7227 E Baseline Rd. Suite 126, Mesa, AZ 85209
Office: 480-868-9650 Fax: 480-834-3606
Intake@AtlasMedicalCare.com

Atlas MEDICAL

1730 E River Rd Suite 110 Tucson, AZ 85718
Office: 520-468-7988 Fax: 520-467-0181
Intake@AtlasMedicalCare.com

NAME OF PATIENT: _____ Date of Birth: _____

Email: _____Phone Number _____☐ Text Msg ☐ Voicemail

GENERAL CONSENT: PROVIDER SELECTION, INFORMED CONSENT AND EMERGENCY CARE.

I hereby request my medical care to be coordinated through Century Care Inc BDA Atlas Medical ("Atlas") and for my medical care to be delivered by its independently licensed Primary Care Providers and Specialists ("Atlas Providers"). I authorize Atlas to assign me, based on location and availability, an Atlas Provider to serve as my only Primary Care Provider to assist in monitoring and managing all aspects of my health care. I understand that if I am receiving in-home or community-based medical services, my assigned Atlas Provider may be changed or services discontinued if I move from my current address. I acknowledge that Atlas may change my Atlas Provider to another Atlas Provider when necessary. I consent to care coordination and referral to specialists, including Specialist Atlas Providers when medically indicated, subject to availability. I understand that I will be provided informed consent prior to any treatment or procedure being performed. However, in a life-threatening emergency, treatment may be provided without prior consent as permitted by law. Atlas does not administer or dispense any medications.

ADVANCED PRIMARY CARE MANAGEMENT(APCM), CHRONIC CARE MANAGEMENT(CCM), CARE PLAN OVERSIGHT(CPO)

To improve the quality of care I receive, I agree to allow my Primary Care Atlas Provider to provide me with Medicare Care Management Services including APCM, CCM, and Home Health and Hospice Care Plan Oversight (CPO) services and to be designated as my only APCM, CCM and/or CPO provider (if applicable). I understand that these are non-face-to-face insurance covered services and Atlas may bill my insurance for these services and depending on my insurance, I may be responsible for a co-pay, co-insurance, or deductible. These covered services include: consultation and ongoing management of my health needs (including preventive, acute, and chronic care), guidance in managing chronic conditions when applicable, medication review & management, assistance with specialist referrals, DME and diagnostic testing, development and ongoing management of a care plan with personal health goals, coordination and sharing of electronic health records with other providers, proactive care coordination including support during care transitions, 24/7 access to clinical staff by phone or electronic communication, and coordination with home health and hospice services when applicable. I understand these services are voluntary and may be refused or revoked by opting out now or at the end of any calendar month by notifying Atlas in writing.

FINANCIAL RESPONSIBILITY

I authorize Atlas to bill my insurance and for my insurance company to make direct payments to Atlas for medical services rendered by independent Atlas Providers. 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 will be for Deductibles, Copays, and Coinsurance; Atlas 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 to Atlas or select a cash payment plan with Atlas.

NOTICE OF PRIVACY PRACTICES, HIPAA AND HEALTH INFORMATION EXCHANGE

Atlas participates in government Health Information Exchange (HIE) programs to which I can opt out at any time by notifying Atlas in writing. Additionally, Atlas may use or disclose my health information as permitted by HIPAA and applicable federal and state law, including for treatment, payment, health care operations, care coordination, quality assurance, and billing. My health information may be shared verbally, electronically, or in writing to parties involved in my care or when required by law.

RELEASE OF MEDICAL RECORDS AND REDISCLOSURE RESTRICTION

I consent & authorize the prompt release of my complete health record from all past and present healthcare providers to Atlas to be reviewed by Atlas Providers; this authorization for release of information covers all past and present medical records, which may include records relating to communicable diseases & treatment of alcohol or drug abuse (unless otherwise specified). Disclosed records may be subject to redisclosure restriction as required by law. I may revoke this release in writing at any time.

HOSPICE CARE AND HOME HEALTH CARE

I understand that if I request Hospice or Home Health Services my Atlas Primary Care Provider will remain designated as my Hospice or Home Health Attending Physician /Attending Provider (GV) unless I otherwise notify Atlas in writing.

TERMINATION OF CARE AND TRANSFER OF CARE

My Atlas Provider(s) reserves the right to terminate services, at any time, without cause, with (30) days prior notice with care coordination. I understand that I may revoke any and all Atlas services immediately, for any reason, by notifying Atlas in writing.

