GET AGING

Welcome

Welcome to Get Aging! We appreciate your trust and willingness to create a partnership that will support you in accomplishing your health-related goals.

Hours of Operation and Contact Information

Monday-Friday from 8:30 a.m. - 5:00 p.m.
Please contact our office for assistance with any questions at (415) 712-0501.

After-hours urgent calls (415) 712-0501

Please note no refills will be given after hours. Refills must be requested as part of the visit with the provider, through your pharmacy or during normal office hours.

Insurance

For the benefit of our Patients, we are in-network with most insurance companies; however, you will want to check with your insurance carrier to verify if we are on their list of providers. If your insurance company requires you to select a primary care provider, **please call them immediately and select Carla Perissinotto as your new PCP**. As part of our contract with these companies, we are legally required to collect co-pays and deductibles from you. All bills from our practice will come from Get Aging.

Prior to our initial visit we must receive a copy of the front and back of your insurance card, along with all paperwork.

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Patient Information

Date: _____

Patient Name: _____

Facility/Home Address: _____ Room/Apt. #: _____

City: _____ State: _____ Zip: _____

Is this the same address on file with your insurance company? O Yes O No

Date of Birth: _____ SSN: _____

Primary Phone Number: _____

Gender:_____ Marital Status (Optional): _____

Email Address: _____

Do you currently have a smart phone or iPad? O Yes O No

Do you currently have internet service? O Yes O No

Emergency Contact

Name: _____

Primary Phone Number: _____ Relationship: _____

Address: _____

City: _____ State/Zip: _____

Email Address: _____

Where should bills for deductibles, co-pays and non-covered items be sent?*

Name: _____

Primary Phone Number: _____ Relationship: _____

Address: _____

City: _____ State/Zip: _____

*I (or my Power of Attorney/Responsible Party) further understand that I (or my Power of Attorney/Responsible Party) will be billed for any deductibles and/or co-pay amounts as required by the Health Care Financing Administration, and I (or my Power of Attorney/Responsible Party) hereby agree to pay any and all such amounts promptly.

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Patient Authorizations

Patient Name: _____

Provider Services Authorization

☐ I hereby authorize Get Aging to be my Primary Care Provider. (**OPTIONAL)**

_____ _____

Signature of Patient, Power of Attorney,or Responsible Party Date

Telehealth Services Authorization

☐ I hereby authorize the following for Get Aging and telehealth services:

1. I hereby authorize Get Aging 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 may not start or end as intended.
3. I accept the professionals can contact interactive session 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. 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.
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.

_____ _____

Signature of Patient, Power of Attorney,or Responsible Party Date

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Chronic Care Management
(consent)

As a patient with two or more chronic conditions, you may benefit from a new Medicare benefit called Chronic Care Management (CCM) and Behavioral Health Integration (BHI) that we are now offering. CCM/BHI Services are available to you because you have:

1. been diagnosed with two or more chronic conditions expected to last at least 12 months, which place you at significant risk of decline, and/or
2. been diagnosed with one or more behavioral health conditions.

Our goal is to ensure you get the best care possible, to keep you out of the hospital, and to minimize costs and convenience to you due to unnecessary visits to doctors, emergency room visits, laboratory testing, or hospital admissions.
By signing this Agreement, you consent to Carla Perissinotto MD *(referred to as "Provider"),* providing chronic care management and/or behavioral health services (referred to as "CCM/BHI Services") to you as more fully described below.

▶ CCM/BHI Services include 24-hours-a-day, 7-days-a-week access to a health care provider in Provider's practice to address acute needs; systematic assessment of your health and behavioral health care needs; processes to assure that you receive timely 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. The Provider will discuss the specific services with you that will be available and how to access those services.

Provider's Obligations

▶ *When providing CCM/BHI Services, the Provider must:*

- Explain to you (and your caregiver, if applicable), and offer, all the Services that are applicable to your conditions.
- Provide to you a copy of the CCM/BHI care plan according to your preference specified under beneficiary rights section.

Beneficiary Acknowledgement & Authorization

▶ *By signing this agreement, you agree to the following:*

- You consent to the Provider providing CCM/BHI Services to you.
- You authorize electronic communication of your medical information with other treating providers as part of the coordination of your care.
- You opt-in to receiving occasional (estimated frequency is one per month) text messages and/or email messages to
- You acknowledge that only one practitioner can furnish CCM/BHI Services to you during a calendar month.
- You understand that cost sharing will apply to these Services, so you may be billed for a portion of the Services even though Services may not involve a face-to-face meeting with the provider.

Beneficiary Rights

▶ *You have the following rights with respect to CCM Services:*
My preference is that I would like to receive/review my CCM care plan using the following method:

- ☐ I would like to receive a copy of my CCM care plan electronically by email or text message
- ☐ I would like to discuss my care plan orally with my chronic care coordinator
- ☐ I would like to receive a written copy during a provider visit

Email address _____

Mobile number _____
(used for text messages)

You have the right to stop CCM Services by revoking this Agreement at the end of a calendar month. You may revoke this agreement verbally or in writing by notifying Provider or care team member. We believe that this new Medicare benefit can provide significant value to our patients, and we appreciate

Patient/Beneficiary Providing Consent

Signature _____

Name _____

Today's Date _____

Date of Birth _____

Beneficiary's Representative *(if applicable)*

Signature _____

Name _____

Today's Date _____

Patient Medical Record Number _____

Get Aging

info@getaging.com

415-712-0501

415-712-1431

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Medical Records Release

I hereby give my permission to release all medical records, including psychiatric records to Get Aging for continuity of care.

