Please fax completed form to 303-647-3647

12600 W Colfax Ave, Suite B-200
Lakewood, CO 80215
Phone (303) 993-1330
Fax (303) 647-3647

New Patient Information - Please complete all fields

Name of Community: _____
Patient Name _____ Date of Birth:_____
Street Address: _____ APT/ROOM#: _____
City, State, Zip:_____
Phone: _____ Fax: _____

Gender Identity: ☐Female ☐Male ☐Transgender Female ☐Transgender Male ☐Non Binary ☐Un-Specified

Are you Hispanic/Latin/a/o/x? ☐Yes ☐No ☐Decline to Provide

Race(s) check all that apply: ☐American Indian/Alaskan Native ☐Asian ☐Black, African American
☐Native Hawaiian/Pacific Islander ☐Other ☐White ☐Decline to Provide

Preferred Language: ☐English ☐Spanish ☐German ☐Russian ☐Chinese ☐Other ☐Decline to Specify

If patient is a new move in, please include move in date: _____
☐Independent Living ☐Assisted Living ☐Memory Care ☐Home

Additional Services:
Home Health: _____ Hospice: _____

INSURANCE INFORMATION:
Medicare ID#: _____ SS #: _____
Primary Insurance: _____ Policy #: _____
Secondary Insurance: _____ Policy #: _____

Medications: _____
_____
Allergies: _____
Pharmacy Address: _____ **Pharmacy Phone**: _____

Social History (Please check all that apply):
Diet ☐Regular ☐Diabetic ☐Low Salt ☐Gluten Free ☐Vegan ☐Other: _____
Support at Home: ☐Wheelchair ☐Walker ☐Cane ☐Eye Glasses ☐Hearing Aid ☐Oxygen

Billable party (if other than patient):
Name: _____ Phone: _____
Street Address: _____
City, State, Zip: _____
Relationship to Patient: _____POA YES/NO
Primary Contact (if different than patient):
Name: _____ Phone: _____
Relationship to Patient: _____POA YES/NO

Please attach **2** signature pages signed by patient or POA

Bloom Healthcare - New Patient Authorization Form
12600 W Colfax Ave Suite B-200 Lakewood, CO 80215
Phone (303) 993-1330 • Fax (303) 647-3647

Authorization to Request & Disclose Health Information

I hereby authorize the following provider to disclose my heath record:

Name of Facilit(y/ies) Releasing Information: _____

Purpose of disclosure: TREATMENT
Please FAX requested information to (303) 647-3647 or mail to the above address.
Information to be used/disclosed:

- Progress notes
- Consultations
- Most recent history and physical
- Immunization Record
- Laboratory reports
- Radiology/Imaging reports
- Radiology films
- Entire medical record

By signing this authorization, I agree to the following:
I understand that authorizing the use and disclosure of this health information is voluntary and that I can opt out of disclosing my health information. I do not need to authorize disclosure of health information in order to receive treatment.

- I understand that my records may be obtained through CORHIO and that I can opt out at any time by contacting the practice.
- 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.

Signature:_____ Patient Name:_____
Date:_____
If not signed by patient, list authority to act for the patient: _____

Authorization to Bill

My signature and date below authorizes/acknowledges authorization to bill, including each of the following:

- Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s) on my behalf.
- Release of my medical information to my insurance providers and their agents.
- 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.

Signature:_____ Patient Name:_____
Date:_____
If not signed by patient, list authority to act for the patient: _____

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 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 12600 W Colfax Ave Suite B-200 Lakewood, CO 80215). Upon receipt of your revocation, the Provider will give you written confirmation (including the effective date) of revocation.

Signature: ____ Date of Birth: _______________

Patient's name (please print clearly): ____

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

- -

NO, DO NOT ENROLL ME, as I refuse this Medicare covered benefit. I have read and understand the above and do NOT want these additional clinical services. _______

AUTHORIZATION FOR THE DISCLOSURE OF HEALTH INFORMATION FROM BLOOM HEALTHCARE TO DESIGNATED INDIVIDUAL (INCLUDING PORTAL ACCESS)

Completion of this document authorizes the use and disclosure of health information about you. Failure to provide all information requested may invalidate this Authorization.

Patient Name:_____ DOB:_____

I hereby authorize Physician Housecalls, LLC d/b/a Bloom Healthcare ("Bloom Healthcare") 12600 West Colfax Avenue, Lakewood, CO 80215 to disclose to _____ (print name of Recipient) at: _____(email) all my information received or maintained about me by or on behalf of Bloom Healthcare, including demographic information, financial information, and health information. The purpose of this disclosure is to permit the above-named Recipient to interact with Bloom Healthcare on my behalf, which I understand will including the Recipient accessing the information Bloom Healthcare receives or maintains about me.

This Authorization is valid until I am no longer eligible to receive services from Bloom Healthcare or for the duration permitted under applicable state law, whichever is earlier. I understand that, except to the extent that a lawful holder of my information has acted in reliance on this Authorization, I have the right to revoke this Authorization, in writing, at any time by sending a written revocation to Bloom Healthcare.

