Office: 480-868-9650 Fax: 480-834-3606
Office@AtlasMedicalCare.com

NEW PATIENT INTAKE PROTOCOL AND REQUIRED DOCUMENTS

1. Signed Atlas Consent Form
   - Must be signed by the Patient, and/or if the Patient has a POA, then the active POA of record must sign the consent.

1. Please complete all pages.
   - Demographics
   - Medical History

1. Sent Supporting Documents
   - Medication list
   - Insurance Card (Copy of Front and Back)
   - POA paperwork (MPOA, FPOA, and/or Court Appointed Fiduciary Information)
   - DNR Documentation
   - H&P, recent TB Test, and other Immunization Records
   - Completed Physician Move-In paperwork from the previous provider

To ensure admission turnaround time within 24hrs, please ensure that all required documents are remitted to Atlas Medical via Fax or Email.

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Email: Office@AtlasMedicalCare.Com

If you have any questions, please do not hesitate to call us at 480-868-9650

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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), its Primary Care Providers and available Specialists. I designate Atlas Medical as my only Primary Care Providers and request that they monitor and assist with all aspects of my health care, and 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 provider 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 this is an insurance covered benefit and Atlas Medical may bill my insurance for CCM and depending on my insurance, I may be responsible for a co-pay. I can refuse these available services by opting out of my CCM benefit at the end of any month by notifying Atlas Medical 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 full financial responsibility for payment of insurance mandated charges such as Deductibles, Copays, and Coinsurance. I am aware that the only bills I will receive from Atlas Medical will be for Deductibles, Copays, and Coinsurance; Atlas Medical will not bill me personally for any services denied by my insurance. I understand that it is my responsibility to continuously provide up-to-date Insurance information or select a cash payment plan with Atlas Medical.

NOTICE OF PRIVACY PRACTICES

Atlas Medical participates in Government Health Information Exchange (HIE) programs to which I can opt out at any time. Atlas Medical may disclose my health information when required to do so by law. Medical information is considered private and confidential; however, I am aware, that in accordance with HIPPA Law, 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 and/or care coordination. Additionally, I understand that Atlas Medical may need to contact me or my designee directly regarding my care. To improve care coordination, I give my permission for Atlas Medical to leave phone messages regarding my medical care/account information. I understand that this consent will remain valid until updated or revoked.

Voicemail: Text Message: Email:

RELEASE OF MEDICAL RECORDS

I authorize the prompt release of my complete health record from all past and present healthcare providers to Atlas Medical; this authorization for release of information covers all past and present medical records, unless otherwise specified, which may include records relating to communicable diseases and treatment of alcohol or drug abuse

HOSPICE CARE

I understand that if I request Hospice or Home Health Services Atlas Medical will remain as Primary Care Provider and act as my Attending Physician (GV), unless otherwise notified in writing.

TRANSFER OF CARE

I understand, that if I am receiving In-Home Provider Services that Atlas Medical may or may not remain as my Primary Care Provider if I change care facilities or move from my current address. Atlas Medical also reserves the legal right to terminate services, at any time, without cause, upon (30) days prior notice. I understand that if I desire a change in provider for any reason that prompt written notification be sent to Atlas Medical. Furthermore, I understand that Atlas Medical may change my assigned Provider to any of Atlas Medical's Associate Providers at any time without prior notice.

My Signature below certifies that I have read, understand, and consent to all the terms and conditions listed above.

_____

Signature of patient or Legal POA Date

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Atlas Medical Location: ☐ Phoenix Metro ☐ Tucson

PATIENT REGISTRATION

First Name: _____ Last Name: _____ (MI): _____

DOB: _____ / _____ / _____ Sex: M / F Patient Personal Cell: _____

Preferred Language: _____ Race: _____ Ethnicity: ☐ Non-Hispanic ☐ Hispanic

Social Security Number: Medicare Number:

PLACE OF RESIDENCE

Community/Facility Name: _____ Move-in Date: _____ / _____ / _____ Room# _____

Home/Community/Facility Address:

PAST PRIMARY CARE PROVIDER AND CURRENT SPECIALISTS

Primary Care Provider Name/Info: _____ Phone #: _____

Specialist: _____ Specialty: _____ Phone #: _____

Specialist: _____ Specialty: _____ Phone #: _____

☐ I AM ON Hospice (Hospice Company: _____)

☐ I AM ON Home Health (PT/OT/Skilled Nursing) (Home Health Company:

DESIGNEE INFORMATION

(Please fax verification of active POA/FPOA to our office)

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

MPOA or Primary Contact: _____ Relation to Patient: _____

MPOA Primary Phone #: _____ MPOA Email Address: _____

MPOA Mailing Address: _____ City: _____ State: ____ Zip: _____

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

FPOA or Primary Contact: _____ Relation to Patient: _____

FPOA Primary Phone #: _____ FPOA Email Address: _____

FPOA Mailing Address: City: State: Zip:

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

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

Insurance Provider and Plan Name: _____

Member ID# _____

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

Insurance Provider and Plan Name: _____

Member ID#

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PATIENT MEDICAL HISTORY

Patient Name: _____ DOB ____ / ____ / _____ Height: _____(Inches) / Weight: _____(lbs)

ADVANCED DIRECTIVES

(Check all that apply / Fax verification of advanced directives to our office)

☐ Living Will ☐ Advanced Directive. ☐ DNR (Do Not Resuscitate). ☐ DNI (Do Not Intubate) ☐ DNH (Do Not Hospitalize)

ALLERGIES AND ALLERGIES TO MEDICATIONS

(include reaction if known i.e. rash, trouble breathing, etc):

_____

_____

SOCIAL HISTORY

Former Profession(s): _____

Current smoker ☐ YES ☐ NO Year started _____ Year Quit _____ Pack/s per day: _____