Patient Name: _____

Date of Birth: _____ SSN: _____

Address: _____

City: _____ State/Zip: _____

Applicable time period: _____

_____ _____

Signature of Patient, Power of Attorney,or Responsible Party Date

PLEASE FAX RECORDS TO: 415-712-1431

Get Aging

info@getaging.com

415-712-0501

415-712-1431

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Medicare Assignment of Benefits

Patient Name: _____ DOB: _____

Facility: _____ SSN: _____

Medicare/Medicare Advantage #: _____ Medicaid #: _____

Secondary Insurance: _____ ID #: _____

I request that payment of authorized Medicare, Medicaid and Secondary Insurance benefits be made on my behalf to Get Aging for any services provided and documented by Get Aging. I authorize any holder of medical information to release to the Health Care Financing Administration, and its agents, any information needed to determine these benefits and/or the benefits payable for related services. The intent of this paragraph is to authorize any insurance provider/company that may be billed for co-insurance to pay Get Aging directly. I permit a copy of this Authorization to be used in place of the original. I understand that this is a lifetime authorization.

_____ _____

Signature of Patient*+ Date

_____ _____

Signature of Power of Attorney or Responsible Party+ Date

_____ _____

Witness Date

***If someone other than the Patient signs the authorization (e.g. a Power of Attorney), the reason for the Patient's inability to sign and the relationship between the Patient and the responsible party must be stated below:**

_____

_____

_____

+ I (or my Power of Attorney/Responsible Party) further understand that I (or my Power of Attorney/Responsible Party) will be billed for any deductibles and/or co-pay amounts as required by the Health Care Financing Administration, and I (or my Power of Attorney/Responsible Party) hereby agree to pay any and all such amounts promptly.

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Notice of Privacy Practices and Patient Consent for Use and Disclosure of Protected Health Information

- O I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.
- O I understand that Get Aging may use or disclose my protected health information for treatment, payment or health care operations, including but not limited to providing health care to me, the Patient, handling billing and payment and taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.
- O Get Aging has a detailed document called *The Notice of Privacy Practices*. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information. I understand that I have the right to read *The Notice of Privacy Practices* before signing this agreement. You may obtain a copy of *The Notice of Privacy Practices* at any time by contacting the office.
- O I understand I will need to provide a copy of my POA, DNR and other important legal documents.
- O I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Get Aging. I understand that the revocation will not apply to the information that has already been released in response to this authorization.
- O I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws and regulations. I also understand authorizing the use or disclosure of the information is voluntary. I need not sign this form to ensure health care treatment.

Signature of Patient _____ Date _____

Signature of Power of Attorney or Responsible Party _____ Date _____

Witness _____ Date _____

My medical information may be disclosed to the following individuals or organizations:

Name _____ Relationship _____

Name _____ Relationship _____

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AGREEMENT TO RECEIVE MEDICARE ADVANCED PRIMARY CARE MANAGEMENT (APCM) SERVICES

Medicare covers Advanced Primary Care Management (APCM) services provided monthly by physician practices. I understand that my primary care physician is assuming responsibility for all my primary care services and will be a continuing focal point for all my needed health care. In agreeing to receive APCM, I understand that my physician and the Get Aging care team are willing to provide such services to me, including the following:

Access and continuity of care

- 24/7 access to the care team for urgent needs.
- The ability to get successive, routine appointments with a member of the care team.
- Alternatives to traditional office visits (for example, home visits or expanded clinic hours).

Comprehensive Care Management

- Needs assessment, including medical and psychosocial.
- Helping ensure I receive recommended preventive services.
- Medication management and support.
- A personalized care plan that outlines my health goals and needs and is regularly reviewed and updated.
- A copy of my care plan accessible to me, my caregivers, and members of my care team.

Care Coordination

- Coordinating my care across settings, such as:
    - Referrals to other physicians and health care providers.
    - Communicating with home- and community-based providers, community-based service providers, hospitals, and skilled nursing facilities others.
- Follow-up care after emergency department visits or discharge from a hospital, skilled nursing facility, or other health care facility.

Enhanced Communication Opportunities

- Additional ways for me and my caregivers to communicate with my physician and care team, such as patient portals, secure messaging, and e-visits.

I also understand that I can revoke this agreement at any time (effective at the end of a calendar month) and can choose, instead, to receive these services from another health care professional after the calendar month in which I revoke this agreement. Medicare will only pay one physician or health care professional to furnish me APCM services within a given calendar month.

I understand these APCM services are subject to the usual Medicare deductible and coinsurance applied to physician services.

My signature authorizes my primary care physician to electronically communicate my medical information with other treating providers as part of the care coordination involved in APCM.

This Designation is effective as of the date below and remains in effect until revoked by me.

Patient name (please print): _____ **Date Of Birth:** _____

Signature: _____**Date:**_____
First and Last name of person who completed, if other than the patient: _____
Relation to Patient: _____