SHAE Medical, PLLC IS NOW CURANA HEALTH

Register Online Here

**PATIENT DEMOGRAPHICS** : ☐ Attach photocopy of patient's ID OR ☐ Email SHAE_registration@curanahealth.com

First Name: _____ Middle_____ Last _____ Preferred Name:_____

DOB___/____/_____ Social Security # _____ Gender: ☐ Male ☐ Female

Phone number (check preferred): ☐ HOME _____ ☐Cell:_____ ☐ I Consent to SMS texts

Patient Email Address: _____ Race:_____Ethnicity:_____

**REQUESTED LOCATION OF MEDICAL CARE REQUEST:** ☐ Facility ☐ Home

Facility/Community Name:_____

Home/Facility Address (including room number): _____

**PREFERRED PHARMACY:** Name:_____Phone:_____

**INSURANCE INFORMATION:** ☐ attach photocopy of insurance cards OR ☐Email SHAE_registration@curanahealth.com

Medicare #:_____ Medicaid #: _____

Other/Supplemental Policy: _____

**SERVICES OF REQUEST:** ☐ Primary Care Provider ☐ Secondary Primary Care Provider

☐ Behavioral Health Talk Therapy and/or Medication Management

**RESPONSIBLE PARTY:** Is patient capable of making own healthcare decision: Yes ☐ No ☐

Check Applicable: ☐ Healthcare POA ☐ Financial POA ☐Legal Guardian ☐ Patient is responsible

**Emergency Contact/Healthcare POA/Legal Guardian:** ☐ legal documents attached ☐ email SHAE_registration@curanahealth.com

Name:_____ Phone (_____)_____

Address:_____

City:_____ State:_____ Zip Code: _____

Relationship to Patient:_____ Email Address:_____

**Additional Name and contact information of any other individuals allowed to obtain details in patient care information**

Name:_____ Phone (_____) _____

Address:_____

City:_____ State:_____ Zip Code: _____

Relationship to Patient:_____ Email Address:_____

☐ Primary Care ☐ Secondary Care REQUIRED FOR FIRST VISIT

CURANA HEALTH

# Consent to Treat

**Patient Name:** _____

**Date of Birth:** _____ **Patient State:** _____

**Patient or Patient Representative Phone Number:** _____

**Patient or Patient Representative Email Address:** _____

**Senior Living Residence Name:** _____

**Residential Setting** (please check a box that best describes your senior living residence):

☐ Independent Living ☐ Assisted Living

☐ Memory Care ☐ Long-Term Care/Skilled Nursing

## COMMUNICATION PREFERENCES

I prefer to be contacted by: ☐ Email ☐ Phone ☐ Both email and phone

☐ I consent to receiving marketing messages from Curana Health.

**General Consent to Treat:** TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, behavioral health, or diagnostic procedure to be used so that you may make the decision to undergo any suggested treatment or procedure after knowing the potential benefits as well as the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form provides us with your permission to perform any reasonable and necessary evaluation to identify the appropriate treatment and/or procedure for any identified condition(s), as well as any reasonable and necessary medical examinations, testing, and treatment for the same.

By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; (2) you consent to treatment by any Curana Health and its affiliated entities' provider, (3) you consent to communication via electronic and/or written format, and (4) you consent to the release of information to your healthcare providers as necessary for continued patient care and other related purposes. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your provider, including the purpose, potential risks, and benefits of any test or treatment ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions of your Curana provider.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or their designees as deemed necessary (collectively "Curana Provider"), to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice.

I understand that my Curana provider may be required by law to repost suspected abuse or neglect or to disclose my private information if they believe I may harm myself or others.

**Consent to Use of Telehealth:** Circumstances may arise where medically necessary telehealth visits are required to address your medical needs, including but not limited to after hours and on weekends. By signing below, (1) I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; (2) I consent to treatment by any Curana Health and its affiliated entities' provider; (3) I consent to communication via electronic and/or written format; and (4) to the extent I initiate any such virtual or telephonic visit, I consent to medical examination and treatment via telephonic, video, or other virtual modalities. This consent will remain fully effective until it is revoked in writing. I have the right at any time to discontinue services. I have the right to discuss the treatment plan with my provider, including the purpose, potential risks and potential benefits of any test or treatment ordered for me. If I have any concerns regarding any test or treatment recommended by my health care provider, Curana encourages me to ask questions of my Curana provider.

**Consent to Use of Remote Medical Monitoring Devices:** I voluntarily request my Curana Provider to use remote medical monitoring devices as reasonable and medically necessary to identify, evaluate, and monitor any medical conditions or diagnoses I may have and determine appropriate treatment and/or procedures for those conditions or diagnoses. Remote medical monitoring devices may include, as determined by my Curana Provider, devices to monitor blood pressure, heart rate, weight, falls, sleep disturbances, and blood sugar, among other clinically important measures. I acknowledge and consent that some of these devices may involve devices that are installed in my room at my medical facility that will continually monitor my relevant health measures. I acknowledge that any remote medical monitoring devices are not intended to be emergency response devices and that while data is collected continually, the data stream is only reviewed at set intervals for limited purposes. I expressly acknowledge and agree that I will not rely on the existence of these devices in the event of a medical emergency but will contact 911 or the medical staff on duty in my facility.

