AMG Senior Medical Group

Tel: 801-716-7008 434 W. Ascension Way #225 schedule@asf-amg.com
Fax: 888-990-1557 Murray, UT 84123 www.amgseniormedical.com

Admission Packet Checklist

Dear Patient,

Thank you for your interest in our **AMG At Home.** Provided by AMG Senior Medical Group and Inspiration Home Health and Hospice.

We are excited to offer what we feel is the best "At Home" program available. Having medical providers, home health and hospice services, we bring a broad continuum of care that allows us to address most health concerns in the convenience of your own home. Through experience, we have learned that one team creates better communication, stronger relationships and an exceptional overall quality of care throughout any medical transition.

We offer a provider to come directly to your house, we can work directly with your primary care provider, we ensure medications are being managed, we have 24/7 on call phone coverage from our providers, we will contact family to give updates or communicate through our Patient Portal and we even send out reminder calls to make sure you are ready for your next appointment! We look forward to serving you.

If you have any questions or concerns please contact our office at 801-716-7008, Monday – Friday between 8am and 5pm.

We will contact you once we have processed paperwork to see if you qualify for our **AMG At Home** Program!

- ☐ Diagnosis Checklist
- ☐ Patient Information / Insurance Form (both sides of card, primary and secondary)
- ☐ Consent to Treat Form
- ☐ Consent to Bill Form
- ☐ Medication/Allergy Lists
- ☐ Release of Information Form

Once checklist above is complete and all forms are obtained, you may email or fax this packet to our office directly.

Email: schedule@asf-amg.com Fax: 888-990-1557.

Please allow 24 hours to process new patient information

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Patient Demographics

Name: _____ **DOB:** _____

SSN: _____ **Gender:** _____

Mailing Address: _____

Patient Phone: _____ (May we leave detailed voicemails?) **YES** ☐ **NO** ☐

Primary Contact: _____ **Relationship:** _____

Primary Contact email: _____

Contact Phone: _____ (May we leave detailed voicemails?) **YES** ☐ **NO** ☐

Would you like to be contacted for appointment reminders? YES ☐ **NO** ☐

Would you like access to our online patient portal? (Must have email access) **YES** ☐ **NO** ☐

Please list your Preferred Pharmacy (with address)

_____

Race: (Please Check One)
- ☐ American Indian /Alaska Native
- ☐ Asian
- ☐ African American
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ White
- ☐ Other Race
- ☐ Decline to Specify

Ethnicity: (Please Check One)
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline to Specify

Height: _____

Weight: _____

Tobacco History:
- ☐ Never Smoker
- ☐ Current Smoker
- ☐ Previous Smoker

Quit Date: _____
Number of years? _____
Number of packs per day? _____

Insurance

(Fill in below and send copies of insurance cards, front and back)

Medicare #: _____ **Medicaid #:** _____

Private/Supplemental Insurance: _____

Policy #: _____ **Group #:** _____

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Consent to Treat Form

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
I consent to allow Amazing Medical Associates (AMG) to use and disclose my Protected Health Information to carry out medical treatment, payment and healthcare operations.

AUTHORIZATION / INSURANCE PAYMENT
I authorize Amazing Medical Associates to provide medical information to my insurance carrier and I authorize payment of insurance benefits to the Amazing Medical Associates for services provided to me.

AUTHORIZATION TO LEAVE VOICE MAIL AND/OR EMAIL
I authorize Amazing Medical Associates to leave messages by voice or email at my home reminding me of scheduled medical appointments and other medical services for myself and/or my family members. I understand, however, that no message will be left regarding confidential medical information unless specifically authorized by my doctor and myself.

By signing this form, I am consenting to Amazing Medical Associates' use and disclosure of my protected medical information as detailed above. However, I may give notice to restrict the use of such information and revoke my consent in writing. I understand that I have the right to review the Notice of Privacy Practices for a more complete description of such uses and disclosures prior to signing this consent.

CARE CONTINUUM
By signing this form, I am choosing to become a patient/member of the AMG/Inspiration Home Health/Hospice Continuum. By structuring the program this way, it maintains the integrity and viability of a home care model. This provides a more efficient and seamless interaction for my medical needs. I agree and choose to elect AMG services for any of my primary care needs, I agree and choose to elect Inspiration Home Health or Hospice for any of my home health and hospice related needs.

CONSENT TO TREATMENT BY PHYSICIAN ASSISTANT OR NURSE PRACTITIONER
I agree to be treated by a Nurse Practitioner or Physician Assistant, a healthcare professional licensed in Utah.

Signature of Responsible Party: _____ Relationship: _____

Print Name of Responsible Party: _____ Date: _____

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Consent To Bill Form

Financial Policy
Our practitioners share your concern about the cost of medical care. We therefore invite you to discuss frankly with us any questions you may have regarding our services or fees. If you anticipate problems with your insurance coverage or personal payment, you are encouraged to contact our Practice Manager. The earlier we know about a possible problem, the better we can develop suitable options for you.

Agreement
This is an agreement between Amazing Medical Associates, as provider and creditor, and the patient named on this form. By executing this agreement, you, the patient, are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. All balances are expected to be paid in full upon receipt of this statement. Payments not received within 30 days of receipt of statement are considered past due and could be subject to late fees or interest penalties.

