Great Plains Geriatrics, L.L.C.
135 Ponderosa Ave
Hill City, SD 57745
605-394-2118

NEW PATIENT FORM

Patient Name:_____ **DOB:**____/____/_____

Social Security #:_____ - _____ - _____ **Phone:**_____- _____- _____

Facility Name:_____ **Room #:**_____

Street Address:_____

City:_____**State:**_____ **Zip Code:**_____

Emergency Contact/POA:_____

Guarantor Address:_____

Phone:_____-_____-_____ **Email:**_____

Relationship To Patient:_____

APCM Consent to treat Signature:_____

Medicare's Advanced Primary Care Management (APCM) is defined as the non-face-to-face services provided to Medicare beneficiaries who have multiple (two or more), significant chronic conditions. In addition to office visits and other face-to-face encounters (billed separately), these services include TCM, CCM and PCM communication with the patient and other treating health professionals for care coordination (both electronically and by phone), medication management, and being accessible 24 hours a day to patients and any care providers (physicians or other clinical staff). This serves to ensure Primary Care meets the level of patient need using quality measures to assess program effectiveness.

SPECIALTY CARE PROVIDERS

Preferred Pharmacy:_____
Past Primary Clinic:_____
Cardiology:_____
Urology:_____
Endocrinogy:_____
Psychology:_____
Other:_____

FAMILY HISTORY

_____
_____

SOCIAL HISTORY

_____
_____

SURGICAL HISTORY

_____

PAST MEDICAL HISTORY

_____
_____

MEDICATION LIST *OK TO ATTACHED MEDICATION LIST*

****ALLERGIES:**_____

_____

Please indicate the name of medication, dose and frequency.

Drug	**Dose**	**Frequency**
Drug	**Dose**	**Frequency**
Drug	**Dose**	**Frequency**
Drug	**Dose**	**Frequency**
Drug	**Dose**	**Frequency**
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Drug	**Dose**	**Frequency**
Drug	**Dose**	**Frequency**
Drug	**Dose**	**Frequency**

PLEASE INCLUDE THE FOLLOWING INFORMATION: (REQUIRED PRIOR TO ADMISSION)

- **Insurance card copies (BOTH PRIMARY AND SECONDARY POLICIES)**
- **POA medical paperwork (if applicable)**

FAX COMPLETED FORMS TO: 605-307-8999 OR EMAIL TO: admissions@gpgcare.org

Great Plains Geriatrics, L.L.C.
135 Ponderosa Ave
Hill City, SD 57745
Telephone: 605-394-2118
Fax: 605-307-8999

Informed consent

1. I _____ (patient name) voluntarily consent and authorize **Great Plains Geriatrics** to provide reasonable and necessary medical examinations, testing and treatment by any clinician within the physician group.
2. I agree to allow **Great Plains Geriatrics** to file necessary insurance claims for reimbursement for the medical care and treatment that I receive.
3. I understand that:
    - **Great Plains Geriatrics** will be required to share and provide medical record information to my insurance company.
    - I agree to pay my share of the costs not covered by insurance.
    - I agree to pay the reasonable cost of such medical care or treatment not covered by my insurance carrier/policy or if not currently insured by any policy.
4. I understand:
    - I have the right to refuse any procedure or treatment at any time.
    - I have the right to discuss all medical treatments regarding purpose, potential risks and benefits of any treatment or testing with my clinician.
    - This consent will remain fully effective until it is revoked in writing. I have the right to discontinue services at any time.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____
Signature of Patient or Representative Date

_____ _____
Printed Name of Patient or Representative Relationship to Patient

Telehealth Consent Form

1. I _____(patient name) voluntarily consent and authorize **Great Plains Geriatrics** to use the telehealth practice platform for telecommunication for evaluating, testing and diagnosing my medical condition.
2. I understand that technical difficulties may occur before or during the telehealth sessions and my appointment cannot be started or ended as intended.
3. I accept that the professionals can contact interactive sessions with video call; however, I am informed that the sessions can be conducted via regular voice communication if the technical requirements such as internet speed cannot be met.
4. Telecommunications with patients will not be recorded and stored.
5. I agree that my medical records on telehealth can be kept for further evaluation, analysis and documentation, and in all of these, my information will be kept private.
6. I agree to allow **Great Plains Geriatrics** to file necessary insurance claims for reimbursement for the medical care and treatment that I receive.
7. I understand:
    - That my current insurance may not cover the additional fees of the telehealth practices and I may be responsible for any fee that my insurance company does not cover.
    - **Great Plains Geriatrics** may be required to share and provide medical record information to my insurance company.
8. I understand:
    - I have the right to refuse any procedure or treatment at any time.
    - I have the right to discuss all medical treatments regarding purpose, potential risks and benefits of any treatment or testing with my clinician.
    - I can withdraw my consent at any time and can ask the questions related to telemedicine appointments and technical requirements for telecommunication.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Signature of Patient or Representative Date

_____ _____

Printed Name of Patient or Representative Relationship to Patient

Great Plains Geriatrics LLC
135 Ponderosa Avenue, Hill City, SD 57745
Ph: 605-394-2118 Fax: 605-307-8999

Great Plains Geriatrics, L.L.C.
135 Ponderosa Ave
Hill City, SD 57745
Telephone: 605-394-2118
Fax: 605-307-8999

HIPAA Release Form

Mail, FAX or email completed forms to:
Address: 135 Ponderosa Ave., Hill City, SD 57445
Email: admissions@gpgcare.org ; FAX: 605-307-8999

Authorization to Release Protected Health Information

Patients/POA must complete this form to authorize the release of protected health information to the account holder.

Please complete this form in its entirety so we can help you receive the information you are requesting. This authorization is voluntary. This information will help your primary care provider to better understand your past medical history in order to provide the highest level of care possible.

Medical Records Requested:

❑ Complete medical records (past 12 mths) ❑ Provider Office Visit Notes ❑ Hospital/ER Encounter Notes ❑ Hospital Discharge Notes	❑ Labs/Diagnostics ❑ Behavioral Health ❑ Other _____
Start Date:_____	**End Date:**_____

Primary Account Holder Information

Last Name	First Name	M.I.
Street Address	City	State ZIP
Email	Phone	SS#

Authorization of HIPAA Release (to be completed by patient or POA)

I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization. You have the right to revoke or cancel this authorization, in writing, at any time. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits).

Date	Patient's Date of Birth	Date of Authorization (Effective for 12 months unless otherwise stated)
Patient/POA Name (Please print)	Patient/ POA Signature	

NOTE: If the person signing above is a personal representative of the named individual, attach a copy of document granting authority to the personal representative.