CROWN HEALTH
MEDICAL HOUSE CALL SERVICE

IMPORTANT INFORMATION REGARDING MEDICARE AND CHRONIC CARE MANAGEMENT

Dear Patient,

We enjoy and appreciate the opportunity to provide you with comprehensive primary care. Medicare has identified the care of chronic health conditions as an important goal. Chronic conditions are ongoing medical problems that must be managed effectively in a partnership between the health care team and the patient to maintain the best possible health. Examples include diabetes, high blood pressure, heart disease, depression, and others. Effective Jan. 1, 2015, federal regulations now enable Medicare to pay for chronic care management.

What is chronic care management?
Your physician and primary care team will carefully monitor and provide comprehensive care for your chronic health conditions in a systematic way to supplement regular office visit care.

How can you benefit from chronic care management?
- You will have 24/7 access to your primary care team.
- You will have preventive care services scheduled, many of which are covered by Medicare, and your medications will be closely monitored.
- You will receive a personalized, comprehensive plan of care for all of your health issues.
- Your care will be coordinated by your physician and staff, including care you may receive at other locations, such as specialists' offices, the hospital, other health care facilities, or your home.

What do you need to know before signing up?
- Understand that this care is charged to Medicare and you are responsible for co-insurance as usual.
- The Service is also subject to your Medicare deductible.
- You must sign an agreement to receive this type of chronic care management.

Please let us know if you have questions about this new benefit.
Accompanying this information regarding CCM is a Consent Agreement form. Please read and sign where indicated if you wish to benefit from this comprehensive care provision.

Sincerely,
Traci M. Mancuso
ARNP
CEO/President

23745 225th Way S.E. Ste 201
Maple Valley, WA 98038
Phone: 888-674-5871
Fax: 206-694-2291
www.crownhealthus.com

CROWN HEALTH

MEDICAL HOUSE CALL SERVICE

Enrollment Form

Patient Information:

Name: _____

Male____ Female____

NAME OF FACILITY WHERE PATIENT RESIDES:

_____

Date of Birth: _____

Social Security Number: _____

Phone: _____

Fax: _____

Email: _____

Address: _____

City: _____

State: _____

Zip: _____

Marital Status: _____

POA/Guardian/Responsible Party

☐ Same as above

Name: _____

Date of Birth: _____

Relationship: _____

Phone: _____

Email: _____

Address: _____

City: _____

State: _____

Zip: _____

Insurance Information

Carrier or Company: _____

ID #: _____

Group #: _____

Subscriber Name: _____

Relationship to patient: _____

Subscriber DOB/SSN: _____

*** Please Include a copy of Insurance Card(s)**

Allergies: _____

_____

Pharmacy: _____

Medications:

_____

_____

_____

_____

_____

Surgical History:

_____

_____

_____

_____

Social History:

Do you smoke cigarettes: _____

Do you drink Alcohol: _____ Drinks per day: ___

Do you use recreational drugs: _____

What drugs: _____

_____

23745 225th Way S.E. Ste 201
Maple Valley, WA 98038
Phone: 888-674-5871
Fax: 206-694-2291
www.crownhealthus.com

CROWN HEALTH

MEDICAL HOUSE CALL SERVICE

Patient Name:

Medical History

Medical HX	NOW:	PAST:
Depression (CCM)		
Anxiety (CCM)		
Schizophrenia (CCM)		
Bipolar Disorder (CCM)		
Alcohol/Substance Abuse		
Sleep problems (CCM)		
Vision problems		
Mouth problems		
Nose problems		
Neck problems		
Migraines (CCM)		
High Blood pressure (CCM)		
Heart Attack (CCM)		
Blood clots (CCM)		
Atrial Fibrillation (CCM)		
Chest Pain		
Congestive Heart Failure (CCM)		
COPD (CCM)		
Emphysema (CCM)		
Asthma (CCM)		
Constipation		
Vomiting		
Diarrhea		
Liver problems (CCM)		
Kidney problems (CCM)		
Alzheimer's Disease (CCM)		
Dementia (CCM)		
Parkinson's Disease (CCM)		
Lower Extremity Edema (CCM)		
Problems with Legs		
Problems with Arms		
Diabetes (CCM)		
Hypothyroidism (CCM)		
Multiple Sclerosis (CCM)		
Down Syndrome		
Cerebral Palsy		
Other		

* Please complete thoroughly

23745 225th Way S.E. Ste 201
Maple Valley, WA 98038
Phone: 888-674-5871
Fax: 206-694-2291
www.crownhealthus.com

CROWN HEALTH
MEDICAL HOUSE CALL SERVICE

Authorization for Disclosure of Health Information

I hereby authorize Dr. _____
Address: _____ City: _____
State: _____ Zip: _____
Phone: _____
To be disclosed to: **Crown Health- 23745 225th Way S.E. Ste 201**
Maple Valley, WA 98038
PH: (206) 641-9694 Fax: (206) 694-2291

Signature: _____ **Date:** _____

Print Name: _____

* **Please Note: IF Patient has a diagnosis of Alzheimer's Disease, Dementia, or other Altered Mental Status, this must be signed by Power of Attorney or Legal Guardian**

CROWN HEALTH
MEDICAL HOUSE CALL SERVICE

Authorization to Treat Patient Statement

Be it known that I have chosen Crown Health to provide my primary medical care> I live at the address on page 1, and this is my private residence, I intend to, or have, lived at this location for longer than six months, and I have no other place that is my home. Further, I hereby authorize other medical and mental health professionals and institutions to release to crown health copies of all records deemed necessary to provide me with medical care. I give specific consent to release information relating to drug and alcohol abuse, mental health and psychiatric disorders, STDs and HIV or AIDS virus. Further, I authorize Crown Health to release copies of my medical records to other medical and mental health professionals when appropriate and related to the matter at hand. This release includes the use of an electronic medical record to other sources of medical care, such as pharmacies, etc. Patient information is regulated and protected by HIPAA standards. The signature below authorizes Crown Health to treat me.