Tobacco use ☐ YES ☐ NO Type: _____ (chew, pipe, cigar, etc)

Alcohol Use: ☐ YES ☐ NO Type: _____ Drinks per week _____

History of Illicit Drug use:

FAMILY HISTORY

Mother ☐ Living ☐ Deceased known health issues: _____

Father ☐ Living ☐ Deceased known health issues: _____

Other family members known health issues (*state relation and health issues*):

_____

SURGICAL HISTORY

Heart Bypass/CABG	Date _____	Cardiac (Heart) Stent	Date _____
Heart Valve Replacement	Date _____	Pacemaker	Date _____
Defibrillator/ICD Placement	Date _____	Tonsillectomy	Date _____
Appendix Removal	Date _____	Gall Bladder Removal	Date _____
Hysterectomy	Date _____	Cataract removal -	Date _____ L / R / Both
Knee Replacement	Date _____ L / R / Both	Hip Replacement -	Date _____ L / R / Both

Other Surgical History_____

HOSPITALIZATION HISTORY

(Please list any hospitalizations in the past 12 months, Hospital name and reason)

_____

_____

_____

_____

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DETAILED MEDICAL HISTORY BY SYSTEM

Patient Name: _____ DOB ____ / ____ / _____

Eyes and Ears:
- ☐ Macular Degeneration
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Blindness (R, L, or both eyes): _____
- ☐ Hearing loss
- ☐ Other: _____

Heart:
- ☐ High Blood Pressure
- ☐ Heart Attack – (Year if known): _____
- ☐ Heart Failure
- ☐ Aortic Stenosis
- ☐ Heart Valve Problems
- ☐ Angina
- ☐ High Cholesterol
- ☐ Atrial Fibrillation (A-fib)
- ☐ Irregular Heart Beats
- ☐ Pacemaker
- ☐ Heart Murmur
- ☐ Edema (swelling)
- ☐ Other: _____

Kidney and Urinary Tract:
- ☐ Recurrent bladder infections (UTI)
- ☐ Chronic Kidney disease
- ☐ Enlarged prostate
- ☐ Prostate Cancer
- ☐ Urinary incontinence
- ☐ Kidney stones
- ☐ Bladder Cancer
- ☐ Other: _____

Endocrine:
- ☐ Underactive Thyroid
- ☐ Overactive Thyroid
- ☐ Diabetes Type 1 (juvenile onset)
- ☐ Diabetes Type 2 (adult onset)
- ☐ Other: _____

Musculoskeletal:
- ☐ Arthritis
- ☐ Chronic back pain
- ☐ Osteoporosis
- ☐ Gout
- ☐ Other:_____

Psychological:
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar
- ☐ Schizophrenia
- ☐ Other: _____

Lungs:
- ☐ Asthma
- ☐ COPD/Emphysema
- ☐ Bronchitis
- ☐ Frequent or recurrent Pneumonia
- ☐ Sleep Apnea
- ☐ Pulmonary Embolism (blood clot in lung)
- ☐ Lung Cancer
- ☐ Other: _____

Gastrointestinal:
- ☐ Reflux/GERD/Heartburn
- ☐ Ulcers
- ☐ Irritable Bowel Disease
- ☐ Liver Disease/Cirrhosis
- ☐ Hepatitis
- ☐ Gallbladder Disease
- ☐ Colon Polyps
- ☐ Diverticulosis/Diverticulitis
- ☐ Blood in Stool
- ☐ Constipation
- ☐ Hernia
- ☐ Colon Cancer
- ☐ Other: _____

Neurologic:
- ☐ Dementia (Type if known): _____
- ☐ Parkinson's Disease
- ☐ Stroke
- ☐ Seizure disorder/Epilepsy
- ☐ Neuropathy
- ☐ Migraines
- ☐ TIA (mini-stroke)
- ☐ Multiple Sclerosis
- ☐ Tremors
- ☐ Other: _____

Vascular:
- ☐ DVT (blood clot in arms or legs)
- ☐ Aneurysm
- ☐ Peripheral Vascular Disease (Poor circulation)
- ☐ Other: _____

Other Health conditions:
- ☐ Anemia
- ☐ Eczema
- ☐ Psoriasis
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Breast Cancer
- ☐ Skin Cancer
- ☐ Other Cancer: _____

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CONSENT TO COMMUNICATE / LEAVE VOICEMAIL / TEXT MESSAGE / EMAIL

Patient Name _____ Date of Birth _____/_____/_____

Atlas Medical may need to communicate with those involved in the care of the patient to discuss patient care and to report test results, appointments, referrals, and/or billing/insurance information. To protect patient privacy and follow federal guidelines, we will NOT leave messages or discuss medical information with anyone except the patient or legal guardian without written permission.

I allow Atlas Medical and its associates to communicate with and/or leave information via Voicemail, Text Message, and/or Email to the individuals listed below.

I fully understand that this consent will remain valid until revoked in writing.

PRIMARY CONTACT (MPOA)

First Name: _____ Last Name: _____
Relation to Patient: _____
Phone: (_____) _____-_____ ☐ Voicemail ☐ Text Message
Email Address _____

SECONDARY DESIGNEE

First Name: _____ Last Name: _____
Relation to Patient: _____
Phone: (_____) _____-_____ ☐ Voicemail ☐ Text Message
Email Address _____

FINANCIAL INFORMATION ONLY DESIGNEE

First Name: _____ Last Name: _____
Relation to Patient: _____
Phone: (_____) _____-_____ ☐ Voicemail ☐ Text Message
Email Address _____

My Signature below certifies that I have read, understand, and consent to all the terms and conditions listed above.

Signature of Patient or Legal POA Date