Bluestone Physician Services

Consent for Services

Patient Full Name: _____ Date of Birth: _____/_____/_____

Community and Room #: _____ City/State: _____

Consent for Services and Disclosure of Information for Treatment: I consent to the performance of any and all medical evaluation and treatment, preventative care service and procedures which are deemed necessary or advisable by Bluestone medical providers and designees. I consent to the use of telemedicine services in the course of my diagnosis and treatment with my Bluestone Provider Team. Telemedicine involves the use of audio, video or other electronic communications to interact with you, and consult with your healthcare provider(s). I also consent to the use and disclosure of my health information by Bluestone for my treatment, including disclosure of my health care information to health care providers and facilities unrelated to Bluestone that may be involved in my care. Bluestone may disclose my health information to and access my health information from other providers using a record locator service or patient information service of a health information exchange for treatment unless **I object by checking here:** ☐

Notice of Privacy Practices and Consent (Acknowledgment of Receipt): I received a copy of Bluestone's Privacy Practices and understand I have a right to review these before signing this consent form. I understand that Bluestone may change its privacy practices in the future, that any changes will be posted on Bluestone's website and that I may request a copy of the new privacy practices at any time. I understand I can contact Bluestone's Privacy Officer with any questions I may have about the Notice of Privacy Practices. In addition to the other uses and disclosures described in this document, I consent to the use and disclosure of my health information for the purposes described in the Notice of Privacy Practices, including Bluestone's health care operations.

Insurance Assignment and Payment Consent: I authorize payments directly to Bluestone of insurance, Medicare or Medical Assistance benefits, or funds from other sources I am entitled to receive as payment for services provided to me. I consent to the use and disclose my health information for payment purposes. In addition, my insurer may share my past, current and future health and account records with Bluestone about services received from Bluestone and care providers unrelated to Bluestone. These records may be used by Bluestone as needed to manage, coordinate and improve the quality of my care.
☐ **My insurer may not release health information from providers unrelated to Bluestone for the purposes described above.**

Use of Health Care Records in Program Evaluations and Training: I give Bluestone permission to use and disclose information gathered during the course of my treatment from Bluestone, including information from my treatment records, for the purposes of program evaluation and training and for quality review of staff performance at Bluestone.

Patient Centered Medical Home and Chronic Care Management: I give Bluestone permission to enroll me in the Bluestone program, which includes appropriate practitioner/care management visits and activities, which will be billed to my insurance with normal deductibles and copays. I understand that only one practitioner may furnish and be paid for CCM services during a given calendar month and that I have the right to stop CCM services at any time. I understand information concerning this program is available on the Bluestone website at www.BluestoneMD.com/forms.

Consent for Use of Medical Records in Academic Research: I authorize Bluestone Physician Services to use or disclose my health records for medical or academic research, including health records created at any time by Bluestone and records Bluestone received from other health care providers, unless I object by checking here: ☐ **I request that Bluestone will tell me the dates on which my health records are released for research and tell me how to contact external researchers who have received my records.**

Immunization Consent: I consent and authorize Bluestone Physician Services to conduct collection, testing, and analysis for the purposes of a COVID-19 diagnostic test. I acknowledge and understand that my COVID-19 diagnostic test will require the collection of an appropriate sample by my healthcare provider through a nasopharyngeal swab, oral swab, or other recommended collection procedures. I give consent to receive CDC-recommended vaccinations (Including but not limited to COVID-19, Influenza, Shingrix/Shingles, Prevnar13/Pneumonia, Pneumovax 23/Pneumonia and Boostrix/Pertussis, Tetanus). Notify us of allergies or adverse reactions to any vaccinations. I understand this consent form is valid as long as I remain a Bluestone Physician Services patient or I request an update. Immunizations and their administration will be billed through patient's insurance. Medicare Part B and Part D covers most vaccinations. There is typically no out-of-pocket cost. Check with your insurance to confirm vaccination coverage benefits. It is the responsibility of the patient or healthcare power of attorney to assure correct insurance information is on file. ☐ **I do not give consent for vaccinations.**

Family/Patient Bluestone Bridge and Patient Portal Access: I authorize my personal representative to access my health care information and communicate with my Bluestone Provider Team electronically through the Bluestone Bridge and/or the Bluestone Patient Portal. If designating a Personal Representative to access your health care records and communicate with your provider team regarding your care please list their name and email address below.

