Please fax completed form to 303-957-5757

10900 W 44th Ave, Suite 200
Wheat Ridge, CO 80033
Phone (303) 993-1330
Fax (303) 957-5757

Bloom Healthcare Referral

Name of Community: _____

Patient Name:_____DOB: _____
Street Address:_____APT/ROOM #: _____
City, State, Zip: _____
Phone:_____Fax: _____
If patient is a new move in, please include move in date: _____

☐ Independent Living ☐ Assisted Living ☐ Memory Care ☐ Home

Insurance

Medicare ID#:_____
Primary Insurance:_____Policy #:_____
Secondary Insurance:_____Policy #:_____

Medication list (including allergies)

_____

_____

Social History (Please circle all that apply)

Diet

Regular Diabetic Low Salt Gluten Free Vegan Other: _____

Support at Home

Wheelchair Walker Cane Eye Glasses Hearing Aid Oxygen

Race (optional)

Hispanic Caucasian Asian African American Decline/Other: _____

Billable party (if other than patient):

Name: _____
Street Address: _____
City, State, Zip: _____
Phone:_____
Relationship to Patient:_____POA Yes/NO

Primary Contact (if different than patient):

Name: _____
Phone:_____
Relationship to Patient:_____POA Yes/NO

Please attach 3 signature pages signed by patient or POA*

Please review, sign and return.

Authorization to Bill

PLEASE SIGN AND RETURN

We are a Medicare Participating Provider

My signature and date below authorizes/acknowledges each of the following:

1. Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s) on my behalf.
2. Release of my medical information to my insurance providers and their agents.
3. Bloom Healthcare and/or any of their corporate affiliates to obtain medical or other information necessary in order to process claim(s), including determining eligibility and seeking reimbursement for medical supplies and/or medication(s) provided.
4. I acknowledge that I have received a copy of the Bloom Healthcare Notice of Privacy Practices.
5. There are certain services Bloom Healthcare provides which are not covered by Medicare and most other insurances. These charges must be paid by the patient or their representative at the time of service. The following charges may apply:
    - Missed Visit Fee **$75**
    - Formal Letter Requests **$40**
    - Records (free to MD office) **$35**
    - Care Plan Oversight (other than Medicare) **$40**
    - Long Term Care Form **$40**

SIGN, DATE AND RETURN THIS PAGE IMMEDIATELY! In order for us to bill Medicare and/or other insurance for your medical supplies and/or medications, this page must be completed, signed, dated and returned immediately.

Name of patient/legal representative: _____

Relationship to patient: _____

SIGNATURE: X_____

Date: _____

Please review, sign and return.

CONSENT AGREEMENT FOR PROVISION OF CHRONIC CARE MANAGEMENT

By signing this Agreement, you consent to Bloom Healthcare (referred to as "Provider"), providing chronic care management services (referred to as "CCM Services") to you as more fully described below.

CCM Services are available to you because you have been diagnosed with two (2) or more chronic conditions which are expected to last at least twelve (12) months and which place you at significant risk of further decline.

CCM Services include 24-hours-a-day, 7-days-a-week access to a health care provider in Provider's practice to address acute chronic care needs; systematic assessment of your health care needs; processes to assure that you timely receive preventative care services; medication reviews and oversight; a plan of care covering your health issues; and management of care transitions among health care providers and settings. The Provider will discuss with you the specific services that will be available to you and how to access those services.

Provider's Obligations. When providing CCM Services, the Provider must:

- Explain to you (and your caregiver, if applicable), and offer to you, all the CCM Services that are applicable to your conditions.
- Provide to you a written or electronic copy of your care plan upon request.
- If you revoke this Agreement, provide you with a written confirmation of the revocation, stating the effective date of the revocation.

Beneficiary Acknowledgment and Authorization. By signing this Agreement, you agree to the following:

- You consent to the Provider providing CCM Services to you.
- You authorize electronic communication of your medical information with other treating providers as part of coordination of your care.
- You acknowledge that only one practitioner can furnish CCM Services to you during a calendar month.
- You understand that cost-sharing will apply to CCM Services, so you may be billed for a portion of CCM Services even though CCM Services will not involve a face-to-face meeting with the Provider.

