# NEW PATIENT INTAKE

**REQUIRED DOCUMENTS**

- Atlas Consent Form
  - This must be signed by the patient or the patient's POA.
- Atlas Demographics Sheet
  - We must have all the necessary information completed.
- A valid photo ID
- Insurance Card (copy of the front and the back)
- Pharmacy Card (copy of the front and the back)

**DOCUMENTS THAT WILL EXPEDITE ADMISSION**

- Medication List
- POA Paperwork (MPOA, FPOA, and/or court appointed fiduciary information)
- Alaska POLST Form or Advance Directives
- Completed move-in paperwork from previous physician

If we are missing any of the following, admission will be delayed:

- Consent Form signed by the correct person
- Up-to-date insurance information
- Basic demographic information, such as legal name, DOB, gender, hospice status, POA status

**SUBMIT**

To ensure timely admission, please submit all requested documentation completed in full. If you have any questions, please call 907-215-4848.

**DOCUMENTS SHOULD BE FAXED TO 907-312-7676 OR EMAILED TO MOBILE@ATLASALASKA.COM**

907-215-4848 (phone)
907-312-7676 (fax)

NAME OF PATIENT: _____

Date of Birth: _____ /_____ /_____ ☐ Mobile: Anchorage ☐ Mobile: Wasilla/Palmer

## SELECTION OF PRIMARY CARE PROVIDER AND MEDICAL CONSENT

I hereby request medical care and treatment by Atlas Medical Alaska (Atlas Medical), its Primary Care Providers and available Specialists. I designate Atlas Medical as my only Primary Care Providers and request that they monitor and assist with all aspects of my health care, and I agree to provide Atlas Medical with a detailed medical history.

## CHRONIC CARE MANAGEMENT (CCM) AND CARE PLAN OVERSITE (CPO)

To improve the quality of care I receive I agree to allow Atlas Medical to provide me with Chronic Care Management (CCM), Home Health and Hospice Care Plan Oversight (CPO) services and to be designated as my only CCM provider. I understand that these are non-face-to-face insurance covered services and Atlas Medical may bill my insurance for these services and depending on my insurance, I may be responsible for a co-pay, co-insurance, or deductible. These services include: consultation, guidance in managing my chronic conditions, reviewing my medications, help with specialist referrals, DME equipment, and tests, receiving a plan of care with personal health goals, sharing e-records and coordination of care with other providers, 24/7 phone access to clinical staff, and working closely with my home health and hospice. I can refuse these services by opting out at the end of any month by notifying Atlas Medical in writing.

## FINANCIAL RESPONSIBILITY

I authorize Atlas Medical to bill my insurance and for my insurance company to make direct payments to Atlas Medical. I accept full financial responsibility for payment of insurance mandated charges such as deductibles, copays, and coinsurance. I am aware that the only bills I will receive from Atlas Medical will be for deductibles, copays, and coinsurance; Atlas Medical will not bill me personally for any services denied by my insurance. I understand that it is my responsibility to continuously provide up-to-date insurance information or select a cash payment plan with Atlas Medical.

## NOTICE OF PRIVACY PRACTICES

Atlas Medical participates in Government Health Information Exchange (HIE) programs to which I can opt out at any time. Atlas Medical may disclose my health information when required to do so by law. Medical information is considered private and confidential; however, I am aware, that in accordance with HIPAA Law, my information may be shared or disclosed verbally, electronically, and on paper as needed to others who are involved in my care and as needed for medical billing and/or care coordination. Additionally, I understand that Atlas Medical may need to contact me or my designee directly regarding my care. To improve care coordination, I give my permission for Atlas Medical to leave phone messages regarding my medical care/account information. I understand that this consent will remain valid until updated or revoked.

Voicemail: Text Message: Email:

## RELEASE OF MEDICAL RECORDS

I authorize the prompt release of my complete health record from all past and present healthcare providers to Atlas Medical; this authorization for release of information covers all past and present medical records, unless otherwise specified, which may include records relating to communicable diseases and treatment of alcohol or drug abuse.

## HOSPICE CARE AND HOME HEALTH CARE

I understand that if I request Hospice or Home Health services, Atlas Medical will remain as Primary Care Provider and act as my Attending Physician (GV), unless otherwise notified in writing.

## TERMINATION OF CARE AND TRANSFER OF CARE

Atlas Medical also reserves the legal right to terminate services, at any time, without cause, upon (30) days prior notice. I understand that if I desire a change in provider for any reason that prompt written notification be sent to Atlas Medical. I understand that if I am receiving Mobile Provider Services that Atlas Medical may or may not remain as my Mobile Primary Care Provider if I change care facilities or move from my current address. Furthermore, I understand that Atlas Medical may change my assigned Provider to any of Atlas Medical's Associate Providers at any time without prior notice.

