CONSENT PACKET

Hansa Medical Groupe

PRIMARY CARE | SPECIALTY CARE

ASSISTED & SENIOR LIVING | MEMORY CARE

SKILLED CARE | POST-ACUTE CARE

847-920-0902

PATIENTCARE@HANSAMEDICALGROUPE.COM

HANSAMG.COM

Hansa Medical Groupe

PATIENT DATA: **Practice Start Date:_____/_____/_____**

Patient's Full Name:_____

Facility Name(if applicable)_____

Address:_____ City:_____ State:_____

Home Phone:_____ Cellphone:_____

REFERRAL SOURCE_____Social Security #_____/_____/_____

Marital Status: S M W D Birthdate:____/____/____ Age:_____ Sex: M / F

Spouse's Name (if applicable)_____Phone_____

POA (if applicable)_____ Phone_____

INSURANCE INFORMATION:

Primary Insurance:_____ Secondary Ins._____

POWER OF ATTORNEY CONTACT INFORMATION:

Name:_____ Relationship:_____

Home Phone #_____ Cellphone#_____

PHARMACY NAME_____ PHARMACY NUMBER_____

MEDICATION LIST

_____
_____
_____
_____
_____

MEDICAL CONDITIONS

_____
_____
_____
_____
_____

HANSA MEDICAL GROUPE FULL CONSENT

My signature below will be applied to all consent pages in this packet except for the Advanced Beneficiary Notice or ABN. You may be asked to sign the ABN in the future based on specific non-payment related circumstances.

By signing below, I am consenting to have read through and understand all aspects of the Hansa Medical Groupe consent packet and the separate practice packet. I understand and agree to all parts of the Hansa Medical Groupe consent packet and responsibilities as a patient, for any primary care medical service, back-up physician medical services, any specialty care, Chronic Care Mgt, Remote Patient Monitoring, Principal Care Management Service, and/or any tele-health services provided by Hansa Medical Groupe. This includes the Credit Card Authorization, unless specified otherwise.

Please check Service type. PCP_____ Back up PCP_____

Patient Name_____Date of Birth_____

Building Name_____APT #_____

Resident Cell Number_____

Building Phone Number_____

POA Name_____POA Phone_____

POA EMAIL_____

Signature of Patient, POA, or Verbal Representative Date

WITH YOUR SIGNATURE BELOW, YOU ARE GIVING HANSA MEDICAL GROUPE, LLC PERMISSION TO CHARGE FOR ALL FORMS OF CHARGES INCLUDING BALANCE PAYMENTS, CO-PAYMENTS, AND ANY OTHER CHARGES RESPONSIBLE BY THE CONSENTED PATIENT. ANY FRADULENT INFORMATION RELATED TO CREDIT CARDS WILL BE TURNED OVER TO THE APPROPRIATE AUTHORITIES.

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize _____ to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date

Hansa Medical Groupe

Dear patient and/or family,

Hansa Medical Groupe offers the Chronic Care Management(CCM), Remote Patient Monitoring(RPM), and Principal Care Management(PCM) program for our Medicare patients. Signing the consent on page 3 will allow us to provide these services when appropriate and contact the patient or Power of Attorney on a monthly basis, to check in, coordinate care, and see how things are going regarding their health and wellness.

These additional services of communicating, specialty focus, and monitoring patients will help with continuity of care, prevent hospitalizations or ER visits, and allow families another way to communicate their concerns. It helps everyone involved work better together as a team, for the betterment of the patient.

I look forward to working even closer with our patients and their families. The CCM program will allow us to do this even better.

Sincerely

Chirag Patel MD
Chief Medical Officer

Hansa Medical Groupe, LLC

Northshore Mailing Only P.O. Box 261, Wilmette, IL 60091
Downtown 405 North Wabash, Suite 4710, Chicago, IL 60611
Northshore 5250 Old Orchard Rd, Suite 300, Skokie, IL 60077

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Hansa Medical Groupe

The Medicare CCM, RPM, and PCM Patient Programs

CONSENT FORM

Hansa Medical Groupe,(HMG) provides **Chronic Care Management (CCM), Remote Patient Monitoring (RPM), and Principal Care Management(PCM)** for qualified Medicare patients. These services allow HMG staff to communicate and develop and revise monthly plan of care, communicate with other treating health professionals, and manage medication on a monthly basis while regularly monitoring key health indicators. These programs allow us to better care for our patients.