I certify that I am competent to make this choice and these authorizations. I also certify that all of the information I provided on page 1 of this document is true and correct as of the date below.

If I am not the patient, then my signature below certifies that I am the legally appointed guardian of the individual named on page 2, and I make this choice and these authorizations on his or her behalf.

Signature: _____ **Date:** _____

Print Name: _____

Authority or Relationship to Individual, if representative: _____

Print Name: _____

Financial responsibility agreement to pay

Patient Name: _____

I accept FULL FINANCIAL responsibility for my CROWN HEALTH home visits. Should my insurance company deny a visit or pay for a portion of a visit, I understand that I will be required to pay for these services IN FULL.

Patient or legally authorized Representative signature:

Signature: _____ Date: _____ I certify that I am the legal Guardian, POA or responsible party for the above named patient.

Acknowledgement of Receipt of Privacy Practices Statement

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Crown Health at 888-674-5871 ext. 250.
Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

(A copy of the Notice of Privacy Practices will be provided upon request)

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

23745 225th Way S.E. Ste 201
Maple Valley, WA 98038
Phone: 888-674-5871
Fax: 206-694-2291
www.crownhealthus.com

*** Please Note: IF Patient has a diagnosis of Alzheimer's Disease, Dementia, or other Altered Mental Status, this must be signed by Power of Attorney or Legal Guardian**

CROWN HEALTH

MEDICAL HOUSE CALL SERVICE

CONSENT AGREEMENT

FOR PROVISION OF CHRONIC CARE MANAGEMENT

By signing this Agreement, you consent to **CROWN HEALTH** (referred to as "Provider"), providing chronic care management services (referred to as "CCM Services") to you as more fully described below.

CCM Services are available to you because you have been diagnosed with two (2) or more chronic conditions which are expected to last at least twelve (12) months and which place you at a significant risk of further decline.

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

Provider's Obligations.

When providing CCM Services, the Provider must:

* Explain to you (and your caregiver, if applicable), and offer to you, all the CCM Services that are applicable to your conditions.
* Provide to you a written or electronic copy of your care plan.
* If you revoke this Agreement, provide you with a written conformation of the revocation, stating the effective date of the revocation.

Beneficiary Acknowledgment and Authorization.

By signing this Agreement, you agree to the following:

* You consent to the Provider providing CCM Services to you.
* You authorize electronic communication of your medical information with other treating providers as part of coordination of your care.

23745 225th Way SE Suite 201 Maple Valley WA 98038
Phone: (206)641-9694 Fax: (206)694-2291

CROWN HEALTH

MEDICAL HOUSE CALL SERVICE

* You acknowledge that only one practitioner can furnish CCM Services to you during a thirty (30)-day period.
* You understand that cost-sharing will apply to CCM Services, so you may be billed for a portion of CCM Services even though CCM Services will not involve a face-to-face meeting with the Provider.

Beneficiary Rights.

You have the following rights with respect to CCM Services:

* The Provider will provide you with a written or electronic copy of your care plan.
* You have the right to stop CCM Services at any time by revoking this Agreement effective at the end of the then-current thirty (30)-day period of services. You may revoke this agreement verbally by calling 206-755-6699 or in writing to Crown Health, 23745 225th Way SE #201, Maple Valley, WA 98038. Upon receipt of your revocation, the Provider will give you written confirmation (including the effective date) of revocation.

Patient Sign Here
Beneficiary

Signature:_____

Print Name:_____

Date:_____

POA/Guardian Sign Here
Beneficiary's Representative and/or Caregiver (if applicable)

Signature_____

Print Name:_____

Date:_____

*** Please Note: IF Patient has a diagnosis of Alzheimer's Disease, Dementia, or other Altered Mental Status, this must be signed by Power of Attorney or Legal Guardian

*** Send Power of Attorney Documents/Guardian Documents with every Enrollment if applicable

23745 225th Way SE Suite 201 Maple Valley WA 98038
Phone: (206)641-9694 Fax: (206)694-2291

CROWN HEALTH
MEDICAL HOUSE CALL SERVICE

23745 225th Way S.E. Ste 201
Maple Valley, WA 98038
Phone: 888-674-5871
Fax: 206-694-2291
www.crownhealthus.com

Family Medical History

Patient Name:

_____

* Please complete thoroughly

	Family Members							
Illness/Age Occurred	Grandparents	Father	Mother	Brother/s	Sister/s	Sons	Daughters	None
Cancer								
Heart Disease								
Diabetes								
Stroke/TIA								
High Blood Preassure								
High Cholesterol or Triglycerides								
Liver Disease								
Alcohol or Drug Abuse								
Anxiety, Depression or Psychiatric Illness								
Tuberculosis								
Anesthesia Complications								
Genetic Disorder								
Other- Describe:								
Other- Describe:								
Other- Describe:								