GENERAL CONSENT FOR TREATMENT & PAYMENT AUTHORIZATION

PATIENT _____ **DATE** _____

CONSENT FOR GRACE AT HOME SERVICES

- I request and authorize medical care as my physician his/her assistant or designees (collectively called "the physician") may deem necessary or advisable. This care may include but is not limited to: diagnostic; radiology and laboratory procedures; administration of drugs, biologicals and other therapeutics; medical and nursing care. I authorize my physician(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient's) care is directed by my physician and that other personnel render care and services to me (the patient) according to the physician's instructions.
- I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or promises have been made to me with respect to results of such diagnostic procedures or treatment.
- I understand that samples of body fluids and/or tissues may be withdrawn from me (the patient) as necessary to perform appropriate diagnostic procedures. I authorize GRACE AT HOME to dispose of the body fluids.
- I have been informed and understand that HIV (human immunodeficiency virus-AIDS) testing and Hepatitis testing may be performed on me without my consent to the extent required by law if a health professional or GRACE AT HOME employee or First Responder sustains an exposure to my blood or other body fluids.
- I have been informed that from time to time, GRACE AT HOME may permit students, externals or potential employees to attend my medical examination. I further understand that these individuals may be exposed to confidential medical information about me. I consent to these individuals' presence during my treatment.

ASSIGNMENT OF INSURANCE BENEFITS

Medicare Certifications: I certify that the information provided by me in applying for payment under TITLE XVII of the Social Security Act is correct and request on my behalf all authorized benefits. I hereby authorize and instruct my insurance carrier to make payment directly to Cinqcare at Home PC(DBA GRACE AT HOME) all benefits (payments) otherwise payable to me. I agree to personally pay for any charges that are not covered by or collected from any insurance program including any deductibles and coinsurance amounts.

All billing statements should be sent to the following address:

Responsible Party Name _____

Responsible Party Address _____

Street Address

_____ _____ _____

City State Zip

PATIENT PHOTOGRAPHY RELEASE

I hereby give permission to GRACE AT HOME to photograph, televise, or otherwise illustrate as deemed advisable for diagnostic, educational, or research purposes and to enhance the medical record. I further authorize the use of such audio-visual material (video tape, audio tape, photographs, motion pictures, and other resulting records) for teaching purposes or to illustrate science papers or lectures at any time hereafter without inspection or approval, on my part, of the finished product or the specific use to which this material may be applied so long as any such material is not individually identifiable. I hereby consent to any or all of the above procedures.

ELECTRONIC COMMUNICATION CONSENT

I understand and agree that Grace at Home may contact me using methods such as automated calls, emails, portal messages, and text messages (together "Electronic Communications") sent to my landline, cellular numbers, or e-mail indicated on my Patient Information Form.

GRACE AT HOME may utilize electronic communications to:

- Notify me of notices available in the Patient Portal, preventive care, test results, treatment recommendations, outstanding balances;
- Remind me of scheduled appointments;
- Market and share information with me regarding new services provided by Grace at Home; or
- Other Grace at Home communications including but not limited to using a virtual assistant/AI for documentation of patient information and communication in the patient's chart.

I understand that by providing my phone number and e-mail address, I am voluntarily consenting to receive automated Electronic Communications. I understand that I may be charged for such calls by my telephone service provider(s) and that such calls may be generated by and automated dialing system. Grace at Home will not charge you for these communications. I understand that there are risks associated with electronic communication. GRACE AT HOME will utilize secure encryption methods to minimize risk.

I understand that I may revoke this consent at any time in writing or orally to Grace at Home.

CONTACT PREFERENCES FOR PROTECTED HEALTH INFORMATION

I grant permission for the disclosure of my Protected Health Information (Protected Health Information would include your name, diagnosis(es), test results, dates of service, treatment plan, etc.) to the following individuals:

Name	Phone Number	Relationship

CONSENT AGREEMENT FOR PROVISION OF CHRONIC CARE MANAGEMENT, ADVANCED PRIMARY CARE MANAGEMENT, CARE PLAN OVERSIGHT, TRANSITIONAL CARE MANAGEMENT OR REMOTE PATIENT MONITORING By signing this Agreement, you consent to Grace At Home providing Transitional Care Management (TCM), Care Plan Oversight (CPO), Chronic Care Management (CCM), Advanced Primary Care Management (APCM) and/or Remote Patient Monitoring (RPM) to you as fully described below.

