changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recent revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain

Complaints:

If you like to submit a compliant complaint about her privacy practices, you can do so by sending a letter outlining her concerns to: Geriatric services of Arizona

If you have reason to believe that your privacy rights have been violated, you may bring the matter to our attention by sending a letter describing the nature of your concern. You will not be penalized or retaliated against for filing a complaint.

I acknowledge receipt and have read again a and understand the notice of health information practices regarding my providers participation in the health information exchange of Arizona and or I have previously received this information and decline another copy.

Acknowledgement

I have received the notice of privacy practices form and the notices of health information practices and have an opportunity to review.

Signature of Client or Signature of power of attorney or authorized signature.   DATE

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CHRONIC CARE MANAGEMENT PROGRAM INFORMED CONSENT

Progress participates in Medicare's chronic care management program which allows us to provide 24X7 Healthcare Services to her clients without requiring face to face visit for every interaction. The program helps play a role in delivering high-quality care at an affordable cost to our clients as well as for Medicare

Ongoing chronic conditions required continued persistent care. Example of chronic conditions include dementia, diabetes, heart failure, blood pressure, arthritis, and depression. Caring for chronic conditions often involves careful coordination between family members, specialist and caregivers and other healthcare professionals. As primary care providers, we are uniquely positioned to manage the care and coordination between these groups and ensure the best outcome for clients

Benefits of participating in our chronic care management program

Improve provider awareness of client issues, health, and overall wellbeing

Frequently reducing healthcare costs

Routine checkups and preventative care services

Continuous care coordination between providers, facilities, labs, radiology, and others

Active medication management between visits

Consistent care plan administration how the program works

How the program works

Client must have at least 2 chronic conditions and have signed this agreement to participate. Only 1 provider from any location may provide the services in any given month. Please let us know if you believe another provider is billing you for the services

Your primary care provider will perform an initial evaluation, prepare a comprehensive care plan and share it with all relevant parties. Each month after that we keep track of any chronic care services provided outside of a face-to-face visit which are billed separately. Your provider will also keep your care plan up to date based on any changes or adjustments during the month

At the end of the month if we have provided more than 20 minutes of services, we will bill your insurance

You will have access to electronic medical records and may request details regarding how CCM time was spent during the month

Consent

I have read Geriatric Services of Arizona as chronic care management program terms and conditions as defined by Medicare, and I agreed to participate in the CCM program

Date____

Client name or legal representative____

Signature____