VANTAGE HEALTHCARE

ENROLLMENT CHECKLIST

☐ All forms must be signed (Only legal stamps will be accepted)

☐ Copy of Insurance cards

☐ Copy of health care proxy and medical Durable Power of Attorney (If applicable)

☐ Activation letter of Health Care Proxy (If applicable)

All enrollment forms should be signed by patients unless HCP or Medical DPOA has been activated. **Without the above documents there will be a delay in enrollment**.

Tel: 781-867-2050 PO Box 520, Seekonk, MA 02771 Fax: 781-867-2040

PERMISSION TO SHARE MEDICAL INFORMATION

I, _____, give permission for Vantage Healthcare to discuss my medical condition with the following family members.

Name	Relationship

_____ _____

Patient/POA Signature Date

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HEALTH INFORMATION PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name _____ Date of Birth _____

I acknowledge that I have received a document titled ***"Notice of Privacy Practices"*** from Vantage Healthcare.

Patient Signature _____ ~OR~ Patient Representative's Signature _____

Date _____ Relationship to Patient _____

FOR OFFICE USE ONLY		
I attempted to obtain the patient's signature on this form and was unable to because of the reason stated below. I affirm that the patient received a copy of the "Notice of Privacy Practices."		
Date:	**Initials:**	**Reason:**

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NOTICE OF PRIVACY PRACTICES

Notice of Privacy Practices – Vantage Healthcare

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. WE HAVE THE RIGHT TO CHANGE AND UPDATE THIS NOTICE.

Uses and Disclosures

Treatment. Your health information may be used by Vantage Healthcare staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment.

Payment. Your health information may be used to seek payment from your health plan or other payers. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Vantage Healthcare. For example, information on the services you received may be used to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the State's public health department.

Other uses and disclosures require your authorization. Disclosure or use of your health information for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may revoke your authorization in writing. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send your information describing other health-related products and services that we believe may interest you.

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NOTICE OF PRIVACY PRACTICES (cont.)

Information for Family Members, Caregivers, or Friends. Unless you object, we may use or disclose your medical Information to notify a family member, a personal representative, or another person responsible for your care of your location, general condition, or death.

Individual Rights. You have certain rights under the federal privacy standards. These include:

- The right to inspect and copy your medical information. However, Vantage Healthcare may deny your request for certain specific reasons. If your request is denied, we will provide you with a written explanation for the denial and give you additional Information about your rights.
- The right to request additional confidentiality for protected health information when used by Vantage Healthcare for the purposes of treatment, payment, or healthcare operations.
    - However, we have the right to approve or deny your request.
    - Additionally, if we approve your request, we have the right to terminate that agreement provided we notify you in writing of our decision to do so.
- The right to request a correction or amendment to your health information. However, Vantage Healthcare may deny your request for certain specific reasons. If your request is denied, we will provide you with a written explanation for the denial and give you additional Information about your rights.
- The right to receive an accounting of the disclosures of your medical information made by Vantage Healthcare in the six years prior to your request. This right begins on April 14, 2019, and applies to disclosures made on or after April 14, 2019. However, the following disclosures do not require an accounting under federal law:
    - Disclosures made for treatment, payment, or other healthcare operations purposes;
    - Disclosures made to you;
    - Disclosures made in such a way that your identity was kept confidential by restricting the amount and type of information that was disclosed;
    - Disclosures made to health oversight agencies or law enforcement agencies if they provide us with a written statement that temporarily prevents us from making such an accounting;
    - Disclosures made for national security or intelligence purposes;
    - Disclosures made to correctional institutions or to law enforcement officials
- The right to request a paper copy of this Notice of Privacy Practices for Protected Health Information.

Vantage Healthcare Duties. We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Vantage's Right to Revise Privacy Practices. As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

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NOTICE OF PRIVACY PRACTICES (cont.)

