Patient Enrollment Form

All information must be completed

Bluestone Physician Services

Patient Information: Please use full legal name.

☐ *Memory Care* ☐ *Assisted Living* ☐ *Group Home* ☐ *Independent Living*

First Name: _____ Last Name: _____ M.I.: ____

Date of Birth: ____/____/____ Social Security #: _____ Gender: ☐ M ☐ F ☐ Other

Facility Name: _____ Phone Number: _____ City/State: _____

Patient Room #: _____ Patient personal cell or direct phone only *(if applicable):* _____

Marital Status *(choose one)*: ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered ☐ Single

Race/Ethnicity: *Choose one or more*
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Declined ☐ Unknown

Primary Language: _____ Country of Origin: _____ ☐ Interpreter Services Needed

Drug Allergies ***(required)***: _____

Insurance: Please submit a copy of insurance cards.

Medicare ID #:_____ (If on Medicare, ID ***required*** for enrollment.)

Primary Plan: _____ Policy ID #: _____ Group #: _____

Secondary Plan: _____ Policy ID #: _____ Group #: _____

Prescription Drug Coverage Name: _____ Plan ID #: _____

Legal Representative

I understand that a patient may voluntarily designate or appoint an individual other than the patient to make medical decisions on the patient's behalf. The individual may be referenced on the applicable authorizing paperwork using the following terms or other similar terms: Power of Attorney, Healthcare Surrogate, Healthcare Proxy, Healthcare Power of Attorney, Guardian, etc. (collectively referred to here as the "Legal Representative"). I acknowledge and agree that by signing this form as Legal Representative, I swear and attest that I am legally authorized to act and make decisions on the patient's behalf. I am required to provide a copy of valid and effective documentation outlining my role as Legal Representative in order to receive related communications, including verbally and via the Bridge. The Bridge is where you can electronically contact Bluestone's care team 24 hours a day, 7 days a week for questions, and is where the care team will connect with you about the patient's care. Upon signing this form or any other required documentation from Bluestone as a Legal Representative for the patient, I hereby release and hold harmless Bluestone Physician Services and its representatives from any claims or damages arising from Bluestone's reliance on my attestation that I am the patient's Legal Representative. If there is a/you are the Legal Representative, please provide their/your contact information below:

Name: _____ Relationship to Patient: _____

Mobile Phone #: _____ Secondary Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Billing Contact:

☐ Same as Healthcare Decision Maker ☐ Self ☐ Other _____

Name: _____ Relationship to Patient: _____

Mobile Phone #: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Updated 8/17/2022

Authorization for Release of Health Information

Bluestone Physician Services

Patient Information: Please use full legal name.

First Name: _____ Last Name: _____ M.I.: _____ Date of Birth: _____/_____/_____

Community and Room #: _____

Release Information From (Required):

Clinic Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Release Information To:

Bluestone Physician Services
Attn: Medical Records Dept.
270 Main Street N., Suite 300
Stillwater, MN 55082

FAX: 855-490-4045 **PHONE:** 877-599-1039

Information To Be Released (Required): Indicate ONLY the information that you are authorizing to be released.

☐ Notes from **four** most recent provider visits ☐ Labs and imaging within last two years

☐ Hospital discharges within **last two years** ☐ Other: _____

By law, you must specifically request the following information for it to be released:

Chemical dependency program: ☐ Yes ☐ No Behavioral health notes: ☐ Yes ☐ No

I hereby authorize the release of my individually identifiable health information described above for treatment and payment purposes. I understand that this authorization to release health information is voluntary. I understand that the information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal or state law.

I understand that my healthcare and the payment for my healthcare will not be affected by my signing of this form. I understand I may request a copy of this form after I sign it. I understand that this authorization may be revoked by me by written notice to Bluestone Physician Services. I understand that if I revoke this authorization it will not have any effect on any actions taken by Bluestone Physician Services before receiving my revocation. This release covers past, present and future encounters/visits unless I write in specific treatment dates here: _____ to _____. This consent does not expire unless I write in a specific expiration date here: _____.

