ADVENT PROVIDERS PLLC

5315B FM 1960 RD. WEST, #138

Houston, TX 77069

Tel: 832-993-7366

Patient Registration Form

PLEASE PRINT CURRENT PATIENT INFORMATION

Patient's Last Name: _____

First Name: _____

Middle Name: _____

Date of birth: _____

SS#: _____

Cell phone: _____

Home phone: _____

Address: _____

Apt: _____

Zip code: _____

Marital status: _____

Sex: _____

Language: _____

Race: _____

Ethnicity: _____

Who referred you: _____

Guarantor required if not patient

Name: _____

Date of birth: _____

SS#: _____

Relation to patient: _____

Cell phone: _____

Home phone: _____

Address: _____

Apt: _____

Zip code: _____

Sexual orientation: _____

Primary Insurance Name: _____

Insurance #: _____

Group #: _____

Insured Name/Guarantor: _____

Company Tel: _____

Secondary Insurance Name: _____

Insurance #: _____

Group #: _____

Insurance Company: _____

Pharmacy: _____

I assert to the best of my knowledge that the information above is complete and accurate.

Patient/Guarantor Sign: _____ Date: _____

Chronic Care Management (CCM) Patient Agreement

Medicare is offering a new benefit for beneficiaries with multiple chronic conditions, and by consenting to this agreement, you allow Nkechi Onwumere NP-C to provide chronic care management services to you. CCM services are only available to patients with two or more chronic conditions. Medicare defines a chronic condition as a condition that is expected to last for at least 12 months, and that increases the risk of death, acute exacerbation of disease, or a decline in function.

Benefits of CCM Services include:

- 24/7 access to a care provider to help with your chronic healthcare needs
- A comprehensive plan of care for health needs, available on paper or electronically
- Coordination with both home and community-based service providers.
- Transition management among health care providers, including referrals, and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities
- Medication oversight and management
- Use of a certified electronic health record (EHR) as mandated by Medicare Should you desire to receive CCM services through your provider, he/she agrees to only bill Medicare for CCM services once per 30-day billing cycle. Furthermore, your provider agrees only to bill Medicare for CCM services if you have more than one chronic condition.

Beneficiary Acknowledgment and Agreement By signing this agreement, you agree to the following terms:

- You consent to your provider providing CCM services to you.
- You certify that your provider has fully explained the scope of CCM services to you.
- You acknowledge that only one practitioner can furnish and be paid for CCM services during a calendar month.
- You authorize electronic communication of your medical information between treating providers as part of your care.
- You understand that CCM services are subject to Medicare Co-Insurance, and so you may be billed for a portion of the CCM services.
- You understand that you have the right to terminate 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 notifying Nkechi Onwumere NP-C by telephone at (832)993-7366, or by mailing your written revocation to 12000 Wilcrest Dr. STE 204, Houston, TX 77031. Your provider will then give you written confirmation, including the effective date of revocation.

Print Patient Name: _____ POA Name _____

Beneficiary/POA signature: _____ Date: _____

Please sign and date each applicable item

Acknowledgement and authorizations:

I have read and understand the FILPAA/Privacy Policy for Advent Providers PLLC

Sign: _____ Date: _____

I hereby assign my insurance benefits to be paid directly to the healthcare provider

Sign: _____ Date: _____

I authorize Advent Providers PLLC to release medical information required to process my claim

Sign: _____ Date: _____

I have read and understand the Financial Policy for Advent Providers PLLC

Sign: _____ Date: _____

I authorize Advent Providers PLLC to obtain/have access to my medication history

Sign: _____ Date: _____

I authorize my provider's office to contact me by mobile phone text/voice and may leave a message

Sign: _____ Date: _____

I authorize my provider to conduct my visit on audiovisual or telephone if I am unable to be seen in person

