PROVIDING QUALITY GERIATRIC HEALTH CARE IN THE COMMUNITY

NORTHWEST Geriatrics

Updated March 2025

NORTHWEST GERIATRICS PATIENT REGISTRATION FORM

FACILITY INFORMATION
(Adult Family Homes, Assisted Living Communities, Memory Care, Independent Living)
Private Residence, please complete with your home address.

Facility Name: _____

Address: _____ City_____Zip_____

Phone: _____(circle one) cell home Fax: _____

NAME OF FACILITY'S ASSIGNED PRIMARY CARE PROVIDER:

_____

PATIENT INFORMATION

Full legal name: _____

Date of birth: _____ Gender: (circle one) M F

Social Security Number: _____

INSURANCE INFORMATION
(Please note that copies of front/back of insurance cards MUST be submitted AND legible)

Primary Insurance: _____

Policy Number: _____

Secondary Insurance: _____

Policy Number: _____

Additional Insurance and Policy Number: _____

PLEASE COMPLETE BACK SIDE

FINANCIAL INFORMATION

Who will be financially responsible for patient? *(please choose one)*

_____Patient

_____ Someone else

If you chose "someone else" please fill out the following:

Full Name: _____

Relationship to patient: _____

Does this person have medical power of attorney? (circle one) Yes No

Mailing address_____City_____Zip_____

Phone: _____ (circle one) cell home

Email address: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: *(OK to leave blank if same as responsible party)*

_____

Relationship to patient: _____Phone number: _____(circle one) cell home

Mailing address: _____City_____Zip_____

Where should billing statements be sent *(please check one)*

_____ Facility address

_____ Financially responsible party mailing address

_____ Emergency Contact mailing address

NORTHWEST Geriatrics

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: _____

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Patient Consent Agreement for Advanced Primary Care Management Services

Medicare offers a benefit for beneficiaries with multiple chronic conditions, and by consenting to this agreement, you allow NORTHWEST GERIATRICS to provide Advanced Primary Care Management Services to you. APCM services are available to patients with one or more chronic conditions. Medicare defines a chronic condition as a condition that is expected to last for at least 12 months, and that increases the risk of death, acute exacerbation of disease, or a decline in function.

Benefits of APCM Services include:
* 24/7 access to a care provider to help with your chronic healthcare needs
* A comprehensive plan of care for health needs, available on paper or electronically
* Coordination with both home and community-based service providers
* Transition management among health care providers, including referrals, and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities
* Medication oversight and management
* Use of a certified electronic health record (EHR) as mandated by Medicare

Should you desire to receive APCM services through your provider, he/she agrees to only bill Medicare for APCM services once per 30-day billing cycle. Furthermore, your provider agrees only to bill Medicare for APCM services if you have more than one chronic condition.

Beneficiary Acknowledgment and Agreement

By signing this agreement, you agree to the following terms:
* You consent to your provider providing APCM services to you.
* You certify that your provider has fully explained the scope of APCM services to you.
* You acknowledge that only one practitioner can furnish and be paid for APCM services during a calendar month.
* You authorize electronic communication of your medical information between treating providers as part of your care.
* You understand that APCM services are subject to Medicare Co-Insurance, and so you may be billed for a portion of the APCM services.
* You understand that you have the right to terminate APCM services at any time by revoking this agreement effective at the end of the then-current month. You may revoke this agreement verbally by notifying NORTHWEST GERIATRICS by telephone at 206-275-3588

Patient's Name (printed) _____ Date of Birth:_____

Patient/Guardian's Signature: _____Date:_____

Printed Name: _____ Relationship_____

P.O. Box 1526 Mercer Island, WA 98040 **T** 206 275 3588 **F** 206 275 2073 www.nwgeriatrics.com

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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: _____