PACWEST
HEALTHCARE

NEW PATIENT ENROLLMENT

Welcome to PacWest Healthcare services, I wanted to take the opportunity to both thank you and tell you a little about us. PacWest is dedicated to improving the quality of care our patients receive by focusing on provider support and engagement. We provide primary care provider and other supportive services in the community through physician supported Nurse Practitioner and Physician Assistant presence. It is our hope that your decision to join us will result in improved health for you as well as a sense of improved communication and overall understanding of your health and care management.

Included is a patient enrollment form which is essential for us to help provide support to your new provider. Please take the time to complete this form thoroughly and return to community liaison, email (officeadmin@pacwesthc.com) and/or by faxing to 509-418-5789. We appreciate the time spent in completing this form.

Next Steps

1. Patient completes Enrollment Form*
2. Patient returns Enrollment form to PacWest through community liaison, fax and/or email
3. Patient information gets uploaded by our PacWest team into Athena*
4. Information is communicated to your new provider to review
5. Our goal is for a visit to be arranged within 2 weeks of enrollment being received
6. Our PacWest Admin will contact your facility to notify them of appointment

    * Please be sure to provide copy of insurance cards
    * Athena is PacWest's electronic medical record used in patient care

If you have questions please contact us by the following methods

*Please note emails/faxes are checked Monday thru Friday 7am till 3pm pacific standard time

- Email: officeadmin@pacwesthc.com
- Fax: 509-418-5789
- Telephone: 360-880-8193
- Website: Pacwesthealthcare.com

Sincerely,
PacWest Healthcare Team

Completion and return of this enrollment form in full is a requirement prior to scheduling provider visit

PACWEST HEALTHCARE

NEW PATIENT ENROLLMENT

Senior Living Community/Adult Family Home

Apartment Number

Name (Last, First, Middle)

Date of Birth (Month/Day/Year)

Phone Number (###) ###-####

Email Address

Marital Status

- ☐ Single
- ☐ Married
- ☐ Widowed
- ☐ Other:_____

Sex/Gender

- ☐ Male
- ☐ Female
- ☐ Other:_____

Language Spoken & Read

- ☐ English ☐ Spanish ☐ Russian
- ☐ Other:_____

Race

☐ Asian ☐ Native American ☐ African American ☐ Pacific Islander ☐ White/Caucasian

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Current/Previous PCP

Pharmacy (*include location/street if known*)

POA/Health Surrogate

Name

Phone Number (###) ###-####

Email Address

Please return completed forms to your community liaison and/or fax to 509-418-5789

Patient Name: _____

PACWEST
HEALTHCARE

Please Include Copies of Medical Insurance Cards

Primary Medical Insurance

Policy Number & Group Number

Secondary Medical Insurance (if applicable)

Policy Number & Group Number

Policy Holder Name/DOB (if self write Self)

Social Security Number

Medical insurance is considered a method of reimbursing the patient for fees paid to the licensed medical provider and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. Patients with a delinquent balance will be required to pay the balance in full for future services. If such fees are not paid, service may be declined.

I authorize the release of any medical information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for all medical and/or surgical benefits, to include major medical benefits to which I am entitled including medicare, private insurance and other agency reimbursements. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Patient/POA/Health Surrogate Signature

Date (Month/Day/Year)

Patient Name: _____

PACWEST HEALTHCARE

Patient Medical History

PERSONAL HABITS:

Do you use the following (Please Circle if Yes): Alcohol Tobacco Marijuana

If Yes to Alcohol please indicate number of drinks per week and type _____

If Yes to Tobacco products please answer the following

If cigarettes: #packs per day ____ If E-cigarettes: #cartridges per day ____ If Marijuana: Times per week ___

Prior Hx of Alcohol, Tobacco and/or Marijuana: If yes please indicate use type and time frame _____

Drug Abuse Hx: if yes please indicate type_____

PRIOR SURGERIES:

Date of Surgery	Descriptions of Surgery	Date of Surgery	Description of Surgery
___/___/___	_____	___/___/___	_____
___/___/___	_____	___/___/___	_____
___/___/___	_____	___/___/___	_____
___/___/___	_____	___/___/___	_____

Allergies: _____

If no known allergies please circle: NKDA

CURRENT MEDICATIONS: PROVIDING COPY OF MED LIST IS OK

Please include non-prescription medications as well as dose and schedule

1. _____	2. _____	3. _____
4. _____	5. _____	6. _____
7. _____	8. _____	9. _____
10. _____	11. _____	12. _____
13. _____	14. _____	15. _____

Patient Name: _____

PACWEST HEALTHCARE

Patient Medical History Continued

Please check any of the following conditions you may have or have had in the past:

