integrative GERIATRICS

REGISTRATION INFORMATION

Patient Identification Information

Patient Name: _____ DOB: _____

Insurance Information (Please enclose photocopies of insurance and Medicare cards)

Medicare Number: _____

Secondary Insurance: _____ ID: _____ Group: _____

Additional Insurance: _____ ID: _____ Group: _____

Legal Representation Information

Name: _____ Relationship to Patient: _____

Preferred Phone Number

Check appropriate descriptor and provide documentation

☐ Cell: _____ ☐ Self ☐ Conservator

☐ Work: _____ ☐ Financial POA ☐ Guardian

☐ Home: _____ ☐ Health Care Agent ☐ None

Address: _____

Email: _____

Alternative Emergency Contact

Name: _____ Relationship to Patient: _____

Cell: _____ Home: _____ Work: _____

Billing Contact Information (if different than above)

Name: _____ Relationship to Patient: _____

Preferred Phone Number

Check appropriate descriptor and provide documentation

☐ Cell: _____ ☐ Self ☐ Conservator

☐ Work: _____ ☐ Financial POA ☐ Guardian

☐ Home: _____ ☐ Health Care Agent ☐ None

Address: _____

Email: _____

CONSENT TO TREAT
PAYMENT AUTHORIZATION

Patient Name: _____ DOB: _____

CONSENT TO TREAT

I give consent for Integrative Geriatrics' providers to perform exams, treatment, diagnostics, scheduled immunizations, minor operations, and other routine medical care and to prescribe and/or administer to me medicine they believe to be necessary for my health.

PAYMENT AUTHORIZATION

1. Payment Responsibility I agree to pay for all services furnished to me by Integrative Geriatrics, including, but not limited to, charges that are not paid in full by my insurance, government program benefits or other third-party payors, upon receipt of a statement, except as prohibited by Integrative Geriatrics' contract with my health plan or applicable law. I also agree to pay or reimburse Integrative Geriatrics for all costs it may incur in collecting such amounts, including, but not limited to, attorneys' fees and collection agency fees.

2. Payment Authorization I authorize Integrative Geriatrics to directly bill my health plan or third-party payor for services rendered to me by or on behalf of Integrative Geriatrics, but acknowledge that Integrative Geriatrics is not obligated to submit claims to third-party payors on my behalf unless required by law or by its contract with a particular third party payor. I also authorize any third-party payor through which I may have benefits to make payment directly to Integrative Geriatrics for such services. If I have a Medigap policy, I request that payment of authorized Medigap benefits be made to Integrative Geriatrics directly on my behalf by my Medigap insurer. I understand and agree that Integrative Geriatrics is not responsible for collecting third-party payments or negotiating disputed settlements on my behalf. I understand I am financially responsible to Integrative Geriatrics for charges not covered by insurance.

3. Statement to Permit Payment for Medicare Benefits to Integrative Geriatrics If I am entitled to Medicare benefits, I request payment of authorized Medicare benefits to me, or on my behalf to Integrative Geriatrics, for any services furnished to me by Integrative Geriatrics, including professional services. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Signature (patient or authorized representative)	Printed Name	Date

If authorized representative, relationship to patient	Reason patient is unable to sign

CONSENT TO RELEASE MEDICAL RECORDS

21897 S Diamond Lake Road
Suite 400-403
Rogers, MN 55374
Office: 763-317-1122
Fax: 855-282-6764

Patient Name: _____ DOB: _____

Address: _____

City/State/Zip: _____ Phone: _____

Release of Information from: (Please provide previous provider information below)

Clinic Name: _____ Fax: _____

Release of Information to Integrative Geriatrics I consent to the release and use of all medical and other information about me by my current or past treating providers to Integrative Geriatrics for purposes of my treatment.

Release and Use of Information by Integrative Geriatrics I consent to the release and use by Integrative Geriatrics of medical and other information about me to the extent permitted by law to the following:

- To a health care provider being advised or consulted in connection with my treatment or care;
- To a health plan, insurer, third party payor, third party administrator or other organization providing me with health benefits, for the purposes of claims payment and benefit determinations, fraud investigations, or quality of care studies or reviews; and
- To a person or organization in connection with Integrative Geriatrics' health care operations. These operations may include interdisciplinary care conferences, quality improvement activities, performance evaluations, business management, and other related activities.
- To a person or organization providing services in connection with Integrative Geriatrics' patient health record portal or the person or organization hosting or providing the portal service.
- To the following individuals (name spouse or family member, coach, trainer, employer or others):

  _____

Revocation I understand that this consent is valid until I revoke it, which I may do at any time by giving written notice to Integrative Geriatrics; provided, however, that such revocation shall not apply to information released in reliance on this consent prior to such revocation.

Acknowledgment of Receipt I acknowledge that I have received Integrative Geriatrics' Notice of Privacy Practices.