*My signature below certifies that I have read, understand, and consent to all the terms and conditions listed above.*

_____

Signature of Patient or Legal POA Date

907-215-4848 (phone)
907-312-7676 (fax)

Atlas Medical Location: ☐ Mobile: Anchorage ☐ Mobile: Wasilla/Palmer

## PATIENT REGISTRATION

First Name: _____ Last Name: _____ (MI): _____

DOB: _____ / _____ / _____ Sex: M / F Patient Personal Cell: _____

Preferred Language: _____ Race: _____ Ethnicity: ☐Non-Hispanic ☐Hispanic

Social Security Number: Medicare Number:

## PLACE OF RESIDENCE

Physical Address: _____

Mailing Address: _____

Optional: Community/Facility Name: Move-in Date: Room #:

## PAST PRIMARY CARE PROVIDER AND CURRENT SPECIALISTS

Primary Care Provider Name/Info: _____ Phone #: _____

Specialist: _____ Specialty: _____ Phone #: _____

Specialist: _____ Specialty: _____ Phone #: _____

☐ I AM ON Hospice (Hospice Company): _____)

☐ I AM ON Home Health (PT/OT/Skilled Nursing) (Home Health Company):

## DESIGNEE INFORMATION (Please fax verification of active POA/FPOA to our office.)

☐ I DO have a Medical Power of Attorney (MPOA) ☐ I DO NOT have a Medical Power of Attorney (MPOA)

MPOA or Primary Contact: _____ Relation to Patient: _____

MPOA Primary Phone #: _____ MPOA Email Address: _____

MPOA Mailing Address: _____ City: _____ State: _____ Zip: _____

☐ I DO have a Guarantor or Financial POA (FPOA) ☐ I DO NOT have a Guarantor or Financial POA (FPOA)

FPOA or Primary Contact: _____ Relation to Patient: _____

FPOA Primary Phone #: _____ FPOA Email Address: _____

FPOA Mailing Address: City: State: Zip:

## PRIMARY INSURANCE (Medicare, Medicare/Medicaid Advantage, Commercial Plan) (Part B, Part C)

Insurance Provider and Plan Name: _____

Member ID # _____

## SECONDARY INSURANCE (Medicare Supplement Plan, Medicaid, or "Medigap" Plan) (Part F, G, K, L, M, N, etc.)

Insurance Provider and Plan Name: _____

Member ID # _____

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## CONSENT TO COMMUNICATE / LEAVE VOICEMAIL / TEXT MESSAGE / EMAIL

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

Atlas Medical may need to communicate with those involved in the care of the patient to discuss patient care, report test results, appointments, referrals, and/or billing/insurance information. To protect patient privacy and follow federal guidelines we will NOT leave messages or discuss medical information with anyone except the patient or legal guardian without written permission.

I give my permission for Atlas Medical and its associates to communicate with and/or leave information via voicemail, text message, and/or email regarding my medical care/account information to the following individuals listed below.

I fully understand that this consent will remain valid until revoked in writing.

### PRIMARY CONTACT (MPOA)

First Name: _____ Last Name: _____

Relation to Patient: _____

Phone Number: (_____) _____-_____ ☐ Voicemail ☐ Text Message

Email Address:

### SECONDARY DESIGNEE

First Name: _____ Last Name: _____

Relation to Patient: _____

Phone Number: (_____) _____-_____ ☐ Voicemail ☐ Text Message

Email Address:

### FINANCIAL INFORMATION ONLY DESIGNEE

First Name: _____ Last Name: _____

Relation to Patient: _____

Phone Number: (_____) _____-_____ ☐ Voicemail ☐ Text Message

Email Address:

*My signature below certifies that I have read, understand, and consent to all the terms and conditions listed above.*

_____

Signature of Patient or Legal POA Date

Atlas MEDICAL

907-215-4848 (phone)
907-312-7676 (fax)

## PATIENT MEDICAL HISTORY

Patient Name: _____ DOB ____ / ____ / _____ Height: _____ (Inches) Weight: _____(Lbs)

## ADVANCED DIRECTIVES (Check all that apply; fax verification of advanced directives to our office.)

☐ Living Will ☐ Advanced Directive ☐ DNR (Do Not Resuscitate) ☐ DNI (Do Not Intubate) ☐ DNH (Do Not Hospitalize)

## ALLERGIES AND ALLERGIES TO MEDICATIONS (include reaction if known i.e., rash, trouble breathing, etc.):

_____

_____

## SOCIAL HISTORY

Former Profession(s): _____

Current Smoker: ☐ YES ☐ NO Year Started _____ Year Quit _____ Packs Per Day: _____

Tobacco Use: ☐ YES ☐ NO Type: _____ (chew, pipe, cigar, etc.)