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 Locations: ☐ Mobile: Phoenix Metro ☐ Mobile: Tucson ☐ Other:

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 ☐ Private Home ☐ Independent Living ☐ Assisted Living ☐ Long-Term Care ☐ Skilled Nursing

Physical Address: _____

Mailing Address: _____

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

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 MPOA/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:

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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CONSENT TO COMMUNICATE / LEAVE VOICEMAIL / TEXT MESSAGE / EMAIL

NAME OF PATIENT: _____ Date of Birth: _____

Atlas and its independently licensed Primary Care Providers and Specialists (Atlas Providers) may need to communicate directly with you and those involved in the care of the patient; to discuss patient care, report test results, appointments, referrals, and/or billing/insurance information. To protect patient privacy and follow federal guidelines we will NOT discuss medical information with anyone except the patient or legal guardian this includes leaving a voicemail or sending a text message/Email about medical information unless provided written permission.

Consent: I give consent for Atlas and Atlas Providers to communicate with and/or leave medical information via voicemail, text message, and/or Email regarding my medical care or other sensitive account information to the following phone numbers, email addresses and individuals listed below

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

PRIMARY CONTACT (PATIENT or MPOA)

First Name: _____ Last Name: _____

Relation to Patient: _____

Phone Number _____ ☐ Voicemail ☐ Text Message

Email Address:

SECONDARY DESIGNEE

First Name: _____ Last Name: _____

Relation to Patient: _____

Phone Number _____ ☐ Voicemail ☐ Text Message

Email Address:

FINANCIAL INFORMATION ONLY DESIGNEE

First Name: _____ Last Name: _____

Relation to Patient: _____

Phone Number _____ ☐ 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

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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

NAME OF PATIENT: _____ Date of Birth: _____

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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CURRENT MEDICATION LIST

NAME OF PATIENT: _____ Date of Birth: _____

Please include all prescription and over-the-counter medication you are taking on a routine basis. Please include the Medication Name, Dosage, Frequency, Reason for Taking, and Current Prescriber. If you need more space, write on back or attach your medication list.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

MEDICATION MANAGEMENT DISCLOSURE

Atlas Providers provide medication management through prescribing, reviewing, and recommending medications as part of treatment planning and care coordination. When applicable, Atlas Providers may obtain medication history from available pharmacy databases and may request current medication administration records from a patient's residence or care facility to support safe and effective care. Patients, or their Medical Power of Attorney (MPOA), are responsible for providing accurate and complete information regarding all medications taken, including prescription, over-the-counter, and supplemental products, and for keeping Atlas Providers informed of any medication changes, side effects, or concerns. All medications are self-administered by the patient or administered by the patient's residence or care facility staff. Atlas Medical does NOT administer, provide, or dispense medications, except for limited vaccines (including influenza and COVID-19) or other injectable medications that may be ordered and administered only by an independently licensed Atlas Provider when clinically indicated and only with separate, individualized informed consent.

If a patient receives care or treatment from any other health care provider or facility, including hospitals, emergency departments, urgent care centers, or specialists, the patient or MPOA is responsible for notifying Atlas of any new, discontinued, or changed medications as soon as reasonably possible.

Failure to provide accurate up-to-date medications may increase health risks and affect the safety and effectiveness of care.

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CONSENT TO PHOTOGRAPH

NAME OF PATIENT: _____ Date of Birth: _____

I hereby authorize Atlas Medical, along with my independently licensed Atlas Providers, to photograph, video record, or otherwise capture visual or audio documentation of me for the following purposes:

- Medical Documentation:
  - For inclusion in my medical records to support diagnosis, treatment, and care coordination.
- Administrative Use
  - For Patient Identification, or for internal operations, billing, compliance, and quality assurance.
- Educational/Training Purposes:
  - For internal education or training (protected identifying information removed.)

I understand that:

- These images or recordings will be stored securely and treated as confidential in accordance with HIPAA and applicable privacy laws.
- I may revoke this consent in writing at any time, except where already relied upon.
- This consent is voluntary, and refusal will not affect the care I receive.

☐ I consent to being photographed or recorded under the conditions above.

(or)

☐ I do not consent to being photographed or recorded.

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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ADVANCE CARE PLANNING & END-OF-LIFE INFORMATION

NAME OF PATIENT: _____ Date of Birth: _____

ADVANCED DIRECTIVES

You have the right to make decisions about your health care, including the right to accept or refuse medical treatment, to the extent permitted by law. Advance directives are legal documents that allow you to communicate your health care wishes if you are unable to speak for yourself. These may include, but are not limited to:

- A Living Will
- A Health Care Power of Attorney
- DNR/DNI, POLST, or other legally recognized advance care planning documents

You are not required to have an advance directive to receive care. Your decision to create or not create an advance directive will not affect your access to care or services. Atlas does not create, or complete advance directive documents on a patient's behalf. You, or your Medical Power of Attorney (MPOA), are responsible for providing current and updated copies of any advance directives or end-of-life documents to Atlas. Atlas must have a copy on file in order to act on your wishes. If you reside in a community/facility, they will follow the documents they have on file. It is your responsibility to ensure that both Atlas and your community/facility have the most current and accurate documentation to ensure your directives are followed.