Requests to Inspect Protected Health Information. You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Vantage Healthcare or the Vantage Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints. If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Jamie Elliott
Privacy Officer
Vantage Healthcare
PO Box 620550
Newton Lower Falls, MA 02462

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint. You can also file a complaint with the Federal Office of Civil Rights.

Contact Person. The name and address of the person you can contact for further information concerning our privacy practices is:

Jamie Elliott
Privacy Officer
Vantage Healthcare
PO Box 620550
Newton Lower Falls, MA 02462

Created: 2/19/2018
Effective: 4/14/2018
Revised: 4/15/2019, 6/10/2021

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AUTHORIZATION AND CONSENT FOR MEDICAL CARE

Authorization for Treatment
The undersigned hereby consents to and authorizes the administration and performance of medical care that may be in the judgment of the physician or clinician are considered advisable and necessary, which may include the performance of certain blood tests for communicable diseases such as Hepatitis and HIV infection.

Release of Information to Insurance Carriers
Vantage Healthcare and physicians or clinicians are authorized to furnish information necessary to process claims to an insurer, compensation carrier, or welfare agency which may be providing financial assistance for hospital care.

Medicare Patient's Certification, Authorization to Release Information and Payment Request
I request that payment of authorized Medicare benefits be made either to me or on my behalf to Vantage Healthcare. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I further authorize the Medicare program to furnish medical or other information acquired on this visit by its intermediary under the Title XVIII Program to the extent necessary to process any complementary coverage claim.

FINANCIAL RESPONSIBILITY
In consideration of the rendering of service to the patient, the undersigned guarantees the payment of any amount due for such services rendered by and physician or clinician over and above the amount covered by Medicare and/or insurance.

I hereby certify that I have read and fully understand the above authorizations.

_____ _____
Patient Name/Signature Date

~OR~

_____ Witness
Patient Representative's Signature

_____
Relationship to Patient

_____

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AGREEMENT TO RECEIVE MEDICARE ADVANCED PRIMARY CARE MANAGEMENT (APCM) AND CHRONIC CARE MANAGEMENT (CCM) SERVICES

Vantage Healthcare, the primary care physician service for you/your loved one, has added the services of a licensed Nurse to our care team. The addition of the Nurse to our care team allows our practice to offer Advanced Primary Care Management (APCM) and Chronic Care Management (CCM) services. These programs are available to Medicare beneficiaries with chronic medical conditions.

The APCM and CCM programs involve comprehensive ***preventative*** management of chronic conditions in partnership between the healthcare team and the patient to maintain the best possible overall health and wellness and reduce hospitalizations. This includes a non-face-to-face component of care that 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 24/7 access to the care team and access to a patient portal.

I understand that I can revoke this consent at any time. Medicare will only pay one physician or health care professional to furnish APCM or CMM services within a given calendar month.

I understand these services are subject to the usual Medicare deductible and coinsurance applied to physician services.

My signature authorizes my primary care physician to electronically communicate my medical information with other treating providers as part of the care coordination involved in the programs.

This designation is effective as of the date below and remains in effect until revoked by me.

For more information:
https://www.medicare.gov/coverage/advanced-primary-care-management-services
https://www.cms.gov/files/document/chronic-care-management-factsheet.pdf

I authorize Vantage Healthcare Services to enroll me in their Advanced Primary Care Management (APCM) and Chronic Care Management (CCM) programs.

Patient's Name _____ Date of Birth _____

Facility Name _____

Name of Authorized Representative (if applicable) _____

Signature of Patient / Authorized Representative _____

AUTHORIZATION AND CONSENT FOR BEHAVIORIAL HEALTH SERVICES / PSYCHIATRIC CARE

Authorization for Treatment

The undersigned hereby consents to and authorizes the administration and performance of Behavioral Health / Psychiatric Care that may be in the judgment of the physician, clinician, or behavioral health specialist considered advisable and necessary, which may include the performance of certain blood tests for communicable diseases such as Hepatitis and HIV infection.