1. **CCM**—Chronic Care management for at least 2 chronic conditions, including assessment of patient's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications. Creation of a patient-centered care plan document, spending 20 minutes for each patient case monthly, and will be communicated by phone on a monthly basis to staff, patient, and/or family or POA.

2. **RPM**--Monthly remote physiologic monitoring treatment management services that may include weight, blood pressure, pulse oximetry, respiratory flow rate and glucose monitoring, 20 minutes or more of clinical qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver, facility staff, family and/or Power of Attorney on a monthly basis.

3. **PCM**—Monthly clinical focus on 1 chronic condition that Will typically be expected to last between 3 months and 1 year, or until the death of the patient. May have led to a recent hospitalization and/or place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline and Is of such complexity that it cannot be managed effectively by primary care and requires management by another, more specialized practitioner

These services are billed to medicare monthly or when performed and you will notice them in your Explanation of Benefits (EOB). The Patient has the right to stop the services at the end of any service period.

_____ CCM _____ RPM _____ PCM

_____ _____
Patient Name Patient Signature Date

_____ _____
POWER OF ATTY NAME Date POA Signature Date

_____ _____ _____
If Verbal Consent: Contact Name Relationship Date of Consent

_____ _____
Patient/POA mobile number Patient/POA email

SENIOR COMMUNITY/FACILITY NAME_____

AUTHORIZATION:

I authorize Hansa Medical Groupe, LLC to release any information obtained by all provided medical care, to other medical facilities, physicians, and/or insurance carriers as deemed necessary by Hansa Medical Groupe, LLC. This practice does not take responsibility for any further disclosures made by those parties. I also authorize my insurance company to make payment to Hansa Medical Groupe for services rendered and shall remain in effect until membership to the practice is terminated by either party.

AKNOWLEDGEMENT:

The consented Patient shall indemnify and hold Hansa Medical Groupe, LLC harmless from any loss, liability, or medical malpractice claim arising from any and all services performed by any Independent Contractor contracted with Hansa Medical Groupe, LLC under this Agreement.

POLICY & AGREEMENT:

With respect to the medical practice and medical services rendered by Hansa Medical Groupe physicians and staff, I agree to the following:

I understand that balance billing to Hansa Medical Groupe is a collectable charge, as obtained from billing for medical services rendered to my health insurance policy. Home visits provided by the practice are not the same as services at a physician's office, hospital, or emergency room. Timing & number of home visits are based on medical necessity determined by the treating provider or physician(s).

All outstanding balances are to be paid according to the set schedule as stated, unless other arrangements have been made with the Group. It is my responsibility to provide insurance information to Hansa Medical Groupe, LLC at the time of initial services, so appropriate billing may be conducted. Otherwise payment is potentially due in full at the time of service. Co-payments, deductibles, and balance billing are only collected according to contractual agreements with private and/or commercial insurance carriers and/or medicare.

I HAVE READ AND ACCEPTED THE ABOVE POLICY, AGREEMENT, AND FAQ PAGES OF THIS PACKET AND UNDERSTAND MY EXPECTATIONS AS A PATIENT OF THIS PRACTICE.

_____ _____

SIGNATURE DATE

MEDICARE PAYMENT PERMISSION OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS AND PATIENTS

(REQUIRED SIGNATURE BY MEDICARE)

_____ _____

Name of Patient Medicare Number (HICN)

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by Hansa Medical Groupe, LLC, including physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits for related services.

Secondary:

_____ _____

MediGap Carrier MediGap Policy Number

I request that payment of authorized MediGap benefits be made either to me or on my behalf for any services furnished to me by Hansa Medical Groupe, LLC, including physician services. I authorize any holder of medical or other information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits for related services.

_____ _____

Signature of Patient Date

Hansa Medical Groupe

Patient Name:_____ Date:_____

CONSENT FOR TREATMENT

I authorize and consent to the administration and performance of all tests, treatments, and services which maybe ordered by any physician or designated assistant of Hansa Medical Groupe, LLC.

Minors must be accompanied by a parent or legal guardian for medical care, except when the minor is seeking specific services for which Illinois State Law does not require an obtained parental consent, accompaniment or guidance.