Sign: _____ Date: _____

Patient Name: _____

ADVENT PROVIDERS PLLC

PATIENT ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/PRIVACY NOTICE

PATIENT NAME: _____ **Date of Birth:** _____

LOCATION OF SERVICE: _____ Date: _____

PRIVACY NOTICE: I acknowledge receipt of the Health Information Privacy Notice for Advent Providers PLLC.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized medical benefits Is made on my behalf direct to the Advent Providers PLLC of service(s) provided to me. I authorize Advent Providers MC to release any medical Information to my health insurance carrier and/or Its legitimate agents that is necessary to process related health Insurance claims and/or to verify plan benefits In accordance with HIPAA health information standards. I authorize payment of services), otherwise payable to me under the terms of my private, group employer's or group health Insurance plan, directly to Advent, I hereby authorize that photocopies of this form to *be* valid as the original,

PAYMENT GUARANTEE: I do hereby guarantee payment of all fees and charges related to all services and durable good provided to me through Advent Providers PLLC and its providers from my first date of examination or treatment, I agree to make full payment Immediately upon receipt of an Advent Providers billing statement whither ft Is an Interim or final bill. In the *vent that I fell to make *full* payment or fill to comply with other payment arrangements made with Advent Providers approval, I understand that appropriate collection measures may be initiated,

ELECTRONIC HEALTH RECORD: Healthcare providers require access to patient medical information whenever or wherever a patient *presents* for care to assure safety, quality and to coordinate patient care across the provider network, avoiding duplication of services. Advent Providers PLLC has a system-wide electronic medical record that Is available to caregivers on a *"need* to know" basis, to share information about patient care provided in the home or office settings. Confidentiality of records including those reflecting treatment for behavioral Issues, HIV/AIDS or drug or alcohol problems is maintained per relevant governmental and regulatory standards, Advent Providers and or Its providers can furnish and release to federal and state healthcare oversight agencies, *or* upon written request, to ail insurance companies or their representatives any information with respect to treatment of the patient herein named Including copies of the meclIcs1 record,

ELECTRONIC PRESCRIBING: I understand that Advent Providers practices and offices may use an electronic prescription system which allows prescriptions end related Information to be electronically sent between Advent providers PLLC and my pharmacy. have been Informed and understand that Advent Providers PLLC using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to Advent Providers PLLC to see this health Information.

Patient Signature / Representative:

Date: _____

ADVENT PROVIDERS PLLC

PATIENT GENERAL CONSENT FOR TREATMENT

TO THE PATIENT: *You have the right, as a patient, to be informed about your condition and surgery, medical, wound treatments and diagnostic procedures to be used so that you may make the decision whether to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is an effort to obtain your permission to perform the evaluation necessary to identify the condition, appropriate treatment and or procedure for any identified condition and to initiate the treatment as explained. This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you Intend that this consent Is continuing in nature even after a specific diagnosis has been made and treatment recommended and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it Is revoked in writing. You have the right time to discontinue services at any time.*

You have the right to discuss the treatment plan with your physician or practitioner about the purpose, potential risks and benefits of any test or treatment ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, Invasive or Interventional procedures are recommended; I will be asked to read and sign additional consent form prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to their contents.

Printed Name of Patient or Personal Representative: _____

Signature of Patient or Representative: _____ **Date:** _____

Printed Name of Witness **Employee Title**

_____ _____

NOTES Name: DOS Time

Power of Attorney: Tel:
PCP: Tel:

Home Health: Tel: Fax:

Pharmacy: Tel:

Vital Signs: BP P RR Temp O2 sat BG A1c /date

Wound site 1: Size Undermin Drain Slough Date

Wound site 2: Size Undermin Drain Slough Date

Wound site 3 Size Undermin Drain Slough Date

Wound site 4 Size Undermin Drain Slough Date

Type of wound 1
Type of wound 2
Type of wound 3
Type of wound 4

Treatment for wound 1

Treatment for wound 2

Treatment for wound 3

Treatment for wound 4

Wound care product: **Company:**

Price per Sq cm:

Start of skin substitute graft:

Associated Dx:

Medication list:

Complaints:
ENT
Cardio
Resp
MSK