Release of Information to Insurance Carriers

Vantage Healthcare and physicians, clinicians, or behavioral health specialist are authorized to furnish information necessary to process claims to an insurer, compensation carrier, or welfare agency which may be providing financial assistance for hospital care.

Medicare Patient's Certification, Authorization to Release Information and Payment Request

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Vantage Healthcare. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I further authorize the Medicare program to furnish medical or other information acquired on this visit by its intermediary under the Title XVIII Program to the extent necessary to process any complementary coverage claim.

FINANCIAL RESPONSIBILITY

In consideration of the rendering of service to the patient, the undersigned guarantees the payment of any amount due for such services rendered by and physician, clinician, or behavioral health specialist over and above the amount covered by Medicare and/or insurance.

I hereby certify that I have read and fully understand the above authorizations.

Patient Name/Signature _____ Date _____

~OR~

Patient Representative's Signature _____ Witness _____

Relationship to Patient _____

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AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Last Name	First Name	MI	Date of Birth
_____	_____	_____	_____

Social Security Number	Telephone	Email Address
_____	_____	_____

Please send my records from:

To: **Vantage Healthcare**
PO Box 520,
Seekonk, MA 02771
Fax: 781-867-2040

Name: _____

Street Address: _____

Town/City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Please send my records from the following Specialist (if applicable):

Name: _____ Street Address: _____

Town/City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Please send my records from the following additional Specialist (if applicable):

Name: _____ Street Address: _____

Town/City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Please send my records from the following additional Specialist (if applicable):

Name: _____ Street Address: _____

Town/City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

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VANTAGE HEALTHCARE

Please send my records from the following additional Specialist (if applicable):

Name: _____ Street Address: _____

Town/City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Please send my records from the following additional Specialist (if applicable):

Name: _____ Street Address: _____

Town/City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I request and authorize the release of information to the organization, agency, or individual named above. I understand that the information to be released may include the following condition(s):

1. Drug Abuse/Alcohol Abuse (Federal Regulation 42C.F.R., Part 2)
2. Psychological or psychiatric conditions
3. A test for the presence of antibodies (HIV, virus which causes AIDS)
4. An AIDS diagnosis and/or an AIDS-related condition

Information Requested *(Check those to be released)*

☐ Doctors' notes ☐ History & Physical ☐ Diagnostic studies
☐ X-ray report ☐ Psychological/psychiatric evaluation ☐ Complete chart
☐ Lab reports ☐ Pathology reports
☐ Other (specify): _____

I certify that this request has been made voluntarily. This authorization is subject to written revocation at any time, except to the extent that action has already been taken to comply with it. In any event, this authorization expires 90 days from the date of signature. I release the above named from liability and claims of any nature pertaining to the disclosure of requested information contained in my medical records.

_____ _____
Signature of Patient or Patient Representative Date

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PATIENT DEMOGRAPHIC INFORMATION *(This section refers to the PATIENT ONLY)*

I am currently a resident at: _____
(Facility Name)

Last Name: _____

First Name: _____ Middle Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Cell: _____

Email: _____@_____.com

Date of Birth: _____ SSN: _____

Spouse Name: *(If Applicable)* _____

Race: _____ Primary Language: _____

Sex: Male Female
(Circle One)

Marital Status: Single Married Divorced Widowed
(Circle One)
Legally Separated Unknown

Employment Status: Employed Self-employed Unemployed
(Circle One)
Disabled Retired Part-time student Full-time student

Employer Name: _____ Work Phone: _____

How did you hear about Vantage Healthcare? _____

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INSURANCE INFORMATION

Please complete thoroughly. We will need a copy of your insurance cards.

Name of Policy Holder: _____

Relationship to patient? ☐ Self ☐ Husband ☐ Wife ☐ Parent ☐ Other: _____

Name of Primary Insurance: _____

Member ID/Policy #: _____ Group #: _____

Name of Secondary Insurance: _____

Member ID/Policy #: _____ Group #: _____

RESPONSIBLE PARTY/GUARANTOR INFORMATION

This is the person who should receive invoices, statements and financial correspondence.