Beneficiary Rights. You have the following rights with respect to CCM Services:

- The Provider will provide you with a written or electronic copy of your care plan.
- You have the right to stop CCM Services at any time by revoking this Agreement effective at the end of the then-current month. You may revoke this agreement verbally (by calling 303.993.1330) or in writing (to 10900 W 44th Ave, Suite 200, Wheat Ridge, CO 80033). Upon receipt of your revocation, the Provider will give you written confirmation (including the effective date) of revocation.

Beneficiary	Beneficiary's Representative and/or Caregiver (**if applicable**)
Signature:_____	Signature: _____
Print Name:_____	Print Name: _____
Date:_____	Date: _____

Authorization To Release Protected Health Information

Please review, sign and return.

Patient Information - please fill out completely	
Patient Name:	
Address:	
City/State/Zip:	Phone Number
Date of Birth: / /	

I hereby authorize the following provider to disclose the above-named individual's health information. I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), genetic testing or screening, behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

Name of Facility Releasing Information:

Provider to whom information will be released:	**Purpose of disclosure:**
Bloom Healthcare 10900 W 44th Ave, Suite 200 Wheat Ridge, CO 80033 Please FAX requested information to (303)957-5757 or mail to the above address	TREATMENT

Information to be used/disclosed:			
Progress notes		Laboratory reports	
Consultations		Radiology/Imaging reports	
Most recent history and physical		Radiology films	
Immunization record		Two-way verbal exchange of communication	
Other:		Entire medical record	
Date Range of Information Disclosed	Start Date / /		End date / /

By signing this authorization, I agree to the following:

- I understand if I authorize my information to be released to persons or organizations not subject to federal privacy laws, the information may be re-disclosed by the recipient and the information will no longer be protected.
- I understand that authorizing the use and disclosure of this health information is voluntary and that I can refuse to sign this authorization. I do not need to sign this form in order to receive treatment.
- I understand that I may inspect a copy of the information to be used or disclosed.
- I understand that I can revoke this authorization at any time by contacting my provider, but any revocation will not apply to the extent that my provider has acted in reliance of this authorization.
- I authorize the use and disclosure of my health information as described above. This authorization expires one year from the date on which it was signed, unless otherwise specified. (Otherwise specified date, event, or condition:_____)

X

_____ _____

Signature of Patient or Personal Representative Date

_____

If not signed by patient, list personal representative's authority to act for the patient

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PRIMARY CARE AT HOME

New Patient Resources

- Practice Policies
- Notice of Privacy Practices

For Reference

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PLEASE KEEP FOR YOUR RECORDS

Practice Polices

Our Goal *To provide the highest quality medical care to our homebound population*

What we provide? We offer a wide variety of services to our patients including primary care, episodic care, wound consultations, palliative care, hospice evaluations, competency evaluations, fall assessments, and home safety evaluations.

Where do we go? We serve our patients in their private homes, assisted living centers, senior apartments, and independent living centers in the Denver metro area.

Insurance Accepted We accept most all insurance plans with the exception of Kaiser. Please note that it is the responsibility of the patient/poa to ensure that the patient's insurance will cover services provided by Bloom Healthcare. In the event that insurance does not cover our services, any balance owed will be the responsibility of the patient.

Hours of Operation Our standard hours of operation are 8:00 a.m. to 5:00 p.m. Monday through Friday. Most patient visits will take place within these hours.

Preparing for Your Visit Be advised that due to the nature of mobile medicine exact appointment times are not possible. Please be prepared for your visit by wearing loose fitting comfortable clothing. Additionally, be sure to have your medications and medication list ready for review along with pertinent medical records. This will help ensure we provide you the best medical care. If a family member wishes to be present please contact our office to make arrangements. If you have trouble getting to and from the door for the visit please consider having a family or friend present or using a door side lockbox.