Alcohol Use: ☐ YES ☐ NO Type: _____ Drinks Per Week _____

History of Illicit Drug Use:

## FAMILY HISTORY

Mother ☐ Living ☐ Deceased Known health issues: _____

Father ☐ Living ☐ Deceased Known health issues: _____

Other family members known health issues (*state relation and health issues*):

## SURGICAL HISTORY

| | | | |
|---|---|---|---|
| Heart Bypass/CABG | Date _____ | Cardiac (Heart) Stent | Date _____ |
| Heart Valve Replacement | Date _____ | Pacemaker | Date _____ |
| Defibrillator/ICD Placement | Date _____ | Tonsillectomy | Date _____ |
| Appendix Removal | Date _____ | Gall Bladder Removal | Date _____ |
| Hysterectomy | Date _____ | Cataract Removal | Date _____ L / R / Both |
| Knee Replacement | Date _____ L / R / Both | | |
| Hip Replacement | Date _____ L / R / Both | | |

Other Surgical History: _____

## HOSPITALIZATION HISTORY (Please list any hospitalizations in the past 12 months; include hospital name and reason.)

_____

_____

_____

_____

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## DETAILED MEDICAL HISTORY BY SYSTEM

Patient Name: _____ DOB ____ / ____ / _____

**Eyes and Ears:**
- ☐ Macular Degeneration
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Blindness (R, L, or both eyes): _____
- ☐ Hearing loss
- ☐ Other: _____

**Heart:**
- ☐ High Blood Pressure
- ☐ Heart Attack (year if known): _____
- ☐ Heart Failure
- ☐ Aortic Stenosis
- ☐ Heart Valve Problems
- ☐ Angina
- ☐ High Cholesterol
- ☐ Atrial Fibrillation (A-fib)
- ☐ Irregular Heart Beats
- ☐ Pacemaker
- ☐ Heart Murmur
- ☐ Edema (swelling)
- ☐ Other: _____

**Kidney and Urinary Tract:**
- ☐ Recurrent Bladder Infections (UTI)
- ☐ Chronic Kidney Disease
- ☐ Enlarged Prostate
- ☐ Prostate Cancer
- ☐ Urinary Incontinence
- ☐ Kidney Stones
- ☐ Bladder Cancer
- ☐ Other: _____

**Endocrine:**
- ☐ Underactive Thyroid
- ☐ Overactive Thyroid
- ☐ Diabetes Type 1 (juvenile onset)
- ☐ Diabetes Type 2 (adult onset)
- ☐ Other: _____

**Musculoskeletal:**
- ☐ Arthritis
- ☐ Chronic Back Pain
- ☐ Osteoporosis
- ☐ Gout
- ☐ Other:_____

**Psychological:**
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar
- ☐ Schizophrenia
- ☐ Other: _____

**Lungs:**
- ☐ Asthma
- ☐ COPD/Emphysema
- ☐ Bronchitis
- ☐ Frequent or Recurrent Pneumonia
- ☐ Sleep Apnea
- ☐ Pulmonary Embolism (blood clot in lung)
- ☐ Lung Cancer
- ☐ Other: _____

**Gastrointestinal:**
- ☐ Reflux/GERD/Heartburn
- ☐ Ulcers
- ☐ Irritable Bowel Disease
- ☐ Liver Disease/Cirrhosis
- ☐ Hepatitis
- ☐ Gallbladder Disease
- ☐ Colon Polyps
- ☐ Diverticulosis/Diverticulitis
- ☐ Blood in Stool
- ☐ Constipation
- ☐ Hernia
- ☐ Colon Cancer
- ☐ Other: _____

**Neurologic:**
- ☐ Dementia (type if known): _____
- ☐ Parkinson's Disease
- ☐ Stroke
- ☐ Seizure Disorder/Epilepsy
- ☐ Neuropathy
- ☐ Migraines
- ☐ TIA (mini-stroke)
- ☐ Multiple Sclerosis
- ☐ Tremors
- ☐ Other: _____

**Vascular:**
- ☐ DVT (blood clot in arms or legs)
- ☐ Aneurysm
- ☐ Peripheral Vascular Disease (poor circulation)
- ☐ Other: _____

