# Bluestone Patient Enrollment Form

Bluestone

All information must be completed

## 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: _____ Facility city/state: _____

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

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

Race/Ethnicity: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino
*Choose one or more* ☐ 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 that by listing my information below and by signing the Consent for Services form as Legal Representative, I swear and attest that I am legally authorized to act and make decisions on the patient's behalf. I will be asked to provide a copy of valid and effective documentation outlining my role as Legal Representative in order to receive related communications, including 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 Legal Representative ☐ Self ☐ Other _____

Name: _____ Relationship to Patient: _____

Mobile Phone #: _____ Email: _____

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

Updated 01/2026

**Fax completed forms to: 855-306-1167**

# Authorization for Release of Health Information

Bluestone

## Patient Information: Please use full legal name.

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

Community and Room #: _____

## Release Information From (Required): *(Previous clinic or healthcare provider)*

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

This authorization is intended to provide my health care providers with the written authorization necessary to allow each of them to disclose my individually identifiable health information regarding my health or medical records to Bluestone Physician Services. I hereby release my expectation of privacy in such situations and agree to hold harmless any covered entity that acts in reliance on this authorization

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:

____/____/____ (mm dd yyyy) to ____/____/____ (mm dd yyyy). This consent does not expire unless I write in a specific expiration date here: ____/____/____ (mm dd yyyy).

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 01/2026

**Fax completed forms to: 855-306-1167**

# Consent for Services

Bluestone

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.*

**Acknowledgement of Receipt of Notice of Privacy Practices (NPP):** The privacy of your protected health information is important to us. We have provided you with a copy of our Notice of Privacy Practices. It describes how your health information will be handled in various situations. We ask that you sign this form to acknowledge you received a copy of our Notice of Privacy Practices. This includes the situation where your first date of service occurred electronically. I have received Bluestone Physician Services, P.A., Bluestone National, LLC, and Bluestone Physician Services Wisconsin, and its subsidiaries and affiliates, (collectively, Bluestone Physician Services (BPS) Privacy Notice.

**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.

**Guiding an Improved Dementia Experience (GUIDE):** Certain Medicare beneficiaries qualify for enrollment into the GUIDE program which is designed to support people with dementia by providing additional resources for their care with no cost sharing. I understand that Bluestone is required to submit my information to Medicare to verify eligibility and to be enrolled into the program. I understand I will not be enrolled until my care team has requested my consent. I give Bluestone permission to enroll me in GUIDE unless I decline. I understand my care plan will be available on the patient portal and that more information concerning this program is available on the website.

**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.

**Advanced Primary Care Management (APCM):** APCM includes services between visits to coordinate my chronic care needs. I understand that these services will be billed to my insurance on a monthly basis with normal cost sharing per my plan's specifications. If I am a Qualified Medicare Beneficiary, I am not responsible for any cost sharing. I understand that only one practitioner may furnish and be paid for APCM services during a given calendar month and that I have the right to stop APCM services at any time, effective at the end of the month. Information about this program is available on the Bluestone website. I understand I will not be enrolled until the billing provider has requested my consent. I give Bluestone permission to enroll me in APCM unless I decline. My APCM care plan will be available on the patient portal.

**Behavioral Health Integration Services (BHI):** I give Bluestone permission to enroll me in BHI services when appropriate. I understand the billing provider will get my permission to consult with relevant specialists including a psychiatric consultation and that cost sharing applies for services even if insurers cover cost sharing.

**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:** ☐

**Consent to Email or SMS 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**

**AI Technology:** I consent to the use of secure, HIPAA-compliant AI technology to capture and transcribe audio from my visit for the sole purpose of assisting with accurate clinical documentation.

**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 will be asked 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: _____

Updated 01/2026

# Consent to Access Protected Health Information (PHI) via the Bluestone Bridge and Bluestone Patient Portal

Bluestone

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

**This consent form is used to request and authorize user access to the Bluestone Bridge and Bluestone Patient Portal.**

**The Bluestone Bridge and Bluestone Patient Portal** are HIPAA compliant communication and health record systems where you and/or someone you authorize can access important health information online and communicate with your Bluestone care team anytime. The Bluestone Bridge allows members of the patient's care team to exchange medically relevant messages between regular visits. The Patient Portal is a separate platform allowing additional access to personal health information.

**If you are the patient** and have signed the Consent for Services form yourself, please sign below section to consent to authorize online access to Protected Health Information for yourself and (optionally) someone who you want to have access to your medical information and the ability to communicate with your care team.


**If you are the Legal Representative** for someone who is not able to consent for themselves, you will need to fax or upload by secure link both 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.***

Please return this form by one of the following methods:
FAX: 855-306-1167 Secure Upload: bluestonemd.sharefile.com/filedrop

*This consent applies to health information Bluestone already has about me as well as 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.*

By signing this form, you acknowledge the information provided herein and request access to the Bluestone Bridge and Bluestone Patient Portal for you or a legal representative as well as (optionally) an additional designated individual. Access to these systems includes patient Protected Health Information records as maintained by Bluestone Physician Services, including the ability to view updates on health care status and the ability to communicate with the assigned Bluestone care team.

☐ **Please sign up myself or a legal representative for the Bluestone Bridge and Bluestone Patient Portal**

**Patient signature:**_____Date:_____

Email:_____Phone:_____

**Or** (only one signature please)

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

Legal Representative printed name:_____Relationship to patient: _____

Email:_____Phone:_____

☐ **(Optional) Please create one additional user login to the Bluestone Bridge and Patient Portal for the person I authorize below**

**Name:**_____Email:_____Phone:_____

***Important: A valid e-mail and phone number are required for access to the Bluestone Bridge and Bluestone Patient Portal***

**If patient is signing this form:** I 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.

**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 will be asked 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.

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

Updated 01/2026