Payment Options If You Have Insurance:
A. You must pay all deductibles, co-pays, and co-insurances.
B. You may choose to pay for all services in full and file with your insurance company. You understand that your visits may be billed under Amazing Medical Associates or Dr. Erika Noonan through the standard billing procedures allowed by your insurance company.

Insurance: We will bill your insurance; however, the insurance company makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If the insurance does not pay within 60 days from the time services are rendered, the balance may be billed to you.

Disputes: You should notify us of discrepancies immediately. We will investigate and resolve your dispute within 30 days. Please email our Practice Manager, Keric Kanistanaux, at kkanistanaux@asf-amg.com, or call 801-716-7008.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we are forced to refer your collection balance to a lawyer, you agree to pay all lawyer fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Salt Lake City, Utah.

Signature of Responsible Party: _____ Relationship: _____

Print Name of Responsible Party: _____ Date: _____

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Medication /Allergy List

Patient Name: _____ DOB: _____

CURRENT PRESCRIPTION MEDICATIONS

(may attach med list if you prefer)

Name of Medication	Strength of Medication	Frequency
Example: Lisinopril	*Example: 10 mg*	*Example: 1 pill every morning*

CURRENT OVER-THE-COUNTER MEDICATIONS AND SUPPLEMENTS

Name of Medication/Supplement	Strength of Medication	Frequency

ALLERGIES

□ No Known Drug Allergies □ Environmental/Seasonal Allergies □ Latex Allergy

List Allergies	Reaction

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Release of Information Form

I, _____ DOB: _____ hereby authorize and request for:

(please list providers you've seen in the last 18 months)

Provider	Phone	Address
Provider	Phone	Address
Provider	Phone	Address

To release all medical records in your possession, concerning my illness and/or treatment during the past 2 (two) years from this request to the below named.

AMG Senior Medical Group
434 West Ascension Way, Suite 225
Murray, UT 84123

Secure Fax: 888-990-1557

Secure Email: schedule@asf-amg.com

Signature of Responsible Party: _____ Relationship: _____

Print Name of Responsible Party: _____ Date: _____

Who may we share your protected health information with? ** If an individual is not listed, we will not release any information about you. **		
Name:	**Relation:**	**Phone Number:**

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Pre-Visit Health Intake Form

AMG At Home Program

Date:_____ Name of Patient:_____ DOB:_____

Patient Address:_____

Patient Phone:_____ Patient Gender: Patient Email:_____

PCP Name:_____ Specialists:_____

Do you plan to continue seeing your PCP? Home Health Agency:_____

Which medical conditions do you have now, or have you had in the past?
Please check all that apply.

☐	Liver Disease/cirrhosis	☐	Hepatitis
☐	Bleeding problems	☐	Difficulty swallowing
☐	Kidney disease	☐	Diabetes
☐	Dementia or Alzheimer's disease	☐	Parkinson's disease
☐	Stroke	☐	Epilepsy or seizures
☐	Neuropathy/nerve damage	☐	Depression
☐	Anxiety	☐	Thrombosis/blood clots
☐	Cancer	☐	Abnormal weight loss/gain
☐	Change of appetite	☐	Persistent cough
☐	Difficulty breathing or shortness of breath	☐	Wheezing
☐	Coughing up blood	☐	Chest pain or tightness
☐	Swelling of feet	☐	Irregular heart beat
☐	Rapid heart beat	☐	Black bowel movements or bloody stools
☐	Abdominal pain	☐	Frequent nausea or vomiting
☐	Frequent diarrhea	☐	Sudden urge to void
☐	Frequent urination	☐	Painful urination
☐	Frequent bladder infections	☐	Frequent headaches
☐	Frequent dizzy spells	☐	Passing out or fainting
☐	Paralysis, leg or arm weakness	☐	Numbness or loss of feeling
☐	Hallucinations	☐	Memory problems

How would you describe your overall health? Excellent☐ Good☐ Fair☐ Poor☐

Do you have a driver's license? _____ If yes, are you currently driving?___

Do you use a cane, walker or wheelchair to get around?____

Have you had a fall in the past year?_____ Describe the fall:_____

AMG SENIOR MEDICAL GROUP
—A Step Forward Company—

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Have you ever smoked cigarettes? _____ If yes, do you currently smoke?____

How many packs per day?_____ If no, when did you quit? _____

For how many years did you smoke?_____

Do you have a medical Durable Power of Attorney?_____

Who should speak for you if you are unable to make health decisions?

Name:_____ Relationship to you:_____ Phone:_____

Do you have a living will, advanced directive or POLST form?_____

Please indicate if you need help doing the following tasks and who helps you:

TASK	No Help Needed	Help Needed	Who Helps?
Feeding yourself			
Getting from bed to chair			
Getting to the toilet			
Getting dressed			
Bathing or showering			
Walking across the room			
Using the telephone			
Taking your medications			
Preparing meals			
Managing money			
Doing laundry			
Cleaning your house			
Shopping for groceries			
Driving			
Climbing a flight of stairs			

Please list specific health concerns that you would like the practitioner to know about before your visit:

_____

_____

_____

Please save this completed form to your computer and email it to schedule@asf-amg.com. You may also fax it to 888.990.1557.