Signature (patient or authorized representative)	Printed Name	Date

If authorized representative, relationship to patient	Reason patient is unable to sign

NOTICE: If you are a legal representative of the patient signing this form, please enclose a copy of supporting documentation regarding this status so that the medical records can be sent without additional delay.

INFORMED CONSENT FOR TELEMEDICINE SERVICES

Patient Name: _____ DOB: _____

- I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider used to deliver services to an individual when he/she is located at a different location or site than I am.
- I understand that the telemedicine visit will be done through a two-way video link-up. The healthcare provider will be able to see my image on the screen and hear my voice. I will be able to hear and see the healthcare provider.
- I understand that the laws that protect privacy and the confidentiality of medical information including (HIPPA) also apply to telemedicine.
- I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.
- 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 by signing this form that I am consenting to receive health care services via telemedicine.

Signature (patient or authorized representative)	Printed Name	Date

If authorized representative, relationship to patient	Reason patient is unable to sign

NOTICE OF PRIVACY PRACTICES FOR INTEGRATIVE GERIATRICS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY AND KEEP FOR YOUR RECORDS.

If you have any questions about this notice, please contact:

Teresa Cyrus, APRN, CNP
Chief Compliance and Privacy Officer, Integrative Geriatrics
21897 S Diamond Lake Rd.
Suite 400-403
Rogers, MN 55374

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information;
- Give you this notice of our legal duties and privacy practices regarding health information about you;
- Follow the terms of our notice that is currently in effect; and
- Notify you in the event there is a breach of any unsecured protected health information about you.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment- related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel who are involved in your medical care and need the information to provide you with medical care. We will get your written consent prior to making disclosures outside of Integrative Geriatrics for treatment purposes, except in emergency circumstances when it is not possible to get your consent.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment. We will get your written consent prior to making disclosures for payment purposes.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the preventive care and the care you receive for certain chronic illnesses is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities. We will get your written consent prior to making disclosures outside of Integrative Geriatrics for health care operations purposes.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you; in that case, we will obtain your written authorization to make such communications. However, we are not required to obtain your written authorization for face-to-face communications.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort. Generally, we will get your written consent prior to making disclosures about you to family or friends. If you are unable to make health care decisions, Integrative Geriatrics will disclose relevant medical information to family members or other responsible people if we feel it is in your best interest to do so, including in an emergency situation.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Federal law permits use and disclosure of health information about you for research purposes, either with your specific, written authorization or when the study has been reviewed for privacy protection by an Institutional Review Board or Privacy Board before the research begins. In some cases, researchers may be permitted to use information in a limited way to determine whether the study or the potential participants are appropriate. Minnesota law generally requires that we get your consent before we disclose your health information to an outside researcher.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat. In addition, Minnesota law generally does not permit these disclosures unless we have your written consent, or when the disclosure is specifically required by law, including the limited circumstances in which Integrative Geriatrics' health care professionals have a "duty to warn."

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information as required by law or with written consent to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military as required by law or with written consent.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domes- tic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. Minnesota law requires that patient identifying information (for example, your name, social security number, etc.) be removed from most disclosures for health oversight purposes, unless you have provided us with written consent for the disclosure.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order or as otherwise required by law.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order or warrant; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner in the case of certain types of death, and we must disclose health records upon the request of the coroner or medical examiner. We may also release the fact of death and certain demographic information about you to funeral directors as necessary to carry out their duties. Other disclosures from your health record will require the consent of a surviving spouse, parent, or your legally authorized representative.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counterintelligence, and other national security activities as required by law or with your written consent.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials as required by law or with your written consent so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official as required by law or with your written consent.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Teresa Cyrus, APRN, CNP, Chief Compliance and Privacy Officer. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to Teresa Cyrus, APRN, CNP, Chief Compliance and Privacy Officer. We may deny your request for an amendment if you ask us to amend information that is accurate and complete, was not created by Integrative Geriatrics, or is not part of the information you would be permitted to inspect and copy,

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Teresa Cyrus, APRN, CNP, Chief Compliance and Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend.

For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Teresa Cyrus, APRN, CNP, Chief Compliance and Privacy Officer. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to Teresa Cyrus, APRN, CNP, Chief Compliance and Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.consultativehealth.com. To obtain a paper copy of this notice, write to:

Teresa Cyrus, APRN, CNP
Chief Compliance and Privacy Officer, Integrative Geriatrics
21897 S Diamond Lake Rd.
Suite 400-403
Rogers, MN 55374

CHANGES TO THIS NOTICE:

The effective date of this notice is June 29, 2017, and it has been updated effective November 30, 2023. We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. If the terms of this notice are changed, Integrative Geriatrics will provide you with a revised notice upon request, and we will post the revised notice on our website and in our office.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Teresa Cyrus, APRN, CNP, Chief Compliance and Privacy Officer. All complaints must be made in writing. You will not be penalized for filing a complaint.

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