I acknowledge and agree that by signing this form as a Legal Representative for the patient, I swear and attest that I am legally authorized to act and make decisions on behalf of the patient. I am required to provide a copy of valid and effective documentation outlining my role as Legal Representative in order to receive related communications. Upon signing the form or any other required documentation from Bluestone as a Legal Representative for the patient, I hereby release and hold harmless Bluestone Physician Services and its representatives from any claims or damages arising from Bluestone's reliance on my attestation that I am Legal Representative.

_____ _____

Patient or Legal Representative Signature ***Date***

_____

Legal Representative Printed Name and Authority to sign for patient *(i.e. Health Care Directive, Medical POA; must include documentation)*

Updated 8/17/2022

Consent for Services

Bluestone Physician Services

Patient Full Name: _____ Date of Birth: _____/_____/_____

Community and Room #: _____City/State: _____

Consent for Services and Disclosure of Information for Treatment: I consent to any and all medical evaluation and treatment, preventative care services and procedures which are deemed necessary or advisable by Bluestone medical providers and designees. I consent to the use of telemedicine services in the course of my diagnosis and treatment with my Bluestone Provider Team. Telemedicine involves the use of audio, video or other electronic communications to interact and consult with the healthcare provider(s). I also consent to the use and disclosure of my health information by Bluestone for my treatment, including disclosure of my health care information to health care providers and facilities unrelated to Bluestone that may be involved in care.

Health Information Exchange: Bluestone may disclose my health information to and access my health information from other providers using a record locator service or patient information service of a health information exchange unless **I object by checking here:** ☐

This applies to health information Bluestone already has about me, information about future care I may receive from Bluestone and information Bluestone receives from third parties. This consent will continue unless I cancel by giving written notice to Bluestone or it expires as required by law. Cancellation will apply after the date when the notice to cancel is received. It will not affect information that is used or disclosed before cancellation.

Notice of Privacy Practices and Consent (Acknowledgment of Receipt): I received a copy of Bluestone's Privacy Practices and understand I have a right to review these before signing this consent form. I understand that Bluestone may change its privacy practices in the future, that any changes will be posted on Bluestone's website and that I may request a copy of the new privacy practices at any time. I understand I can contact Bluestone's Privacy Officer with any questions I may have about the Notice of Privacy Practices. In addition to the other uses and disclosures described in this document, I consent to the use and disclosure of my health information for the purposes described in the Notice of Privacy Practices, including Bluestone's health care operations.

Patient Financial Consent: I understand that it is my responsibility to know what the terms of my insurance are, and in compliance with those terms, I understand I will pay all applicable co-pays or co-insurance and outstanding account balances as they become due. I understand that it is my responsibility to read and review the Bluestone Physician Services (BPS) Patient Financial Consent policy located online at BluestoneMD.com and agree to be bound by its terms.

Use of Health Care Records in Program Evaluations and Training: I give Bluestone permission to use and disclose information gathered during the course of my treatment from Bluestone, including information from my treatment records, for the purposes of program evaluation and training and for overall quality review, including staff performance and outcomes at Bluestone.

Chronic Care Management: I give Bluestone permission to enroll me in the Bluestone program which includes chronic care management (CCM) when appropriate. The program and CCM include practitioner/ care management visits and activities, which will be billed to my insurance with normal deductibles and copays. I understand that only one practitioner may furnish and be paid for CCM services during a given calendar month and that I have the right to stop CCM services at any time. I understand information concerning this program is available on the website at BluestoneMD.com/forms.

Consent for Use of Medical Records in Academic Research: I authorize Bluestone Physician Services to use or disclose my health records for medical or academic research, including health records created at any time by Bluestone and records Bluestone received from other health care providers, unless I object by checking here: ☐ **I request that Bluestone tell me the dates on which my health records are released for research and how to contact external researchers who have received my records.**

Consent to Email or Text Usage: I authorize Bluestone to communicate with me, including potentially sensitive information about me like billing, payment, and appointment- related information, via text message (also known as SMS) and e-mail.