DO NOT RESUSCITATE (DNR) / END-OF-LIFE ORDERS

If you have an existing DNR, DNI, POLST, or similar order, you may provide a copy to Atlas for inclusion in your medical record. Existing directives will be honored as applicable and as permitted by law. In emergency situations, if advance directives or end-of-life orders are not immediately available, then emergency care may be provided as necessary to protect life and safety.

MEDICAL DECISION-MAKING AUTHORITY & COMMUNICATION

Atlas Medical and Atlas Providers may discuss medical information and health care decisions only with:

- The patient, or
- An individual who has been explicitly authorized through:
  - A valid Medical Power of Attorney (MPOA)
  - Court-appointed guardianship or conservatorship
  - Public fiduciary appointment
  - Ward-of-the-state designation
  - Other legally recognized documentation, or the persons listed on the Atlas communication consent form on file

Absent appropriate legal documentation or written authorization, Atlas is not permitted to discuss medical decisions or protected health information with family members, friends, or other parties.

INCAPACITATION, GUARDIANSHIP, AND PUBLIC FIDUCIARY

If a patient is determined to be incapacitated, medical decision-making authority will follow applicable law and court orders. This may include decision-making by: Medical Power of Attorney, A court-appointed guardian or conservator, A public fiduciary, or the State, if the patient is a ward of the state. Required documentation must be provided to Atlas to support recognition of decision-making authority. Until appropriate documentation is received, Atlas will continue to act in accordance with applicable law and existing records. When requested and clinically appropriate, Atlas Providers may evaluate and document incapacity and may participate in required medical certifications or letters of incapacity as permitted by law and based on clinical judgment.

ADVANCED CARE PLANNING DISCUSSIONS

Patients or their authorized representatives may voluntarily discuss advance care planning and end-of-life preferences with their Atlas Provider. These discussions may be insurance-covered services, and Atlas may bill your insurance for covered advance care planning services, including those reported under applicable CPT codes.

By signing below, I acknowledge that I have received information regarding advance care planning, end-of-life decisions, and medical decision-making authority, and understand my responsibility to provide current and any future updated documentation.

_____

Signature of patient or Legal POA Date

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PATIENT RIGHTS AND RESPONSIBILITIES

GENERAL PATIENT RIGHTS

As a patient, you have the right to:

- Be treated with dignity, respect, and consideration at all times.
- Be free from abuse, neglect, exploitation, coercion, or retaliation.
- Receive care without discrimination based on race, color, religion, sex, sexual orientation, gender identity, age, disability, or source of payment.
- Participate in decisions regarding your health care and treatment.
- Receive information about your health condition and services in a manner you can understand.
- Ask questions and receive clear, honest answers.
- Refuse or discontinue services.
- Privacy and confidentiality of your medical and financial information in accordance with HIPAA and applicable laws.
- Access your medical records and request amendments as permitted by law.
- Designate a representative to assist with health care decisions.

THE RIGHT TO INFORMED CONSENT

You have the right to receive informed consent prior to any service or procedure requiring it. This includes receiving information about the nature of the service, potential risks and benefits, alternatives, and the right to refuse treatment except in rare emergency situations as permitted by law.

THE RIGHT TO TREATMENT AND MEDICATION

You have the right to be informed about medications prescribed or recommended by your provider, including their purpose, potential risks, and expected benefits, and to ask questions, discuss concerns, or refuse or discontinue medications as permitted by law.

THE RIGHT TO COMPLAINTS AND GRIEVANCES

You have the right to voice concerns, complaints, or grievances regarding your care or services without fear of retaliation

- Complaints may be submitted verbally or in writing directly to Atlas via phone, mail or Email.
- Concerns will be reviewed promptly and fairly.
- Filing a complaint will not affect your access to care or result in retaliation.
- If a concern cannot be resolved through Atlas's internal complaint process, patients may contact the appropriate professional licensing board for the treating provider, their insurance carrier, or applicable federal or state agencies, as appropriate.

THE RIGHT TO REVOKE SERVICES

You have the right to revoke any and all services at any time by notifying Atlas.

Including:

- Primary Care Provider Services
- Specialty Provider Services
- Advanced Primary Care Management (APCM)
- Chronic Care Management (CCM)
- Care Plan Oversight (CPO)
- Health Information Exchange (HIE) participation
- Communication via Text/Email/Voicemail
- Any other services

You can revoke any service by sending written notice to the email, fax or address listed on this document or our website. Revocation of any service may affect access to other services and insurance-covered benefits; however, emergency care is not affected by revocation. Your Atlas Provider or Atlas Office Staff can answer any questions about our services or revocation.