Team Select
Mobile Physician Services

PATIENT REGISTRATION FORM

Team Select Mobile Physician Services

2999 N. 44th Street, Suite 110
Phoenix, AZ 85018

Phone: (602) 715-2568
Fax: (602) 288-8831

Patient Name: _____ Social Security Number: _____

Date of Birth: _____ Sex: ☐ M ☐ F ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Address (where patient will be seen): _____
Street City/State/Zip

Mailing Address: _____

Home Phone: _____ Email Address: _____

Would you be interested in having communications sent to you via your email address? (Appointment reminders, administrative updates, and health bulletins) ☐ Y ☐ N

How did you hear about our practice? _____

_____

Person responsible for bill or parent (Complete only if different from patient)

Guarantor Name: _____ Social Security Number: _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent Phone Number: _____

Who to call for an emergency

Name: _____ Address: _____

Home Phone: _____ Work Phone: _____ Relationship: _____

Primary Insurance Information - LEGIBLE CARD COPY MUST BE ATTACHED TO PACKET

Plan Name: _____ ID Number: _____

Address: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder's SSN: _____ Sex: ☐ M ☐ F

Secondary Insurance Information - LEGIBLE CARD COPY MUST BE ATTACHED TO PACKET

Plan Name: _____ ID Number: _____

Address: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder's SSN: _____ Sex: ☐ M ☐ F

Medicare # - even if patient is on a HMO Plan - LEGIBLE CARD COPY MUST BE ATTACHED TO PACKET

ID Number: _____ Policy Holder: _____

This is an example of what we need to see for your Medicare card.

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Team Select Mobile Physician Services. I acknowledge that I am financially responsible for payment that is not covered by insurance.

Signature: _____ Patient Initial _____ Date: _____

PLEASE ATTACH COPY OF INSURANCE CARDS & POWER OF ATTORNEY PAPER WORK SO WE MAY SPEAK WITH YOU REGARDING THE ABOVE PATIENT.

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AUTHORIZATION AND CONSENT TO TREATMENT

Consent to Treatment

As a TSMPS patient, I voluntarily consent to the rendering of such care and treatment as TSMPS providers and personnel, in their professional judgment, deem necessary for my health and well-being.

My consent shall cover medical examinations and diagnostic testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, minor surgical procedures (including suturing), cast application/removals and vaccine administration. My consent shall also cover the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my TSMPS provider nor any care center staff have made any guarantee or promise as to the results that may be obtained.

Assignment of Benefits

I hereby certify that the insurance information I have provided is accurate, complete and current and that I have no other insurance coverage.
I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers to the provider or supplier of any services furnished to me by that provider or supplier. If my health insurance plan does not pay TSMPS directly, I agree to forward to TSMPS all health insurance payments which I receive for the services rendered by TSMPS and its health care providers. I understand that if my insurance plan does not participate in the TSMPS network, or if I am a self-pay patient, this assignment of benefits may not apply.

Financial Policy

In consideration of the services provided by TSMPS and its providers, I agree that I am responsible for all charges for services provided not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I agree to pay all charges not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I further agree that, to the extent permitted by law, I will reimburse TSMPS for all costs, expenses and attorney's fees incurred by TSMPS to collect those charges.

If my insurance has a pre-certification or authorization requirement, I understand that it is my responsibility to obtain authorization for services rendered according to the plan's provisions. I understand that my failure to do so may result in reduction or denial of benefit payments and that I will be responsible for all balances due.

Consent to Call, Email, Text, and Photography

I understand and agree that TSMPS may contact me using automated calls, emails and/or text messaging sent to my landline and/or mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from TSMPS. I understand that I may opt out of receiving such communications from TSMPS by informing my provider's staff.
If I request or elect to receive health information via email, I acknowledge that I understand the following risks associated with the communications of e-mail between Team Select Mobile Physician Services and me; that the information that is sent is not encrypted, that a third party may be able to access the information and read it since it is transmitted over the Internet, and that once the email is received by me, someone may be able to access my email account and read it.