I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient of such information and may no longer be protected by federal or state law. Bloom Healthcare will not condition my treatment or services on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to: inspect or copy the information to be used or disclosed as permitted under federal or state law; refuse to sign this Authorization; and receive a copy of this Authorization. I have read the above information and authorize the disclosure of my information by Bloom Healthcare for the purpose described herein.

By signing below, I acknowledge that I have read and agree to the terms of this Authorization.

_____ _____

Patient Signature* Date

*Please be aware that the **patient** is required to sign this document to designate an alternate individual who will be authorized to access the Bloom Health Patient Portal. If the patient is unable to sign this document (such as due to incapacity), kindly engage in a discussion with the Bloom staff for further guidance.

BLOOM HEALTHCARE NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: February 9, 2024

Physician Housecalls, LLC d/b/a Bloom Healthcare ("Bloom Healthcare") is required by law to maintain the privacy of your health information in accordance with federal and state law. This Notice of Privacy Practices ("Notice") outlines our legal duties and privacy practices with respect to health information. We are required by law to provide you with a copy of this Notice and to notify you following a breach of your unsecured health information.

We will abide by the terms of the Notice. We reserve the right to make changes to this Notice as permitted by law. We reserve the right to make the new Notice provisions effective for all health information we currently maintain, as well as any health information we receive in the future. If we make material or important changes to our privacy practices, we will promptly revise our Notice. Each version of the Notice will have an effective date listed on the first page. If we change this Notice, you can access the revised Notice on our website at https://bloomhealthcare.com/policy/ or from the Bloom HealthCare office at 12600 West Colfax Avenue Suite B-200, Lakewood, CO 80215.

You have the right to file a complaint if you believe your privacy rights have been violated. If you would like to file a complaint about our privacy practices, you can do so by sending a letter outlining your concerns to: 12600 West Colfax Avenue Suite B-200, Lakewood, CO 80215 or by sending an email to us at consents@bloomhealthcare.com. You also have the right to complain to the Secretary of the United States Department of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION:

The following categories describe the ways that we may use and disclose your health information without your written authorization.

Treatment. We may use and disclose your health information to provide you with medical treatment and services. For example, your health information may be disclosed to physicians, nurses, or other health care providers who are involved in your care to coordinate or manage your health care services or to facilitate consultations or referrals as part of your treatment. We also may disclose your health information to persons outside our organization involved in your treatment, such as other health care providers.

Payment. We may use and disclose your health information to obtain payment for the services we provide to you. For example, we may disclose your health information to seek payment from your insurance company or from another third party. We may also inform your insurance company about a treatment you are going to receive so that we obtain prior approval for the treatment or in order to determine whether your insurance company will cover the cost of the treatment.

Health Care Operations. We may use and disclose your health information to conduct certain of our business activities, which are called health care operations. These uses and disclosures are necessary to run our business and make sure our patients receive quality care. For example, we may use your health information for quality assessment activities, necessary credentialing, and for other essential activities. We may also disclose your health information to third party "business associates" that perform various services on our behalf, such as transcription, billing, and collection services. In these cases, we will enter into a written agreement with the business associates to ensure they protect the privacy of your health information.

Family Members and Friends for Care and Payment and Notification. If you verbally agree to the use or disclosure and in certain other situations, we may make the following uses and disclosures of your health information. We may disclose certain health information to your family, friends, and anyone else whom you identify as involved in your health care or who helps pay for your care; the health information we disclose would be limited to the health information that is relevant to that person's involvement in your care or payment for your care. We may also make these disclosures after your death as authorized by applicable law unless doing so is inconsistent with any prior expressed preference. We may use or disclose your information to notify or assist in notifying a family member, personal representative, or any other person responsible for your care regarding your location, general condition, or death. We may also use or disclose your health information to disaster-relief organizations so that your family or other persons responsible for your care can be notified about your condition, status, and location.

Required by Law. We may disclose your health information when required by law to do so.

Public Health Reporting. We may disclose your health information to public health agencies as authorized by law. For example, we may report certain communicable diseases to the state's public health department.

Reporting Victims of Abuse or Neglect. We may disclose health information to the appropriate government authority if we believe you have been the victim of abuse, neglect, or domestic violence. We only make this disclosure if you agree or when we are required or authorized by law to make the disclosure.

Health Care Oversight. We may disclose your health information to authorities and agencies for oversight activities allowed by law, including audits, investigations, inspections, licensure and disciplinary actions, or civil, administrative, and criminal proceedings, as necessary for oversight of the health care system, government programs, and civil rights laws.

Legal Proceedings. We may disclose your health information in the course of certain administrative or judicial proceedings. For example, we may disclose your health information in response to a court order.

Law Enforcement. We may disclose your health information to a law enforcement official for certain specific purposes, such as reporting certain types of injuries.

Deceased Persons. We may disclose your health information to coroners, medical examiners, or funeral directors so that they can carry out their duties.

Organ and Tissue Donation. We may use and disclose your health information to organizations that handle procurement, transplantation, or banking of organs, eyes, or tissues.