ONLY *complete this section if the Responsible Party/Guarantor is NOT the Patient or the Policy Holder.*

☐ Self (Skip to Emergency Contact Section) ☐ Policy Holder (Skip to Emergency Contact Section)

Last Name: _____ First Name: _____ Middle Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Pager: _____

PREFERRED PHARMACY

Pharmacy Name: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

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EMERGENCY CONTACT INFORMATION *(This section refers to the EMERGENCY CONTACT ONLY)*

Patient's Relationship to Emergency Contact: _____

Is emergency contact a guardian? ☐ Yes ☐ No

Last Name: _____ First Name: _____ Middle Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Pager: _____

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FUNCTIONAL ABILITY SCREENING *(This section pertains to the PATIENT ONLY)*

Facility Name: _____Last Name: _____First Name: _____

ACTIVITIES OF DAILY LIVING

We want to know if you need help with any of the following tasks and who helps you.

Please check the appropriate columns below.

Task	I Don't Need Help	I Need Help	Who Helps Me
Feeding yourself			
Getting from bed to chair			
Getting to the toilet			
Getting dressed			
Bathing			
Walking			
Using the telephone			
Taking your medicines			
Preparing meals			
Managing money			
Financial affairs			
Checkbook			
Doing laundry			
Doing housework			
Shopping for groceries			
Driving			
Doing "handyman" work			
Climbing a flight of stairs			
Getting to places beyond walking distance			
Other:			

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PLANNING FOR FUTURE HEALTH CARE *(This section pertains to the PATIENT ONLY)*

Facility Name: _____Last Name: _____First Name: _____

ADVANCED DIRECTIVES
Please provide copies of all pertinent legal documentation related to the questions below.

Topic	Yes	No	Copy Attached? Yes/No	Additional Information
Do you have a Medical Durable Power of Attorney?				
Do you have a Health Care Proxy?				
Do you have a Living Will?				
Do you have a MOLST?				

Would you like us to provide you with a Wishes Colorado MOST Form? ☐ Yes ☐ No

Are there any religious or social issues we need to be aware of in advising you about your advanced directives? (Blood transfusions/Feeding tubes) ☐ Yes ☐ No

If yes, please explain: Use separate page or attach documentation, if needed.

_____

_____

_____

_____

_____

_____

_____

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VANTAGE HEALTHCARE

Resident & Family Portal Access Request

Resident's First Name _____ Last Name _____

Resident's Date of Birth ___/___/_____ Sex _____

Name of Assisted Living Community _____

Check one box below and provide the requested signature(s) and e-mail address to grant user access to the Vantage Healthcare Resident & Family Portal:

☐ **Resident access** - The resident is their own health care decision-maker. The resident requests access to the portal and their own records.

Resident

E-mail _____ Signature _____

☐ **Resident authorizes access for family member/representative** - The resident is their own health care decision-maker; however, the resident requests access to the portal for a family member or other representative.

Authorized family / representative

Name _____ E-mail _____

AND

Resident

Signature _____

☐ **Resident has legal health care decision-maker** - The resident IS NOT their own health care decision-maker. The resident's legal health care decision-maker requests access to the portal.

Authorized health care decision-maker

Name _____ E-mail _____

Signature _____

An e-mail with subject line "Invitation to sign-up for Patient Portal!" addressed from "no-reply@mdops.com" will be sent to the email address listed above. Please follow the instructions provided in the e-mail.

COMPREHENSIVE QUESTIONNAIRE *(This section pertains to the PATIENT ONLY)*

If you have completed "AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION" (page 10) for record request from your current primary care provider then completion of the "COMPREHENSIVE QUESTIONNAIRE" is not necessary.

Facility Name: _____Last Name: _____First Name: _____

Since this is your medical history and it will be used in evaluating your health, it is extremely important that the questions be answered as accurately as possible. All information provided is kept confidential.