*This consent applies to health information Bluestone already has about me, information about future care I may receive from Bluestone and information Bluestone receives from third parties. This consent will continue unless I cancel by giving written notice to Bluestone Physician Services or it expires as required by law. Cancellation will apply **after the date** when the notice to cancel is received. It will not affect information that used or disclosed before cancellation.*

Patient signature (or legal representative): _____ Date: _____

Relationship to patient: _____

Email address: _____

Personal Representative Name: _____

***Note:** Must be signed by patient, unless mentally or physically unable.*

☐ *No email address* ☐ *Decline access to Bridge/Portal*

Fax completed forms to: **MN:** 855-306-1167 **WI:** 888-972-8297 **FL:** 855-523-3935 **VA:** 833-324-0652

Bluestone Physician Services

Patient Enrollment Form

Patient Information: Please use full legal name.

☐ *M* ☐ *F*

First Name: _____ Last Name: _____ M.I. _____

☐ *Memory Care* ☐ *Assisted Living*
☐ *Group Home* ☐ *Independent Living*

Date of Birth: _____/_____/_____ Social Security #: _____

Community and Room #: _____ City/State: _____

Race/Ethnicity: *Choose one or more*
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Declined ☐ Unknown

Primary Language: _____ Country of Origin: _____ ☐ Interpreter Services Needed

Insurance:

Medicare ID #:_____ (If on Medicare, ID ***required*** for enrollment.)

Primary Plan: _____ Policy ID #: _____ Group #: _____

Secondary Plan: _____ Policy ID #: _____ Group #: _____

Prescription Drug Coverage Name: _____ Plan ID #: _____

Personal Representative (Healthcare Decision Maker): Provide copy of Health Care Directive and/or Guardianship Paperwork.

☐ Self; I make my own medical decisions and have no Medical Power of Attorney or Health Care Directive.

Name: _____ Relationship to Patient: _____

Mobile Phone #: _____ Secondary Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Billing Contact:

☐ Same as Healthcare Decision Maker ☐ Self

Name: _____ Relationship to Patient: _____

Mobile Phone #: _____ Secondary Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Your Healthcare Information:

Drug allergies and specific reactions: _____

Current diagnoses: _____

Code status: ☐ Full code ☐ Do Not Resuscitate (DNR) ☐ Other (Please include paperwork, if applicable.)

Family History (siblings or parents; check all that apply): ☐ Alzheimer's/Dementia ☐ Heart Disease ☐ Diabetes
☐ Hypertension ☐ Depression/Mental Health Conditions ☐ Cancer (Type): _____
☐ Other: _____

**Enrollment in Bluestone Physician Services subject to approval after initial provider visit.*

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Bluestone Physician Services

Authorization for Release of Health Information

Patient Information: Please use full legal name.

First Name: _____ Last Name: _____ M.I. _____ Date of Birth: _____/_____/_____

Community and Room #: _____

*Release Information From (Required):

Clinic Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Release Information To:

MINNESOTA/WISCONSIN/VIRGINIA
Bluestone Physician Services
Attn: Medical Records Dept.
270 Main Street N., Suite 300
Stillwater, MN 55082

FAX: 855-490-4045 **PHONE:** 651-342-4275

FLORIDA
Bluestone Physician Services
Attn: Medical Records Dept.
10150 Highland Manor Drive, Suite 240
Tampa, FL 33610

FAX: 877-916-7631 **PHONE:** 844-799-4513

*Information To Be Released (Required): Indicate ONLY the information that you are authorizing to be released.

☐ Notes from **four** most recent provider visits
☐ Labs and imaging within last two years
☐ Hospital discharges within **last two years**
☐ Other: _____

By law, you must specifically request the following information for it to be released:

Chemical dependency program: ☐ Yes ☐ No
Behavioral health notes: ☐ Yes ☐ No

I hereby authorize the release of my individually identifiable health information described above for treatment and payment purposes. I understand that this authorization to release health information is voluntary. I understand that the information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal or state law.

I understand that my healthcare and the payment for my healthcare will not be affected by my signing of this form. I understand I may request a copy of this form after I sign it. I understand that this authorization may be revoked by me by written notice to Bluestone Physician Services. I understand that if I revoke this authorization it will not have any effect on any actions taken by Bluestone Physician Services before receiving my revocation. This release covers past, present and future encounters/visits unless I write in specific treatment dates here: _____ to _____. This consent does not expire unless I write in a specific expiration date here: _____.

_____ _____

Patient or Legal Representative Signature ***Date***

_____

Legal Representative Printed Name and Authority to sign for patient *(i.e. Health Care Directive, Medical POA; must include documentation)*

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