During Your Visit The initial visit is comprehensive and includes all past and current medical conditions, patient specific goals, and ordering of appropriate treatments. Typical initial visit length is over one hour. Follow up intervals and visits vary according to medical need. Assisted living patients must be seen at least four times a year due to state regulations.

After Your Visit Our office processes the orders for home health agencies, hospice, durable medical equipment, oxygen and pharmacy, simplifying your medical care. We also assign an approximate follow up date at the end of your visit. Our office will call you or your contact person to arrange the details. If you should have a change in condition or question about your care, please call our office.

Emergencies In a life threatening emergency please call 911 or go to the nearest emergency room. If an urgent medical problem arises during a time when the office is closed, simply call the office at (303) 993-1330 and you will have access to the on-call provider.

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Medication Refills

LOCAL PHARMACY: At least 7 days prior to needing your medication please have your pharmacy eprescribe our office and request a refill.

MAIL ORDER PHARMACY: Please have your pharmacy request refills from our office by eprescribe. We do NOT initiate fax prescriptions to mail order pharmacies.

NARCOTICS: Schedule II prescriptions cannot be called or faxed to pharmacies. If you require schedule II medications it is your responsibility to call our office at least 14 days prior to the end of your prescription, this will ensure ongoing coverage.

Medication Storage Your medications bottles and medication list should be stored in a box, a shoe box works well. If needed, pills can then be distributed into daily pill minders. This box of medication should be available at the time of a visit. Always store your medications safely and out of reach of children.

Letters and Forms Unless done as part of a provider visit there is a **$40** charge for letters and forms that need to be completed and signed by our office. Examples include VA benefit forms, long-term disability forms, letters of competency, guardianship and conservator letters and jury letters. Please allow a 7 days for completion.

Contacting Us Our office number is **(303) 993-1330; our FAX is (303) 957-5757**. For urgent medical needs please call our main number. Call coverage is provided 24 hours a day though visits typically take place only during office hours. In an emergency call 911.

Claims Submission We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Any remaining balance or denied service will be billed to the patient. Any changes to your insurance coverage must be reported in writing to our office. Failure to do so may result your financial responsibility.

Chronic Care Coordination services (CCM) Bloom Healthcare provides chronic care management services (CCM) for our patients. CCM involves a combination of face-to-face and non-face-to-face services to ensure that each patient's healthcare needs are met. The non-face-to-face component of CCM involves the creation of a patient-centered plan of care, medication monitoring, management of care transitions, electronic care coordination and exchange of health information with other health care providers as necessary, while providing you or your caregiver 24/7 access to your care team. Bloom Healthcare will bill my insurance for this service, and patients are responsible for any copayment or deductible. Any patient can revoke permission to bill CCM at any time by notifying Bloom Healthcare in writing.

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PRIMARY CARE AT HOME

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Medical Records Should the need arise your medical records can be faxed directly to any other medical provider free of charge. Should you also need a hard copy of your records there will be a minimum charge of **$35**. A release of information request may need to be completed prior to transfer of records.

Missed Appointments A missed appointment fee of **$75** will be charged to anyone not calling to cancel their appointment at least 24 hours in advance.

Hospitals While we do not round at hospitals, we work closely with hospitalists serving these facilities. We provide ongoing communication between these providers and our office to ensure coordination of care. This allows our patients to choose any hospital they wish.

Testing in the Home We can arrange a variety of home testing including blood draws, x-ray, ultrasound, echocardiogram, circulation testing, and pulmonary function testing. Depending on the test and insurance there may be a fee that is not covered by insurance.

Home Health We work with most agencies ensuring ongoing communication and care of the medically complex home bound patients. Home health services available include physical therapy, occupational therapy, skilled nursing, speech therapy, home health aide, and homemaker services. Insurance limitations apply.

Hospice Due to the nature of our practice some of our patients choose hospice when appropriate. We continue to work closely with the hospice team and coordinate care as the patient's attending.