☐ **I would like to opt-out of receiving text messages**
☐ **I would like to opt-out of receiving e-mails from Bluestone**

If Legal Representative signing this form: I acknowledge and agree that by signing this form as a Legal Representative for the patient, I swear and attest that I am legally authorized to act and make decisions on behalf of the patient. I am required to provide a copy of valid and effective documentation outlining my role as Legal Representative in order to receive related communications. Upon signing the form or any other required documentation from Bluestone as a Legal Representative for the patient, I hereby release and hold harmless Bluestone Physician Services and its representatives from any claims or damages arising from Bluestone's reliance on my attestation that I am Legal Representative.

Patient signature: _____ Date: _____

Legal Representative signature *(if authorized to sign for patient):* _____ Date: _____

Legal Representative printed name: _____ Relationship to patient: _____

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Consent for Access to Protected Health Information (PHI)

Bluestone Physician Services

Patient Full Name: _____ Date of Birth: _____/_____/_____

The Bridge and the Patient Portal are HIPAA compliant communication and health record systems where you and/or people you authorize can stay updated or access important health information online and access the Bluestone care team anytime. Both are very important tools for delivering high quality healthcare and keeping everyone informed. The primary way to reach your provider team is through the Bridge!

If patient is signing this form: I can authorize a personal representative to access my health care information and communicate with my Bluestone Provider Team electronically through the Bluestone Bridge and/or the Bluestone Patient Portal by filling out the PHI form with the **appropriate information.**

If Legal Representative is signing this form: I acknowledge and agree that by signing this form as a Legal Representative for the patient, I swear and attest that I am legally authorized to act and make decisions on behalf of the patient. I am required to provide a copy of valid and effective documentation outlining my role as Legal Representative in order to receive related communications with the Bluestone Provider Team electronically through the Bluestone Bridge and/or the Bluestone Patient Portal. Upon signing the form or any other required documentation from Bluestone as a Legal Representative for the patient, I hereby release and hold harmless Bluestone Physician Services and its representatives from any claims or damages arising from Bluestone's reliance on my attestation that I am Legal Representative.

If you are the patient and have signed the Consent for Services form yourself, please complete the below section to consent to authorizing access to Protected Health Information for those who you want to have access to your medical information and care providers. Return via fax to the number listed below or use our secure upload feature.

If you are the Legal Representative for someone who is not able to consent themselves, you will need to fax or email this form **and the supporting legal documents** (Health Care Directive, Healthcare Power of Attorney forms, proof of guardianship, etc.) to our office as soon as possible. ***Receiving this paperwork is the only way we can provide access to Protected Health Information to someone other than the patient.***

FAX: 855-306-1167 **Secure Upload: bluestonemd.sharefile.com/filedrop**

This consent applies to health information Bluestone already has about me, information about future care I may receive from Bluestone and information Bluestone receives from third parties. This consent will continue unless I cancel by giving written notice to Bluestone Physician Services or it expires as required by law. Cancellation will apply ***after the date*** *when the notice to cancel is received. It will not affect information that used or disclosed before cancellation.*

People who the signer of this consent grants access to Bridge and Patient Portal: please ensure accuracy of this info or there will be delays

Name: _____ Email: _____ Phone: _____

Name: _____ Email: _____ Phone: _____

Name: _____ Email: _____ Phone: _____

Name: _____ Email: _____ Phone: _____

Name: _____ Email: _____ Phone: _____

REQUIRED: By signing below, you acknowledge the above and that you are giving the following individuals access to your health care records maintained by Bluestone, including updates on your health care status.

Patient signature: _____ Date: _____

Legal Representative Signature *(if authorized to sign for patient):* _____ Date: _____

Legal Representative printed name: _____ Relationship to patient: _____

For IT questions about Bridge or patient portal registration, please contact the IT Help-Desk Line: 855-794-9476
For questions about enrollment or about Legal Representative forms, please contact the Enrollment Team at: 877-599-1039

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