MEDICATIONS

1. List all medicines that you use. *(Prescriptions, Non-Prescriptions/Over-the-Counter, Natural products, supplements)*
   Please use separate page, if needed.

Name of Current Medications Used Regularly	What Strength/Dose?	How do you use it? (How many? How many times a day?)
Example: Tylenol	*500 mg*	*1 pill 3 times a day by mouth*

2. Do you have any medication allergies/adverse reactions? ☐ Yes ☐ No
   If Yes, please specify below. Please use separate page, if needed.

Name of Medication	Reaction

3. Do you take a daily aspirin? ☐ Yes ☐ No

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COMPREHENSIVE QUESTIONNAIRE *(This section pertains to the PATIENT ONLY)*

Facility Name: _____Last Name: _____First Name: _____

SURGERIES

List Surgeries (Operations)

Please use separate page, if needed.

Date	Type of Surgery (Operations)

HOSPITALIZATIONS

List other Hospitalizations you have had in the last three (3) years.

Please use separate page, if needed.

Date	Reason

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VANTAGE HEALTHCARE

COMPREHENSIVE QUESTIONNAIRE *(This section pertains to the PATIENT ONLY)*

Facility Name: _____ Last Name: _____ First Name: _____

IMMUNIZATIONS

1. When was your last **tetanus** shot? _____
2. Do you get an **annual influenza** vaccination? ☐ Yes ☐ No
3. When was your last **influenza** vaccination? _____
4. Have you had a **pneumonia** vaccination (Pneumovax)? ☐ Yes ☐ No When: _____
5. Have you had a **shingles** vaccination (Zostavax)? ☐ Yes ☐ No When: _____
6. Have you had a **COVID-19** vaccination? ☐ Yes ☐ No

   Dose 1: _____ Dose 2: _____ Brand: _____
7. Have you had a **tuberculosis** skin test (PPD or Tine)? ☐ Yes ☐ No
   If yes, was it negative? ☐ Yes ☐ No When: _____

DIAGNOSTIC STUDIES & SCREENINGS

Please check all of the diagnostic studies and/or screenings you have had performed.
Include the four-digit year and month in the table below.

Diagnostic Study/Screening (Test)	Year	Month	Comments
Bone Densitometry			
Mammogram			
Prostate Cancer			
Sigmoidoscopy or Colonoscopy			
Sonogram (AAA)			

HEARING EVALUATION

Have you had a hearing evaluation? ☐ Yes ☐ No
Do you wear or need hearing aids? ☐ Yes ☐ No

DEPRESSION SCREENING

1. Do you have little interest or pleasure in doing things? ☐ Positive ☐ Negative
2. Are you feeling down, depressed or hopeless? ☐ Positive ☐ Negative

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COMPREHENSIVE QUESTIONNAIRE *(This section pertains to the PATIENT ONLY)*

Facility Name: _____ Last Name: _____ First Name: _____

ADDITIONAL QUESTIONS

1. Are you a current smoker? ☐ Yes ☐ No
2. Are you a former smoker? ☐ Yes ☐ No
3. Are you a non-smoker? ☐ Yes ☐ No
4. Have you ever used illegal or illicit drugs? ☐ Yes ☐ No
5. Did you have a drink containing alcohol in the past year? ☐ Yes ☐ No

FAMILY HISTORY

1. Age at death

_____ Father ___ Mother ___ Brother ___ Sister ___ Child _____

2. Have any members of your family had or currently have any of the following conditions?
   Check all that apply.

Condition	Yes	No	Relationship to Patient	Age at Diagnosis
Alzheimer's disease				
Cancer, of what?				
Dementia				
Depression				
Diabetes				
Heart disease				
Hypertension				
Kidney disease				
Liver disease				
Stroke				
Other:				

3. Did anyone in your family die at a young age (<60)? ☐ Yes ☐ No

Relationship to Patient: _____ Age at Death: _____

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