Research. Under certain circumstances, we may disclose your health information to researchers who are conducting a specific research project. For certain research activities, an Institutional Review Board (IRB) or Privacy Board may approve uses and disclosures of your health information without your authorization.

To Avert a Serious Threat to Health or Safety. If there is a serious threat to your health and safety or the health and safety of the public or another person, we may use and disclose your health information in a very limited manner to someone able to help lessen the threat.

Specialized Government Functions. In certain circumstances, HIPAA authorizes us to use or disclose your health information to authorized federal officials for the conduct of national security activities and other specialized government functions.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your health information to the correctional institution or law enforcement official to assist

them in providing you health care, protecting your health and safety or the health and safety of others, or providing for the safety of the correctional institution.

Workers' Compensation. We may disclose your health information as necessary to comply with laws related to workers' compensation or other similar programs.

Fundraising. We may use certain information (such as demographic information, dates of services, department of service, treating physicians, outcomes, and health insurance status) to send fundraising communications to you. However, you may opt out of receiving any such communications.

Please be aware that state and other federal laws may have additional requirements that we must follow or may be more restrictive than HIPAA on how we use and disclose certain of your health information. If there are specific more restrictive requirements, even for some of the purposes listed above, we may not disclose your health information without your written permission as required by such laws. For example, we may be required by law to obtain your written permission to use and/or disclose your mental illness, developmental disability, or alcohol or drug abuse treatment records, HIV, STD, or other communicable disease related information, or your genetic test results in certain situations.

OTHER USES AND DISCLOSURES:

Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. Some examples include:

- Psychotherapy Notes: We usually do not maintain psychotherapy notes about you. If we do, we will not use and disclose your psychotherapy notes without your written authorization except as otherwise permitted by law.
- Marketing: We will not use or disclose your health information for marketing purposes without your written authorization except as otherwise permitted by law.
- Sale of Your Health Information: We will not sell your health information without your written authorization except as otherwise permitted by law.

If you change your mind after authorizing a use or disclosure of your health information, you may withdraw your permission by revoking the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of your health information that occurred before you notified us of your decision, or any actions that we have taken based upon your authorization. To revoke an authorization, you must notify us in writing at 12600 West Colfax Avenue Suite B-200, Lakewood, CO 80215 or by email at consents@bloomhealthcare.com.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION:

This section describes your rights regarding the health information we maintain about you. All requests or communications to us to exercise your rights discussed below must be submitted in writing to 12600 West Colfax Avenue Suite B-200, Lakewood, CO 80215 or by email at consents@bloomhealthcare.com.

Right to Request Restrictions. You have the right to request restrictions on how your health information is used or disclosed for treatment, payment, or health care operations activities. However, we are not required to agree to your requested restriction, unless that restriction is regarding disclosure of health information to your health insurance company and: (1) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (2) the health information pertains solely to a health care item or service for which you or another person (other than your health insurance company) paid for in full. If we agree

to your requested restriction, we will comply with your request unless the information is needed to provide you emergency treatment.

Right to Request Confidential Communications. You have the right to request that we communicate your health information to you in a certain manner or at a certain location. For example, you may wish to receive information about your health status through a written letter sent to a private address. We will grant reasonable requests. We will not ask you the reason for your request.

Right to Inspect and Copy. You have the right to inspect and receive a copy of your health information. We may charge you a fee as authorized by law to meet your request. You may request access to your health information in a certain electronic form and format, if readily producible, or, if not readily producible, in a mutually agreeable electronic form and format. Further, you may request in writing that we transmit such a copy to any person or entity you designate. Your written, signed request must clearly identify such designated person or entity and where you would like us to send the copy.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed by a licensed health care professional chosen by us. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. You have a right to request that we amend or correct your health information that you believe is incorrect or incomplete. For example, if your date of birth is incorrect, you may request that the information be corrected. To request a correction or amendment to your health information, you must make your request in writing and provide a reason for your request. You have the right to request an amendment for as long as the information is kept by or for us. Under certain circumstances we may deny your request. If your request is denied, we will provide you with information about our denial and how you can file a written statement of disagreement with us that will become part of your medical record.

Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures we make of your health information. Please note that certain disclosures need not be included in the accounting we provide to you. Your request must state a time period which may not go back further than six years. You will not be charged for this accounting, unless you request more than one accounting per year, in which case we may charge you a reasonable cost-based fee for providing the additional accounting(s). We will notify you of the costs involved and give you an opportunity to withdraw or modify your request before any costs have been incurred.

Right to a Paper Copy of This Notice. You have the right to receive a paper copy of this Notice at any time, even if you previously agreed to receive this Notice electronically. A paper copy of this Notice can be obtained from the Bloom HealthCare office at 12600 West Colfax Avenue Suite B-200, Lakewood, CO 80215 or by contacting us at the information below. You may also view and print a copy of this Notice on our website at https://bloomhealthcare.com/policy/.

CONTACT INFORMATION:

If you have questions or concerns about your privacy rights, or the information contained in this Notice, please contact us at https://bloomhealthcare.com/contact/ or 303-993-1330.