ASSIGNMENT OF BENEFITS

I hereby assign, transfer, and set over to Hansa Medical Groupe, LLC and/or any legal entity providing billing services to Hansa Medical Groupe, LLC, all my rights, title, and interest to medical reimbursement benefits under my insurance policy(s) as indicated below. If my insurance benefits are provided through an ERISA plan, (Employment Retirement Income Security Act) I hereby assign, transfer, and set over all rights, title, and interest as beneficiary of the ERISA plan to Hansa Medical Groupe, LLC, with regard to my treatment and care by Hansa Medical Groupe, LLC

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION FOR PAYMENT

I authorize Hansa Medical Groupe, LLC to release medical information or copies of my medical records to insurance companies, third party payers, or authorized agents including claims review organizations in order to process a claim for payment on my behalf. This information may be disseminated to any and all employers' insurance companies or their representatives who may provide coverage for medical charges and to comply with the requirements of any Professional Review Organization. This authorization may be revoked by writing at any time.

PAYMENT AGREEMENT

I agree to hereby assume full responsibility for and agree to pay all costs, charges, and expenses incurred by the patient, to Hansa Medical Groupe, LLC. I understand this constitutes a direct undertaking by myself and is not conditioned or contingent upon payment of any such costs, charges, or expenses by any third party. Assignments of benefits of any insurance policy or medical reimbursement plan shall not be deemed as a waiver of the Provider's right to require payment directly from the undersigned. The Provider reserves its right to require such payment. In the event an obligation remains unpaid and requires referral for collection, the undersigned agrees to pay all costs of collection services, including but not limited to attorney's fees. If the undersigned is more than one person, every obligation hereunder shall be joint and several.

We accept cash, check, or all major credit cards. A $70 charge per service rendered, will be applied when any insurance company fails to any amount. Our charges are usual and customary for our area. You are responsible for payment regardless of any insurance company's determination of usual and customary rates, unless Hansa Medical Groupe, LLC has a participating agreement with that company.

By signing below, you acknowledge and consent to the sections specifically indicated above: Consent for Treatment, Assignment of Benefits, Authorization to Disclose Medical Information for Payment, and Payment Agreement.

_____ _____

Signature of Patient/Parent/Guardian/POA Date

_____ _____

Witness Date

CHRONIC OPIOID USAGE CONTRACT FOR PAIN

Recognizing that a specific group of chronic pain patients benefit from chronic opioid or controlled substance usage, this contract is enacted to ensure the safe and proper use of these controlled substances.

1. Patients should have shown via a trial period of usage that their pain is controlled adequately and proper dosing is being followed.
2. Physician must review prescription every 30 days. Refills are per the discretion of the physician with coordinated care and advise from facility nursing staff.
3. Prescriptions will be for 30 days only with no refill. This may be waived by the physician for terminal or invalid patients.
4. Refills are to be requested by the patient or facility staff at least 5 days prior to need.
5. Refills that have been approved by the physician to be mailed will be mailed appropriately.
6. Patients missing appointments will only be given refills to last until the next available appointment which will be within 1-2 WEEKS. If the rescheduled appointment is missed, no further refills will be given.
7. Lost or stolen medications or prescriptions will not be accepted as a reason for refill prior to the 30 day period. Local law enforcement agencies will be need to be notified. A police report will be have to be filed in the chart before any further prescriptions.
8. Adjusting dosages without contacting the physician will not be accepted and will terminate the prescribing relationship.
9. If abuse occurs, the medication will be discontinued.
10. Abuse of prescription and/or noncompliance by the patient will initiate notification of all area physicians and necessary legal authorities.
11. *Patients will use one pharmacy and notify physician of name and phone number.
12. No prescriptions for opioids will be written in the evenings, holidays, or weekends.
13. I authorize my physician to share information with other physicians.
14. The prescribing relationship will terminate if the patient attempts to obtain opioid medication from another physician outside this practice.
15. I agree to participate in all phases of my multidisciplinary treatment plan, which may include referrals to physical therapy, various other physicians, and/or a pain psychologist.
16. *My designated pharmacy is _____ Phone #: _____

_____ _____

Patient Signature Date Witness Date

_____

Provider Signature Date

Hansa Medical Groupe, LLC

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