bloom healthcare
PRIMARY CARE & HOSPICE

540 Maryville Centre Dr.
Suite 340, St. Louis, MO 63141
Phone: 314.333.6000
Fax: 314.818.0008

New Patient Information - Please complete all fields

Please fax completed form to: 314.818.0008

Where did you hear about us?_____

Residence: ☐ Home ☐ Independent Living Center ☐ Assisted Living ☐ Memory Care **Move In Date:**_____

Name of Community: _____**Fax:** _____

Patient Name: _____**Date of Birth:** _____**APT#:**_____

Address:_____

Phone: _____ **Check mark if Patient is the following**: ☐ Billable Party ☐ Scheduling Contact

Do you consent to receive text messages related to your care (e.g., appointment reminders, etc): ☐ Yes ☐ No

Authorized Contact (family, etc) Involved in Your Care(that you consent to receive information about you relevant to their involvement):

Name:_____**Phone**:_____

Address:_____**Relationship to Patient:**_____

Roles: ☐ Billable Party ☐ Primary Scheduling Contact ☐ Emergency Contact ☐ Medical POA ☐ Financial POA

Does this person consent to receive text messages relevant to their involvement in your care? ☐ Yes ☐ No

Billable Party Name (if not indicated above):_____

Address:_____

Is this an Authorized Contact (family, etc) Involved in Your Care(that you consent to receive information about you relevant to their involvement)**:** ☐ Yes ☐ No **Relationship to Patient:**_____**Phone**:_____

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ White ☐ Black, African American ☐ Other_____ ☐ Decline to Specify

Language: ☐ English ☐ Spanish ☐ Other: _____

Ethnicity: ☐ Hispanic/Latino ☐ NonHispanic/Latino ☐ Other: _____ ☐ Decline to Specify

Gender Identity: ☐ Female ☐ Male ☐ Non-Binary ☐ Transgender: ☐ M ☐ F ☐ Decline to Specify

Insurance Information:

Medicare Number:_____**SSN #:**_____

Primary Insurance:_____**Policy #:** _____

Secondary Insurance:_____**Policy #:**_____

Medical Conditions: _____

_____

Pharmacy:_____**Allergies:**_____

Additional Services: Home Health_____ **Hospice:**_____

Some or all of my communications with Bloom Healthcare and the providers I interact with may be recorded through an automated scribe note taking tool. Bloom Healthcare uses this automated scribe to more accurately and efficiently capture the details of my discussions with my provider and the outcomes of my appointments. Use of this automated scribe allows my provider to focus more on the provider's conversation with me and less on manual note taking, enhancing the quality of care I receive. I understand can opt out at any time during my appointment by letting my provider know. For more information on how Bloom Healthcare uses the recordings, please see Bloom Healthcare's Notice of Privacy Practices.

Please initial to acknowledge that you have read and understand the terms above: _____

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.
• I understand that I am financially responsible for any out-of-network charges, applicable in-network co-pays and deductibles, and for non-covered services where Bloom is in-network.

Signature*: _____

Authorization to Request & Disclose Health Information

I hereby authorize the following provider(s) to disclose my heath record to Bloom Healthcare:

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

Purpose of disclosure: TREATMENT

Please FAX requested information to (314) 818-0008 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. I do not need to authorize disclosure of health information 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 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.
• 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.

Signature*: _____

Patient Name:_____Date:_____

*If not signed by patient, list authority to act for the Patient:_____

Consent Agreement for Provision of

Advanced Primary Care Management and Chronic Care Management Services

By signing this Agreement, you consent to Bloom Healthcare (referred to as “Provider”), providing Advanced Primary Care Management services (referred to as “APCM Services”) and Chronic Care Management Services (referred to as "CCM Services") to you as more fully described below.

APCM and 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.

Both APCM and 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 APCM or CCM Services, the Provider must:
• Explain to you (and your caregiver, if applicable) and offer to you, all the 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 APCM or CCM Services; your Provider will determine which service is most beneficial to your care based on your health needs.
• 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 APCM or CCM Services to you during a calendar month.
• You understand that cost-sharing may apply to APCM and CCM Services, so you may be billed for a portion of APCM or CCM Services even though APCM or CCM Services will not involve a face-to-face meeting with the Provider.

Beneficiary Rights You have the following rights with respect to APCM and CCM Services:
• The Provider will provide you with a written or electronic copy of your care plan.
• You have the right to stop APCM or 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 314.333.6000) or in writing (to 540 Maryville Centre Dr. Suite 340, St. Louis, MO 63141). Upon receipt of your revocation, the Provider will give you written confirmation (including the effective date) of revocation.

Signature: _____Date of Birth:_____

Patient Name (print clearly):_____

If not signed by patient, list authority to act for the patient:_____

NO, DO NOT ENROLL ME, as I refuse these Medicare covered benefits. 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") 540 Maryville Centre Dr. Suite 340, St. Louis, MO 63141 to disclose to:

Print Name of Recipient:_____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 include 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 16, 2026

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 540 Maryville Centre Dr. Suite 340, St. Louis, MO 63141.

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: 540 Maryville Centre Dr. Suite 340, St. Louis, MO 63141 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.

Artificial Intelligence Technologies. We may use artificial intelligence ("AI") technologies, machine learning algorithms, and automated systems to support various aspects of your health care experience in accordance with applicable law. When we use AI technologies, your health information may be processed through these systems. These technologies may be used, for example, in treatment and healthcare operations/administrative functions to enhance the quality, efficiency, and safety of services we provide. One example, without limitation, is that some or all your communications with your health care providers may be recorded through an automated scribe note taking tool, allowing your provider to focus more on the provider's conversation with you and less on manual note taking. We implement safeguards designed to protect your health information when processed through AI technologies, and we enter into business associate agreements with third party vendors who process your health information on our behalf.

Substance Use Disorder ("SUD") Treatment Records. Bloom Healthcare is not a substance use disorder treatment program directly regulated by the federal privacy rules under 42 CFR Part 2; however, in the course of providing your care, we may receive information about your SUD treatment from such a program where you have consented to that program sharing your SUD records with us. We generally may use and disclose your SUD records as permitted by HIPAA as outlined in this Notice, except that your SUD treatment records, or testimony relaying the content of such records, will not be used or disclosed in civil, criminal, administrative, or legislative proceedings against you unless based on written consent, or a court order after notice and an opportunity to be heard is provided to you or the holder of the record, as provided in 42 CFR Part 2. A court order authorizing use or disclosure of your SUD records must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested SUD record is used or disclosed.

Health Information Exchange ("HIE") Participation and Data Sharing. We participate with one or more Health Information Exchanges (each, an "HIE"), which makes it possible for us to access and share your health information electronically through the HIEs in accordance with applicable law. Other health care providers that are also connected to the same HIE network as us can exchange your health information for treatment and other authorized purposes, to the extent permitted by law. You have the right to "opt-out" or decline to participate in having us access or share your health information through networked HIEs. If you choose to opt-out of data-sharing through HIEs, we will no longer access or share your health information through an HIE network, however, it will not prevent how your information otherwise is typically accessed and released to authorized individuals in accordance with the law.

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 540 Maryville Centre Dr. Suite 340, St. Louis, MO 63141 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 540 Maryville Centre Dr. Suite 340, St. Louis, MO 63141 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 540 Maryville Centre Dr. Suite 340, St. Louis, MO 63141 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 314.333.6000.