eventus WHOLE HEALTH

Part 1: Patient Demographic/Billing Information

Facility Name:_____ Date:_____

Patient Name: _____ _____
(Last Name) (First Name) (MI)

DOB _____/_____/_____ Gender: ☐ M ☐ F

Is patient capable of making his/her own healthcare decisions? ☐ Yes ☐ No

If no, does patient have Surrogate Decision Maker (Family Member, Legal Guardian, POA)? ☐ Yes* ☐ No

Name:_____ Relationship to Patient: _____

Phone: (___)_____ Email:_____

**Note: Surrogate listed here should be same as Surrogate signing on next page*

Insurance Information: *PLEASE ATTACH A COPY OF YOUR FACILITY FACE SHEET & INSURANCE CARDS - WITHOUT THESE ITEMS, WE CANNOT SEE PATIENT*

SERVICES REQUESTED:

	Primary Care	To include all primary care services
	Mental Health	To include psychiatry and psychotherapy, for the purposes of managing emotional, behavioral, or cognitive problems, and/or psychotropic medication management
	Podiatry/Foot Care	Requested for management of foot care
	Optometry	Requested for management of diagnosis, prevention, and treatment of ophthalmic diseases and visual disorders
	Audiology	Requested for management of diagnosis, prevention, and treatment of auditory diseases and hearing impairment

x	Chronic Care Management	This box should be checked for all patients unless Chronic Care Management Services are declined. CCM is offered to **ALL** eligible patients who have been diagnosed with two (2) or more chronic conditions that are expected to last at least twelve (12) months and that place patient at significant risk of further decline. Initial if declined by patient: _____

[Consent and Acknowledgement Follow on Next Page]

When complete, please fax to 855-827-1740 along with Facility Face Sheet and Insurance Cards, AND legal documentation of Surrogate Decision Maker. Patient cannot be seen until all documentation is received.

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Part 2: Patient Consent and Acknowledgement Form

Patient Name:_____ **Facility:**_____

DOB:____/____/_____

Consent for Services and Acknowledgement of Receipt of Policies:

By signing below:

- I request and consent for the healthcare services indicated above to be provided to me by Eventus WholeHealth, PLLC and/or its contracted partner, OnsiteCare, PLLC.
- I authorize the release of any medical or other information necessary to determine available health care benefits and to remit and process third party payment claims for services rendered on my behalf.
- I understand that my insurance company may assign a portion of a bill for services as patient liability.
- I understand that my records will be kept on file at the facility where services are provided and securely in an Electronic Medical Record
- I authorize the release of information to my Attending Physician and/or facility as applicable.
- I agree that my responsible party (financial agent) may be informed that I am receiving services for billing purposes unless I request otherwise.
- I acknowledge I have received Eventus's Client Rights and Grievance Policies.
- I acknowledge that I may request a copy of Eventus's Notice of Privacy Practices or find a copy on Eventus's company website.
- Unless otherwise noted above, I also consent to receive Chronic Care Management (CCM) Services from Eventus, which includes my acknowledgement that
  - Electronic communication of my medical information will be made with other treating providers as part of coordination of my care.
  - Cost-sharing will apply to CCM Services, so I may be billed for a portion of CCM Services even though CCM Services will not necessary involve a face-to-face meeting with the Provider.
  - I may revoke this consent for CCM Services at any time.
  - I have received a copy of Eventus's Chronic Care Management Policy

_____ _____

Patient Signature **Surrogate Decision Maker Signature**

Printed Name: _____ **Printed Name:** _____

Date: _____

_____

Surrogate's Designation: (Family Member, POA, Legal Guardian, etc.)**

***If a legally appointed surrogate, please include copy of documents verifying relationship / legal capacity.*

***Incapacity to Sign:** Patient consents to the terms set forth herein, but was unable to sign this Consent and Acknowledgement Form due to (please be specific and include two Witness Signatures (one of which may be the healthcare provider):*

_____

_____ _____

Witness Signature / Date **Witness Signature / Date**

When complete, please fax to 855-827-1740 along with Facility Face Sheet and Insurance Cards, AND legal documentation of Surrogate Decision Maker. Patient cannot be seen until all documentation is received.