THESE SERVICES ARE AVAILABLE TO YOU BECAUSE:

- You are transitioning from an inpatient setting back to your community setting, and/or;
- You are receiving Medicare covered home health or hospice services for complex and/or multidisciplinary health care issues, and/or;
- 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, and/or;
- You have a diagnosis that will benefit by remote patient monitoring services.
- TCM, CPO, CCM, APCM and/or RPM services include 24-hours-a-day, 7-days-a-week access to a health care provider to address acute 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 a management of care transitions among health care providers and settings. Your provider from Grace At Home will discuss with you the specific services that will be available and applicable, and how to access those services.

OUR OBLIGATION TO YOU:

When providing TCM, CPO, CCM, APCM and/or RPM services, we will:

- Explain to you (and your caregiver, if applicable), and offer to you, all the services that are applicable to your specific conditions
- Be available to provide advice on the urgency of any concerning medical issue 24 hours a day, by calling (317) 429-0120 during normal business hours or calling our After Hours/On-Call Line at (317) 426-1119.

BENEFICIARY RIGHTS, ACKNOWLEDGEMENT, AND AUTHORIZATION:

By signing this agreement:

- You consent to Grace At Home providing TCM, CPO, CCM, APCM and/or RPM services to you.
- You authorize electronic communication of your medical information with other treating providers as part of coordination of your care.
- You are acknowledging that only one (1) practitioner may furnish TCM, CPO , CCM, APCM, and/ or RPM services to you during a calendar month.
- You have the right to stop TCM, CPO, CCM and/or RPM 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 317-429-0120), or in writing (to PO Box 503108, Indianapolis IN 46250). Upon receipt of the revocation, Grace At Home will provide you written confirmation (including the effective date) of revocation.

GRACE at Home

IMPORTANT INFORMATION REGARDING MEDICARE AND CCM/APCM

We enjoy and appreciate the opportunity to provide you with comprehensive primary care. Medicare has identified the care of chronic health conditions as an important goal. Chronic conditions are ongoing medical problems that must be managed effectively in a partnership between the health care team and the patient to maintain the best possible health. Examples include diabetes, high blood pressure, heart disease, depression, and others. Effective Jan. 1, 2015, federal regulations enable Medicare to pay for chronic care management. The staff at Grace At Home will carefully monitor and provide comprehensive care for your chronic health conditions in a systematic way to supplement regular visit care.

HOW CAN YOU BENEFIT FROM CHRONIC CARE MANAGEMENT/ADVANCED PRIMARY CARE MANAGMENT?

- You will have 24/7 access to your primary care team.
- You will have preventive care services scheduled, many of which are covered by Medicare, and your medications will be closely monitored.
- You will receive a personalized, comprehensive plan of care for all of your health issues.
- Your care will be coordinated by Grace At Home, including care you may receive at other locations, such as specialists' offices, the hospital, other health care facilities, and your home.

WHAT IS REMOTE PATIENT MONITORING?

- If appropriate medical necessity and diagnosis are present your Grace A Home provider may prescribe certain remote Bluetooth or cellular enabled patient monitoring equipment to be used daily in your home (BP monitor, scale, or other). Readings taken in your home will be immediately available to your Grace At Home clinical team and provider.

WHAT DO YOU NEED TO KNOW BEFORE SIGNING UP?

- Understand that this care requires you to pay a small copay (your Medicare coinsurance amount) to your primary care practice each month that you receive chronic care management and/or remote patient monitoring. The service is also subject to your Medicare deductible.
- You must sign an agreement to receive this type of chronic care management and/or remote patient monitoring.

Please let us know if you have questions about this new benefit. I authorize Grace At Home to conduct chronic care management (CCM), Advance Primary Care Management (APCM) and/or remote patient monitoring (RPM) services on my behalf as may be medically appropriate.

I HAVE READ OR HAD READ TO ME AND FULLY UNDERESTAND THIS CONSENT. I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAVE HAD THESE QUESTIONS ANSWERED.

_____ _____

PATIENT/POA SIGNATURE **DATE**