I hereby acknowledge that I have received Team Select Mobile Physician Services Financial Notice and Notice of Privacy Practices. This form and assignment of benefits applies and extends to subsequent visits and appointments with TSMPS providers.
I hereby authorize the use of photos to use as an identifier (such as headshots) and of any dermatological conditions to provide ongoing documentation (written, electronic or photographic) and to document progress of healing and/or to assist in the treatment decisions for care by TSMPS.

I also authorize TSMPS to share such photography and ongoing documentation (written, electronic or photographic) with my care team and with insurance carriers for the purpose of treatment decisions and/or for authorization of care. I understand that this photography may be used for medical or scientific purposes such as documentation or planning care, teaching purposes, research or publication. I further understand that these images may be used any time hereafter without inspection or approval, on my part, of the finished product or the specific use to which material may be applied.

I hereby consent to any and/or all of the above.

Patient Initial: _____

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AUTHORIZATION AND CONSENT TO TREATMENT

HIPAA

I hereby acknowledge that TSMP's Privacy Notice is available at https://bit.ly/3jkY2Xz and my care center's website and that I may request a paper copy from TSMPS.

I hereby acknowledge that I have received TSMP Notice of Privacy Practices. I understand that Team Select participates in the Arizona Health Information Exchange, as well as data exchanges related to any Organized Health Care Arrangements in which Team Select participates. I understand I may refuse to sign, revoke this consent at any time and/or inspect and/or copy my records from the HIE and data exchange systems

Test Results Notification Via Telephone

I authorize the Practice, its physicians, advanced practice providers, and employees to leave detailed messages specific to my medical care including test results on the phone number(s) listed below. I understand once a voicemail exists, it is no longer covered under HIPAA and is not protected from unauthorized access. Patients opting not to sign this authorization will receive medical information such as test results personally rather than via voice messaging.

Phone Number: _____ Patient Initials: _____

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AUTHORIZATION AND CONSENT TO TREATMENT

Informed Consent for Telemedicine Services

Introduction

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to medical care by enabling a patient to remain in his/her primary residence (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors;

By signing this form, I understand the following:

- I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
- I understand that I have the 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 care or treatment.
- I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
- I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time.
- I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
- I understand that it is my duty to inform my provider of electronic interactions regarding my care that I may have with other healthcare providers.
- I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

I acknowledge that I have read and understand all of the above information regarding Authorization and Consent to Treatment and Telemedicine Services.

Printed Name of Patient: _____

Patient Signature/Initial: _____

Email: _____

Date: _____

Printed Name of POA: _____

POA Signature: _____

Email: _____

Date: _____

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PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Prior PCP: _____ Last Visit with PCP: _____

Prior PCP Full Address and Phone Number: _____

Drug Allergies/Sensitivities (Required):_____

Medical Problems We Are Seeing You For	Date	Specialist Type, Address, and Phone Number	Date

Have you had any of these vaccinations? ☐ Flu Date _____ ☐ Tetanus Date _____ ☐ Pneumonia Date ___ ☐ Shingles Date _____

Advanced Directive		Y		N	Date of Last Medical Test	Date
	DNR		Full Code		Mammogram	
					Colonoscopy	
If yes, Date of Adv. Dir:					Bloodwork	
THE BELOW IS REQUIRED					ECG/EKG	
Height ___ ft, ___in					DEXA (bone density)	
Weight _____lbs					Skin Cancer Screen	
					Ultrasound or CT Scan	
					Pap Smear	

Preferred Pharmacy

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone:_____

Patient Initial: _____

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AUTHORIZATION TO OBTAIN NEEDED INFORMATION

I grant Team Select Mobile Physician Services' permission to obtain all medical information (which may contain medication history, confidential HIV/AIDS related information, communicable disease related information, information relating to mental health and/or alcohol/drug use) that any healthcare provider or agency may have on record for the purpose of further medical care Information to be requested.

I authorize the disclosure of the following protected health information:

☐ Entire medical record, including records relating to mental health care, communicable diseases, HIV or AIDS and treatment of alcohol/drug abuse.