**Other Health Conditions:**
- ☐ Anemia
- ☐ Eczema
- ☐ Psoriasis
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Breast Cancer
- ☐ Skin Cancer
- ☐ Other Cancer: _____

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## MENTAL HEALTH QUESTIONNAIRE

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

| PHQ-9 Questionnaire | Not At All | Several Days | More Than Half the Days | Nearly Every Day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things in the last 2 weeks? | ☐ | ☐ | ☐ | ☐ |
| 2. Feeling down, depressed, or hopeless in the last 2 weeks? | ☐ | ☐ | ☐ | ☐ |
| 3. Trouble falling or staying asleep, or sleeping too much in last 2 weeks? | ☐ | ☐ | ☐ | ☐ |
| 4. Feeling tired or having little energy in last 2 weeks? | ☐ | ☐ | ☐ | ☐ |
| 5. Poor appetite or overeating in last 2 weeks? | ☐ | ☐ | ☐ | ☐ |
| 6. Feeling bad about yourself or that you are a failure or have let yourself or family down in last 2 weeks? | ☐ | ☐ | ☐ | ☐ |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television in last 2 weeks? | ☐ | ☐ | ☐ | ☐ |
| 8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual in last 2 weeks? | ☐ | ☐ | ☐ | ☐ |
| 9. Thoughts that you would be better off dead, or of hurting yourself in some way in last 2 weeks? | ☐ | ☐ | ☐ | ☐ |
| 10. How difficult have these made it for you to do your work, take care of things at home, or get along with other people? | ☐ | ☐ | ☐ | ☐ |

| GAD-7 Questionnaire | Not At All | Several Days | More Than Half the Days | Nearly Every Day |
|---|---|---|---|---|
| 1. Feeling nervous, anxious or on the edge in the last 2 weeks? | ☐ | ☐ | ☐ | ☐ |
| 2. Over the past 2 weeks have you not been able to stop or control worrying? | ☐ | ☐ | ☐ | ☐ |
| 3. Worrying too much about different things in the last 2 weeks? | ☐ | ☐ | ☐ | ☐ |
| 4. Trouble relaxing in the last 2 weeks? | ☐ | ☐ | ☐ | ☐ |
| 5. Being so restless that it is hard to sit still in the last 2 weeks? | ☐ | ☐ | ☐ | ☐ |
| 6. Becoming easily annoyed or irritable in the last 4 weeks? | ☐ | ☐ | ☐ | ☐ |
| 7. Feeling afraid as if something awful might happen? | ☐ | ☐ | ☐ | ☐ |

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PREFERRED PHARMACY: _____

CURRENT MEDICATION LIST

Please include all prescription and over-the-counter medication you are taking on a routine basis. Please include the medication name, dosage, frequency, reason for taking, and current prescriber. If you need more space, write on back or attach your medication list.

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# MEDICAL RECORDS RELEASE FORM

Patient Name: _____ DOB: _____ Gender: ☐ M ☐ F

Community/Facility Name: _____

☐ I **DO** have a Medical Power of Attorney (MPOA) or Legal Guardian ☐ I **DO NOT** have a MPOA or Legal Gurdian

**Documentation of current MPOA or Legal Guardianship status is required to be provided to Atlas Medical for verification.**

MPOA or Guardian: _____ Relation to Patient: _____

Primary Phone #: _____ Secondary Phone #: _____

Email Address: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

**AUTHORIZATION OF RELEASE OF INFORMATION**

I authorize Atlas Medical Alaska and its associates to use and **receive** the protected health information described below **from** the individual or organization listed below. I authorize the release of my **complete** health record which may include records relating to communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse **to** Atlas Medical Alaska. Please release **all** records, including but not limited to, progress notes, operative notes, laboratory test results, diagnostic tests, and x-rays requested below.

*Authorization for Use or Disclosure of Protected Health Information. Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164**

**RELEASE OF MEDICAL RECORDS**

☐ Release All Medical Records Dates **OR** ☐ Release Records From _____ To _____

Practice/Organization/Facility Name/or Relation: _____

_____

_____

Send records by mail to 3831 E Blue Lupine Drive, Suite B1, Wasilla, AK 99654 **OR** by email to mobile@atlasalaska.com **OR** by fax to 907-312-7676.

**I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS NOTED ABOVE.**

Signature of Patient or Legal POA: _____ Date: _____

**Send completed forms via fax at 907-312-7676 or email at mobile@atlasalaska.com**