**Consent to Use of Ambient Recording of Medical Visit for Charting Purposes:** I understand that my Curana Provider has access to a tool to assist them in completing their medical charts. This tool will record the conversation between me and my Curana Provider during my medical visit so that my Curana Provider will be able to have a record of our conversation for charting purposes after the visit. The conversations are stored securely where no one else can access them and are deleted after the provider has completed the medical chart documentation. The provider will turn the tool on to record at the beginning of the medical visit with me and turn it off at the end of the visit with me. The tool will not record any other conversations outside of the medical visit nor will it remain in my room when the provider is not in my room. The tool will assist my Curana Provider in completing the medical chart by providing the content of our conversation during the visit in a written format that the Curana Provider can then use to complete the chart. I consent to my Curana Provider's use of this tool for the purpose of ensuring that my medical records are complete and accurate.

**Consent to Share Medical Records with Other Providers:** I understand that in order for my Curana Provider to provide the best care to me, my Curana Provider needs a complete picture of my medical history and medical care. I hereby authorize Curana and my Curana Provider to share my medical records, including both receiving records and providing records, with all other health care providers, past or present, from whom I have received or am receiving care or treatment, in any form, including, without limitation, from any Health Information Exchange or Electronic Health Record in which those records might be stored. This authorization is continuing for as long as I am a patient of Curana and my Curana Provider unless I revoke this authorization in writing addressed to the Curana Chief Compliance Officer at 8911 North Capital of Texas Hwy Building 1, Suite 1110, Austin, TX 78759.

**Assignment of Professional Benefits:** I hereby assign all insurance benefits and/or Medicare/ Medicaid benefits to Providers and/or medical professionals providing services to me and

authorize direct payment to Providers. This assignment specifically includes, but is not limited to, major medical and disability insurance proceeds and benefits. I agree to pay for any and all charges not paid pursuant to this assignment. A photocopy of this assignment shall be valid as the original.

**Statement of Responsibility:** I understand that I am financially responsible to my Curana Provider as the patient, insured, or in my fiduciary capacity as a representative for the patient or insured for all charges not covered by the above assignment. Charges may include co-payments, insurance deductibles, co-insurance or out-of-pocket expenses.

**Health Plan Statement:** Unless I am a member of the following health plans, I understand that my Curana Provider is not providing treatment on behalf of health maintenance organization membership: Align Senior Care, AgeRight Advantage, Pruitt Health Premier, ProCare, NHC Advantage, KeyCare, Perennial, and Lifeworks Advantage.

**Notice of Privacy Practice:** I understand that the Medical Group Notice of Privacy Practices describes how medical information about me may be used and disclosed. I acknowledge that the Medical Group Notice of Privacy Practices is available for me to access online, at CuranaHealth.com/Privacy-Policy/ and is also available upon request.

## NOTICE OF PRIVACY PRACTICE

To read the Notice of Privacy Practice, scan the QR code on the left.

**I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents. I also acknowledge that I have been given a copy of Curana's Notice of Privacy Practices.**

Signature of Patient or Patient Representative

Date

Printed Name of Patient or Patient Representative

Relationship to Patient

**If signed by a Patient Representative, please include signing authority paperwork along with this consent form.*

SHAE Medical, PLLC IS NOW CURANA HEALTH

PATIENT FULL NAME: _____

Patient History Questionnaire

PATIENT DATE OF BIRTH: _____/_____/_____

**PREVIOUS PRIMARY CARE PROVIDER or CURRENT SPECIALISTS (Cardiologist, etc):** _____

_____

**MEDICATION LIST :** ☐ copy attached to this packet, OR ☐ list sent via email to info@shaemedical.com

| Name of Medication | Dosage | Quantity | How often taken | Date started if known |
|---|---|---|---|---|
| | | | | |
| | | | | |

**ALLERGIES:** _____

**HOSPITALIZATION HISTORY (last 2 years):** _____

**SURGICAL HISTORY:** _____

**FAMILY HISTORY:**

MOTHER: ☐ Living ☐ Deceased, if so, age: _____ Medical History: _____

FATHER: ☐ Living ☐ Deceased, if so, age: _____ Medical History: _____

BROTHER(S) OR SISTERS: ☐ Living #_____ ☐ Deceased, if so, age: _____ Medical History: _____

CHILDREN: ☐ Living #_____ ☐ Deceased, if so, age: _____ Medical History: _____

**SOCIAL HISTORY:**

**Marital Status**: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed **Occupation:** _____

**Level of Education** ☐ Grade: _____ ☐ High School/ GED ☐ College ☐ Post-Graduate Degree: _____

**Tobacco Use** ☐ Current, #/day _____ # Years used: _____ ☐ Former Smoker, Quit Date _____ ☐ Never

**Alcohol Use** ☐ Personal History of Alcoholism ☐ Current: # Drinks/day _____ or # Drinks/week _____ ☐ Never

**Drug Use**: ☐ Personal History of Drug/Illicit Substance Abuse, Type: _____ Quit Date: _____

☐ Current user, Substance of use: _____, amount/frequency used: _____ ☐ Never

**PREVENTATIVE HISTORY:** *Has patient received any of the following, please include date(s) if known:* ☐ Influenza _____

☐ Prevnar13 _____ ☐ Pneumococcal 23 _____ ☐ COVID-19 _____ ☐ Tetanus/Tdap _____

☐ Colonoscopy _____ ☐ Mammogram _____ ☐ Bone Density/DEXA _____ ☐ Eye Exam _____

Updated 4.29.2025