topmednow

Office: 801.784.8414 **Fax:** 801.701.8189 **Email:** Office@topmednow.us

Outpatient Information/ Consent to Treat/ Financial Responsibility

Date:_____

Patient Name:_____( ) M ( ) F

Address:_____

Phone #:_____**Email:**_____

Date of Birth:_____**Age:**_____**Marital Status:**_____

Emergency Contact:_____**Relationship:**_____

Phone:_____**Email:**_____

Primary Insurance:_____

Secondary Insurance:_____

Primary Care Physician:_____

Financial Responsibility and Assignment of Insurance Benefits or Cash Pay

I guarantee payment to Valarie Jacobs FNP, Valdar LLC, Top Medical Now LLC (hereinafter referred to as Provider), and its affiliates of all charges for services provided to the patient. I understand and am personally responsible for all charges not covered by my insurance. I authorize payment of surgical and medical benefits and care which would otherwise be payable to me, to provide for services rendered. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under titles V, XVIII, and /or XIX of the Social Security Act is correct. I acknowledge that many insurers will only pay for services that are determined to be medically necessary and that meet other coverage requirements and may need preauthorization. If my insurer determines that any services provided are not medically necessary or fail to meet other coverage requirements the insurer may deny payment for that service. I agree that if my insurer denies any part of my provider charges, or if I have no insurance or an HMO or out-of-network plan, I will be personally and fully responsible for the payment of the provider's charges. Should my account be referred to an attorney or a collection agency due to refusal of payment, I agree to pay actual attorney fees and collection agency expenses. If I carry an insurance plan not accepted by the provider, I understand that I am responsible for any or all of the charges incurred and or may be charged the self-pay rates.

Consent for Healthcare and release of Medical information

I hereby voluntarily request treatment from Valarie Jacobs FNP, Valdar LLC. I voluntarily consent to healthcare treatment ('treatment') prescribed or recommended by the provider. I consent to any prescribed lab work, including HIV testing, x-rays, or other imaging. I authorize practitioners to perform medical treatment, diagnostics, telemedicine, technical procedures, and the administration of drugs, including injections, and to render care as their judgment may indicate to be necessary or advisable. I also consent for practice to perform non-clinical activities related to my care. I am aware that the practice of medicine is not an exact science. No guarantees have been made to me regarding the result of treatments or examinations by my caregivers. I consent to the use and disclosure of protected health information about me for treatment, payment, and healthcare operations. I understand that the provider may have students at times, and consent to their presence during my exams if indicated. I consent to the release of my current or past personal medical information from my current or past healthcare providers, including other healthcare entities to the practice or from this practice. I understand that the practice participates in Medicare chronic care management program (CCM) and remote patient monitoring (RPM), and hereby give my consent to this. I have had the opportunity to read this form. I have had the opportunity to ask questions and my questions have been answered. I have had the opportunity to receive a handout on my rights with CCM. (please see HIPAA form).

Patient Signature:_____

Responsible Party:_____

Release of Client Medical Information

To:_____

_____

I Herby authorize you to release any and all medical or confidential information contained in the record of

_____

Specific Information requested_____

By signing this consent, I give authorization for my hospital records to be reviewed electronically or in paper or electronic format I furthermore give my consent for Valarie Jacobs DNP, FNP-BC or her affiliates to share information and or access my information as deemed necessary for my comprehensive care for purpose of patient care or billing.

Information to be released to:

Dr. Valarie Jacobs DNP/Valdar LLC/Top Medical Now

topmednow

Phone: 801.784.8414 **Fax: 801.701.8189** **Email: Office@topmednow.us**

_____

Patient Signature Representative/Guardian Date

Name: _____DOB:_____

topmednow

Office: 801.413.3395 **Fax:** 385-213-0093 **Email:** Office@topmednow.us

Patient Information

Date:_____

Patient Name:_____( ) M ( ) F

Height:_____**Weight:**_____**Drug Allergies:**_____

Current Medication List (Name and Dosage):_____

_____

_____

_____

_____

_____

_____

_____

Medical History/Chronic Conditions:

_____

_____

_____

_____

_____

_____

_____

Primary Care Physician:_____

Pharmacy Name and Address_____

topmednow

Office: 801-784-8414 **Fax:** 801-701-8189 **Email:** Office@TopMedNow.us **Website:** www.TopMedNow.us

Chronic Care Management Program

Dear Patient,

Medicare has introduced a new program that provides services to help you manage your chronic conditions. This program is available to Medicare patients with two or more chronic conditions and your doctor believes that this program could help to manage your chronic conditions.

Here are the benefits of the program:

- We will create a care plan that is custom-designed to meet your goals. (You'll receive a copy)
- We will do a full assessment of your health needs.
- Every month, we will check in to make sure things are going well.
- You will have access to a healthcare provider who can address your chronic conditions 24/7.
- We will be able to address health issues outside of the office, resulting in fewer office visits and fewer hospital admissions.

