NORTHWEST Geriatrics

Facility Name: _____

(Leave blank if the home is a Private Residence)

Address: _____

City:_____ **State:**_____ **Zip:** _____

Phone:_____ **Fax:**_____ **Patient's Room** _____

Patient Information

Name: _____

Social Security Number:_____ Gender: (circle one) M / F

Date of Birth: _____

Medicare Number (include suffix): _____

DSHS Patient Identification Code (PIC): _____

Secondary Insurance _____

If the patient has a HMO such as Medicaid/Molina/United HealthCare/WAHLOP/WA Apple Healthcare) we **cannot enroll or see the patient** until the family calls the insurer and assigns our provider as the named **Primary Care Provider.**

Please attach copies of ALL patient insurance cards (including Medicare).
We cannot process your registration form without correct insurance information.

Additional Contact / Responsible Party / Emergency Contact Information

Name: _____

Address: _____

City:_____ State:_____ Zip:_____

Phone:_____ Work/Cell Phone: _____

Does this person have medical **Power of Attorney**? (Circle One): Yes No Is this person the **financially responsible party**? (Circle One): Yes No

Consent to Treatment I voluntarily consent to the rendering of treatment as Northwest Geriatrics providers deem necessary for my health and well-being. My consent shall cover medical examinations and diagnostic testing. My consent shall also cover the carrying out of the orders of my treating provider.

If I request or initiate a telehealth visit, I hereby consent to participate in such telehealth visit.

Assignment of Benefits and Authorization to Release Medical Information. 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 of any services furnished to me by that provider. I authorize Northwest Geriatrics to file an appeal on my behalf for any denial of paymenht and/or adverse benefit determination related to services and care provided. If my insurance company pays me directly, I agree to forward to Northwest Geriatrics all health insurance payments which I receive for the services rendered by Northwest Geriatrics and its health care providers. I authorize Northwest Geriatrics or any holder of medical information about me or the patient named abolve to release to my health insurance plan such information needed to determine those benefits or the benefits payable for related services. I understand that if my insurance does not participate in the Northwest Geriatrics network, or if I am a self-pay patient, this assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification I agree that I am responsible for all charges for services not covered by my health insurance plan. I agree to pay all charges not covered by my health insurance plan for which I am responsible.

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 provision. I understand that my failure to do so may result in reduction or denial of benefit payments that I will be responsible for all balances due.

Consent to Call, Email & Text

I understand and agree that Northwest Geriatrics may contact me using 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 communication from Northwest Geriatrics.

HIPAA. I understand that Northwest Geriatric's privacy notice is available at www.nwgeriatrics.com and that I may request a paper copy by contacting the office at (206) 275-3588.

I hereby acknowledge that I have received Northwest Geriatric's Financial Policy and Notice of Privacy Practices. I agree to the terms of the Financial Policy and consent to my treatment by Northwest Geriatric's providers. This form and assignment of benefits applies and extends to subsequent visits and appointments with Northwest Geriatrics providers.

Patient's Name (print): _____Date of Birth: _____

Patient/Guardian's Signature: _____ Date: _____

Printed name: _____ Relationship: _____

NORTHWEST Geriatrics

COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

By signing below, I confirm and understand the following:

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted.
- I understand that I am opting for treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my treatment at this time.
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:
  - Fever
  - Runny Nose
  - Shortness of Breath
  - Sore Throat
  - Dry Cough
  - Loss of Taste or Smell
- I verify that I have NOT traveled in the past 14 days.
- I am informed that Northwest Geriatrics has implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be risk of becoming infected with COVID-19 by proceeding with this treatment.
- I have been offered a copy of this consent form.

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATIONS TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL NORTHWEST GERIATRICS PROVIDERS FOR MY PRESENT AND FOR ANY FUTURE CONDITION FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient's Name (print): _____Date of Birth: _____

Patient/Guardian's Signature: _____ Date: _____

Printed name: _____ Relationship: _____