Century Care Inc DBA Atlas Medical
7227 E Baseline Rd Suite 126
Mesa, AZ 85209
(o) 480-868-9650 (f) 480-834-3606

PATIENT REGISTRATION

First Name: ___________________________ Last Name: ____________________________ (MI): _______

DOB: _____ / _____ / _____ Sex: M / F Marital Status: S / M / D / W

Community/Facility Name: ___________________________ Facility Move-in Date: _____ / _____ / _____

Social Security Number: ________________________ Medicare Number: ___________________________

Preferred Language: _______________Race: __________________Ethnicity: ☐ Non-Hispanic ☐ Hispanic

Current Specialists

Contact: ___________________________________ Phone #: _________________ Specialty: __________

Contact: ___________________________________ Phone #: _________________ Specialty: __________

☐ I am NOT on Hospice ☐ I AM ON Hospice (Hospice Company: _______________________________)

☐ I DO have a Medical Power of Attorney (MPOA) ☐ I DO NOT have a Medical Power of Attorney

MPOA or Primary Contact: ________________________________ Relation to Patient: _______________

Primary Phone #: ___________________________ Email Address: ________________________________

Mailing Address: ____________________________ City: __________________ State: _____ Zip: _______

☐ I DO have a Guarantor or Financial POA (FPOA) ☐ I DO NOT have a Guarantor or Financial POA

FPOA or Guarantor: ______________________________________ Relation to Patient: _______________

Primary Phone #: ___________________________ Email Address: ________________________________

Mailing Address: ____________________________ City: __________________ State: _____ Zip: _______

-Please complete all sections that apply-

Without accurate insurance information we will be unable to bill your insurance and we will have to bill you directly.

PRIMARY INSURANCE (Medicare, Medicare Advantage, Commercial Plan) (Part B, Part C)

Insurance Provider and Plan Name: ____

Member ID# ____

SECONDARY INSURANCE (Medicare Supplement Plan or "Medigap" Plan) (Part F, G, K, L, M, N, Etc)

Insurance Provider and Plan Name: ____

Member ID# ____

Medicaid/AHCCCS/ALTCS or TRICARE (Medicaid is always the last payer to other insurances)

Insurance Provider and Plan Name: ____

Member ID# ____

FAX COMPLETED FORMS AND INSURANCE CARDS TO 480-834-3606

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Name of Patient: ____

Date of Birth: ____ /____ /____ Community/Facility Name: ____________________________

SELECTION OF PRIMARY CARE PHYSICIAN and MEDICAL CONSENT
I hereby request medical care and treatment by Century Care Inc DBA Atlas Medical (Atlas Medical) and its Specialists. I designate Atlas Medical and its Associates as my only Primary Care Providers and request that they monitor and assist with all aspects of my health care including Chronic Care Management and Care Plan Oversight and as such I agree to provide Atlas Medical with a detailed medical history.

CHRONIC CARE MANAGEMENT (CCM)
I agree to allow Atlas Medical to provide me with Chronic Care Management (CCM), Home Health and Hospice Care Plan Oversight services and to be designated as my only CCM provider. Services include: 24/7 phone access to clinical staff, consultation and guidance in managing my chronic conditions, reviewing my medications, help with scheduling specialist visits and tests that my doctor ordered, receiving a plan of care with personal health goals, sharing e-records and coordination of care with other providers, and working closely with my home health and hospice. I understand that Atlas Medical may bill my insurance for these services and depending on my insurance, I may be responsible for a co-pay. I can refuse or optout of these services and stop my CCM at the end of any month by contacting Atlas Medical by telephone or in writing.

FINANCIAL RESPONSIBILITY
I authorize Atlas Medical to bill my Insurance and for my insurance company to make direct payments to Atlas Medical. I accept financial responsibility for payment of insurance mandated charges such as Deductibles, Copays, and Coinsurance. Atlas Medical cannot bill your insurance if we are provided with incorrect information; therefore, to avoid being billed directly, I understand that it is my responsibility to continuously provide up-to-date Insurance information.

NOTICE OF PRIVACY PRACTICES
Medical information is considered private and confidential. However, I am aware, that my information may be shared or disclosed verbally, electronically, and on paper as needed to others who are involved in my care and as needed for medical billing. Atlas Medical participates in Government Health Information Exchange (HIE) programs to which you can opt out at any time. Furthermore, I understand that Atlas Medical may disclose my health information when required to do so by law.

HOSPICE CARE
I understand that in the event that Hospice services are required Atlas Medical will remain as Primary Care Provider and act as my Hospice Care - Attending Physician (GV), unless otherwise notified in writing.

TRANSFER OF CARE
I understand that Atlas Medical may not remain as my Primary Care Provider in the event that I move from my current care facility. Atlas Medical also reserves the legal right to terminate services, at any time, without cause, upon (30) days prior notice. I understand that if a change in provider is needed for any reason that prompt written notification be sent to Atlas Medical.

*My Signature below certifies that I have read and understand and consent to all terms and conditions listed above. *This agreement is to remain in the patient chart**

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Signature of patient or Legal POA Date