☐ Medical record, excluding records relating to mental health care, communicable diseases, HIV or AIDS and treatment of alcohol/drug abuse.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Revocation must be in writing.

This authorization will expire automatically twelve months from the date on which it is signed.

I understand that I am under no obligation to sign this form. I am not signing this form to ensure receipt of healthcare treatment.

Signature _____ ☐ Patient ☐ Legal Representative Date _____

Legal Representative Name (Print) _____ Relationship to Patient _____

Reason patient is unable to sign: ☐ Lacks decision-making capacity ☐ Unresponsive ☐ Other: _____

OFFICE USE ONLY

Signature of Witness (TSMPS employee) _____ Employee ID _____ Date _____

Phone consent of legal representative if he / she is not present to sign at the time of admission

Phone Number Called _____ Date _____

Legal Representative Name (please print) _____ Relationship to patient _____

Reason patient is unable to sign: ☐ Lacks decision-making capacity ☐ Unresponsive ☐ Other: _____

Signature of Witness 1 (TSMPS employee) _____ Employee ID _____ Date _____

Signature of Witness 2 (TSMPS employee) _____ Employee ID _____ Date _____

Patient Name _____ Patient ID _____

Patient Initial: _____

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CHRONIC CARE MANAGEMENT AGREEMENT

By signing this Agreement, you consent to having Team Select Mobile Physician Services (hereinafter referred to as "Provider"), provide chronic care management services (hereinafter referred to as "CCM Services") to you as more fully described below:

CCM Services are available to you if 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 significant risk of further decline. Per Medicare, Chronic conditions include but are not limited to: Acute Myocardial Infarctions, Anemia, Arthritis, Asthma, Atrial Fibrillation, Cancer, Cardiovascular issues, Cataracts, Cerebral Vascular Disease, High Cholesterol, Chronic Heart Failure, Chronic Kidney Disease, Deep Vein Thrombosis, Dementia, Depression, Diabetes, Dysphasia, Gall Bladder Disease, Gastro Esophageal Reflux Disease, Glaucoma, High Blood Pressure, Hyperlipidemia, Hypertension, Hypothyroidism, Incontinence, Irritable Bowel Syndrome, Joint diseases, Liver Disease, Metabolic Syndrome, Pneumonia, Respiratory ailments, Sleep Apnea, Stroke or history of Stroke, Transient Cerebral Ischemia and many more.

CCM Services include 24-hour-a-day, 7-day-a week access to a health care provider in the 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 all the patient's health care providers and settings. The Provider will be available to you and will advise you on how to access those services.

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 confirmation of the revocation, stating the effective date of the revocation.

By signing this Agreement, you agree to the following:

- As clinically appropriate, we may need to share your health information electronically with other healthcare professionals involved in your care. Please rest assured that we continue to comply with all laws related to the privacy and security of your health information.
- Medicare covers these services at 80% and we will courtesy bill all supplemental insurances, if applicable, for the additional 20%. If you don't carry a supplemental plan, you may responsible for the balance.
- Only one provider can bill for this service for you. Therefore, if another one of your providers outside of Team Select Mobile Physician Services has offered to provide you with this service, you will have to choose which provider is best able to treat you and all of your conditions. Please let your provider or our Team Select staff know if you have entered into a similar agreement with another provider/practice.

You have the following rights with respect to CCM Services:

- The Provider will furnish you with a written or electronic copy of your care plan upon request.
- 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.
- You have the right to stop CCM Services at any time by revoking this Agreement effective at the end of the then current month. You may revoke this agreement verbally (by calling (602) 715-2568) or by mailing a revocation to: Team Select Mobile Physician Services: 2999 N. 44th Street, Suite 110, Phoenix, AZ 85018.

This program is available to qualifying patients, that meet the above outlined requirements. If you do not meet the above criteria to participate in the Chronic Care Management program, you will be notified by the Agency.

Patient **OR** **Patient's POA**

_____ _____

Signature of Patient or Patient's Assigned (POA) Signature

_____ _____

Printed Name and Date Printed Name and Date

Patient Initial: _____