RESIDENTIAL MEDICAL KARE, LLC.

CONTINUING KARE ENROLLMENT AND CONSENT

DEMOGRAPHICS

First Name: _____Last Name: _____

Date of Birth: _____ Gender: ☐ Female ☐ Male

Preferred Method of Communication

☐Phone May Leave Message ☐Phone Do not leave a Message

☐Email ☐Text Number:

MEDICAL POWER OF ATTORNEY

Name: _____ Relationship: _____

Email: _____ Phone: _____

Alternate Email: _____

Address: _____

City: _____ State: VA Zip Code: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Note: This entity is required by law to provide each patient with a copy of our Notice of Privacy Practices, obtain acknowledgment that the Notice was provided, and keep the acknowledgment in our records. You will be given a copy of this acknowledgment with the Notice of Privacy Practices for your records.

Document on practice Website www.resmedkare.com

ACKNOWLEDGEMENT OF PATIENT

Residential Medical Kare, LLC, is required by law to maintain the privacy of and provide individuals with access to the Notice of our legal duties and privacy practices concerning protected health information. I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document and understand that I may obtain a copy for my records upon request.

Release of Information

The patient or the patient's representative must read and agree to the following statements: I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law, including research-related treatment, which may be conditioned upon this authorization. Residential Medical Kare, LLC may condition the provision of health care solely to create protected health information for disclosure to a third party upon my signature of this authorization. I understand that information released according to this authorization may lose the protection of federal privacy regulations due to re-disclosure by the recipient.
Access to medical records may be subject to additional state and federal regulations. I understand that this disclosure may include information regarding drug and alcohol abuse, psychiatric and/or mental illness, accidents, disability, birth defects, cancer, and genetic information. I understand that I may revoke this authorization at any time by notifying the providing organization in writing. **TO THE PARTY RECEIVING THIS INFORMATION:** This information is being disclosed to you from records where confidentiality may be protected by federal and/or state laws. If so, regulations 42 CFR, Part 2, prohibit further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation.

Consent for Services

Residential Medical Kare, LLC offers its patients face-to-face and telehealth services as deemed medically appropriate and under the guidance of state and licensure requirements in the Commonwealth of Virginia. Residential Medical Kare, LLC does not provide Emergency Services.
Practice Hours: Monday through Friday from 8:00 AM to 5:00 PM EST.
Provider- an autonomous practice Virginia Licensed Nurse practitioner who shall provide medical services to the client either in-person or via telehealth at home, in an independent, assisted living, or memory care setting.
Client- includes all parties signing for or on behalf of the person to whom services are provided / the patient.
Responsible Party- If this Agreement is executed by an attorney-in-fact under a power of attorney, herein referred to as the Responsible Party, agrees to be bound as Client by the terms of this agreement. The obligations created by this Agreement are joint obligations of the Client, Attorney-in-fact, and Responsible Party.
Care settings:
Home-Based: Patient residing in a location that is independent and not part of a residential community. Aging in place at home. Additional fees apply to this location as identified below.
Residential Community: Independent, Assisted, or memory care locations as part of a continuing care community.
Visit Modalities:

Face-to-face: In-person care is the "traditional" way to receive healthcare, counseling, and treatment. The provider will visit you at your living or clinic location.

Telehealth - the delivery of health care services using interactive phone/video conferencing to enable a health care provider to provide treatment to his/her patients and for patients to receive treatment without having to visit the office or travel long distances. In many instances, telehealth technology is available, and the patient is not able to manage the technology; these visits are conducted telephonically. Patient / POA will not record any telehealth sessions with the provider. The provider will not record telehealth sessions without my consent. This is so that your privacy can be protected.

Services:

New Patient Visit - The provider shall collect pertinent medical history and perform a thorough assessment to diagnose, maintain, and treat identified problem(s). Medication reconciliation will be done. The provider will order any home health care services, therapy, radiology, laboratory, or DME deemed medically necessary.

Follow-up Visit- routine, sick, urgent, routine annual wellness exams, cognitive assessments to ensure all medical issues have been addressed and resolved and address new concerns as necessary.

Coordination of care and Communication- All services beyond the normal scope of medical care include but are not limited to communication with the patient's Family/Responsible Party as requested through phone calls, email, or reports. This also includes requests to fill out documents and medical-related forms. Coordination of care, including communication will be considered part of the patient's visit and will be billed or charged accordingly. When coordination of care requirements becomes extensive the patient will require an independent care manager to be hired.

Advanced Primary Care Management (APCM) — I agree to participate in APCM to develop a comprehensive care plan based on your diagnoses and treatment goals for all your chronic conditions. This plan coordinates the care you receive from all your healthcare professionals. I understand that there may be a copayment for this service however this will be waived by the practice.

Psychiatric collaborative care management services (CoCM) - includes a behavioral health care manager who implements a measurement-guided care plan based on evidence-based practice guidelines and focuses particular attention on patients not meeting their clinical goals. I understand that there may be a copayment for this service however this will be waived by the practice.

Use and Disclosure of Medical Information - I understand that practices about the use and disclosure of my medical information are described in the current Notice of Privacy Practices as required by HIPAA and that I have been offered either on paper or read the complete notice available online at www.resmedkare.com

Termination of Services: Services may be discontinued by the Provider or the Patient / Client at any time with a (7) day written notice by email or mail.

RESIDENTIAL MEDICAL KARE, LLC.

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Services Not Covered By Insurance, billable to the patient:

Item	Fee
Accounts past 30 days will be assessed interest monthly until paid	2.5 %
Bounced check fee per occurrence of returned checks	$40
Capacity Assessment with Letter	$100
Capacity-Related Services/Court Preparation Fees/Provide statement/testimony or any other court-related proceedings	$300/hr
Facility Move-in Paperwork / History and Physical	$350
Medical Forms and paperwork fee (i.e.: FMLA, VA assistance, long-term care insurance, Fast-Tran, etc.)	$ 50
Phlebotomy services - home-based	$65

Assignment of Benefits: I request payment of authorized Medicare and other insurance benefits be made on my behalf for any services furnished to me by Residential Medical Kare, LLC, and its independent contractors. I authorize Residential Medical Kare, LLC to provide my insurance company with any information about services rendered to me as necessary to process claims.

Deductibles, Copayments, and non-covered services – I understand that I am financially responsible for all charges for services rendered to me by Residential Medical Kare, LLC, and its independent contractors, including any balances owed after insurance payments. Balances will be charged to the patient invoices provided to the facility

I consent and authorize Residential Medical Kare, LLC and its independent contractors to care for and treat me in my home, place, or residence, whether in-person or via Telehealth. I have read and understood the information above. I hereby give my informed consent for medical services during my treatment. I agree with the above regarding the assignment of benefits and services not covered by insurance. I understand that my plan or care may change, and if so, these changes will be discussed with me, and the final decision shall be mine. I agree to notify my Provider of any changes in my condition, any side effects of medications, or any other events related to my health and well-being. This authorization will expire only upon my death unless I revoke this authorization by written notice to Residential Medical Kare, LLC.

The patient or patient representative has read the above and must sign below.
I certify that all information provided is correct to the best of my knowledge.

Signature: _____ Date: _____

Name: _____