- ☐ ANEMIA
- ☐ HEART DISEASE
- ☐ A FIB
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ STROKE
- ☐ BLOOD CLOTS
- ☐ DIABETES
- ☐ ALCHOHOL ABUSE
- ☐ DRUG ABUSE
- ☐ CANCER
- ☐ KIDNEY DISEASE
- ☐ THYROID DISEASE
- ☐ COPD
- ☐ LIVER DISEASE
- ☐ TUBERCULOSIS
- ☐ DEPRESSION
- ☐ MENTAL HEALTH ISSUES
- ☐ SEIZURE
- ☐ MIGRAINE
- ☐ NEUROPATHY

☐ OTHER _____

FAMILY & SOCIAL MEDICAL HISTORY:

CONDITION	MOTHER	FATHER	BROTHER	SISTER	OTHER
Cancer					
Diabetes					
Heart Disease					
High Blood Pressure					
High Cholesterol					
Alcoholism					
Drug Abuse					
Mental Illness					
Stroke					
Other					

Patient Name: _____

PACWEST
HEALTHCARE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

TELEHEALTH CONSENT

I consent to treatment involving the use of electronic communications to enable health care providers at different locations to share my individual patient medical information for diagnosis, therapy, follow-up, and/or education purposes. I consent to forwarding my information to a third party as needed to receive telemedicine services, and I understand that existing confidentiality protections apply. I acknowledge that while telemedicine can be used to provide improved access to medical care, as with any medical procedure, there are potential risks and no results can be guaranteed or assured. These risks include, but are not limited to: technical problems with the information transmission; equipment failures that could result in lost information or delays in treatment. I understand that I have a right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future treatment and without risking the loss or withdrawal of any program benefits to which I would otherwise be entitled. I acknowledge, that as a courtesy, the practice may bill my insurance company for services.

I, the undersigned, hereby voluntarily consent to all healthcare services ordered or provided by PacWest Healthcare as my Primary Medical Care Provider. I give authorization to PacWest to obtain medical records and share medical records with other health care providers pertaining to care delivery. I understand that I can terminate this agreement at any time.

Patient/POA/Health Surrogate Signature	Date (Month/Day/Year)

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date: _____ Initials: _____

Reason: _____

Please return completed forms to your community liaison and/or fax to 509-418-5789

Patient Name: _____

PACWEST HEALTHCARE

Agreement to Receive Chronic Care Management Services

As a patient with two or more chronic conditions, you may benefit from a new program providing chronic care management services to Medicare patients. Chronic care management services include:

- Care management for chronic conditions, including systematic assessment of your health care needs, timely scheduling of preventive care services, and medication review and oversight;
- Access to your care team 24-hours-a-day, 7-days-a-week, including non-face-to-face access such as telephone, email, and secure messages;
- Successive routine appointments with a designated member of your care team;
- Creation of a comprehensive plan of care for your selected health issues;
- Management of care transitions among health care providers and settings, including referrals to other clinicians, follow-up after an emergency department visits, and follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities;
- Coordination with home and community based clinical service providers

Your Rights

- As part of the chronic care management services, you will receive a copy of your comprehensive plan of care.
- You have the right to stop these chronic care management services at any time, effective at the end of the calendar month. Please contact our practice at officeadmin@pacwesthc.com to revoke your consent.

You agree and consent to the following by signing this agreement:

- You consent to PacWest Healthcare providing chronic care management services to you and billing for them.
- You acknowledge that only one provider can furnish and bill for chronic care management services for you during a calendar month. Please let us know if you have entered into a similar agreement with another practice.
- You consent to electronic communication of your health information with others involved in your care.
- You understand that standard coinsurance, copays, and deductibles apply to chronic care management services, so you may be billed for these services up to once a month, whether or not you had a face-to-face meeting with your provider.

Patient/POA/Health Surrogate Signature	Date (Month/Day/Year)

This sample form does not constitute legal advice. Please consult with your legal counsel to ensure compliance with current applicable regulations.

*please note that this serves as an agreement to the above however your provider will assess your current medical history for appropriateness for potential benefit prior to initiating service

PACWEST
HEALTHCARE

Authorization for Release of Medical Records

Release To: PacWest Healthcare

Patient Name: _____

Date of Birth: _____

***Please Check Box below for Type of Medical Information you Authorize for Release to PacWest**

☐ All Labs ☐ All Imaging ☐ All Office Notes/Visits

☐ Only Most Recent Labs, Imaging, Office Notes/Visits

I understand that this authorization may be revoked in writing at anytime. I have been informed and understand my right to privacy, security, and confidentiality of medical information. I understand that no information may be released without my expressed written consent or that of my legal representative, or otherwise provided by law. This facility, its employees, officers, and physicians are hereby released, from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____

Patient/POA/Health Surrogate Signature Date