Before we start, we need you to consent to the following:

- We may share your information with your other providers and this may be done electronically. This will allow all those involved with your care to stay up-to-date with your progress in this program.
- Only one provider can provide this service to you during a 30-day period, and you agree that our office will be that one provider.
- You can cancel or revoke this program at any time by talking to our staff. We will provide you with a form to sign if you decide to cancel.
- Depending on your insurance, you may be billed for a small portion of the CCM Service. In many cases, the service is free without copay. In some cases, there is an $8-9 / month copay. If you have a financial hardship and you are unable to pay this copay, please call our office to discuss your options.

Print Name: _____ Date of Birth: _____

Best Phone # for me to be reached at: (_____) _____-_____

Patient Signature: _____ Today's Date: _____

(Optional): Legal Rep or Power of Attorney: _____ Signature: _____

Top Medical Now/ Valdar LLC/ Valarie Jacobs FNP
230 South Main Street
Bountiful Utah, 84010

topmednow

Office: 801.413.3395 **Fax:** 385-213-0093 **Email:** Office@topmednow.us

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

Provider Order for Life-Sustaining Treatment (POLST)

Utah Life with Dignity Order

Bureau of Health Facility Licensing and Certification, Utah Department of Health
State of Utah Rule R432-31 v3.1 February 2016 (http://health.utah.gov/hflcra/forms.php)

Patient's Last Name		First Name/Middle Initial		Effective Date of this Order	
Date of Birth		Last 4 of SS#		Address (street/city/state/zip)	
Medical Provider's Name (MD/DO/PA/APRN)	Valarie Jacobs DNP, FNP-BC			Medical Provider's Phone	8017848414
Brief description of patient's medical condition					
Patient's stated goals for medical care					

A. CARDIOPULMONARY RESUSCITATION (CPR) Treatment options when the patient **does not have a pulse and is not breathing** (CHECK ONE)

- ☐ Attempt to resuscitate (selecting attempt to resuscitate requires selecting full treatment in Section B)
- ☐ Do not attempt or continue any resuscitation (DNR) (Allow Natural Death)
- ☐ I do not wish to express a preference (selecting this may lead to attempt to resuscitate)

B. MEDICAL INTERVENTIONS Treatment options when the patient **has a pulse and is breathing** (CHECK ONE)

- ☐ **FULL TREATMENT:** *Prolonging life by all medically effective means.* Medical care may include endotracheal intubation, mechanical ventilation, defibrillation/ cardioversion, vasopressors, and any other life-sustaining care that is required. Also includes medical care described below.
- ☐ **LIMITED ADDITIONAL INTERVENTIONS:** *Treating medical conditions while avoiding burdensome measures.* Medical care may include treatment of airway obstruction, bag/valve/mask ventilation, monitoring of cardiac rhythm, IV fluids, IV antibiotics and other medications as indicated. Also includes medical care described below. No endotracheal intubation or mechanical ventilation. Generally avoid the Intensive Care Unit.
- ☐ **COMFORT MEASURES:** *MAXIMIZING comfort and dignity.* Medical care may include oral and body hygiene, reasonable efforts to offer food and fluids orally, medication, oxygen, positioning, warmth and other measures to relieve pain and suffering. Transfer to the hospital only if comfort measures can no longer be managed at the current setting.
- ☐ **NO PREFERENCE:** I do not wish to express a preference (selecting this may lead to full treatment).

Other Instructions or clarification; Describe goals and/or time period if a trial intervention is desired:

C. ARTIFICIAL NUTRITION

- ☐ Long term artificial nutrition with feeding tube
- ☐ Trial period of artificial nutrition with feeding tube
- ☐ No artificial nutrition
- ☐ I do not wish to express a preference

Describe goals and/or time period if a trial is desired:

D. ADVANCE DIRECTIVE AND PATIENT PREFERENCES

- ☐ Advance Directive available, reviewed and confirmed without conflicts
- ☐ No Advance Directive available

Health care agent named in Advance Directive | Phone Number

- ☐ I, the patient, want this order to serve as a general guide. I understand in some situations, the person making decisions for me may decide something different if they think it is consistent with my preferences.
- ☐ I, the patient, want this order to be followed strictly.

Discussed with:

REQUIRED SIGNATURES

Print Name	Relationship: (write self if patient)	Signature

Signature of Medical Provider (MD/DO/PA/APRN) Two signatures required for minors	Print Name	License Number	Date
Val Jacobs	Valarie Jacobs DNP, FNP-BC	348597-4405	
Signature of licensed professional preparing form	**Print Name**	**Title**	**Date**

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