PARKER AT YOUR DOOR
PARKER JEWISH INSTITUTE

NYC –Metro Physician Services PC
Consent for Service

Patient's Name: _____

I hereby consent and authorize NYC –Metro Physician Services PC, its agents and associates to provide care and treatment to me in my home. 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 your home or any other satellite location. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend 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 forms prior to the test(s) or procedure(s).

Authorization For Release of Information
I hereby consent and authorize NYC –Metro Physician Services PC to release and receive protected health information for the purposes of treatment and healthcare operations. The exchange of information may occur between, but is not limited to, physician, other healthcare providers and regulatory and/or accrediting reviewers.

Supplies
I understand that I will be informed of any DME (Durable Medical Equipment) that is recommended by the care team and that right to decide not to have the equipment ordered. I understand that this equipment may be paid for by my health plan (Medicare, Medicaid). I will be informed of any copays and/or charges I am liable for before equipment is ordered

Consent
This consent to Service is applicable to NYC –Metro Physician Services PC. I understand what I have read what was explained to me and agree to the agreement. Additionally, I understand that either party may terminate this agreement for any reason and/or any time.

SIGN HERE

Signature of Patient or Representative Date

Name of Patient or Representative Relationship to Patient

Name of Witness

Signature of Witness Date

PARKER AT YOUR DOOR
PARKER JEWISH INSTITUTE

NYC-METRO PHYSICIAN SERVICES PC
FINANCIAL POLICIES AND PATIENT RESPONSIBILITY

Please complete all sections.

Date: _____

Last Name: _____ First: _____ S.S#: _____

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

Sex: _____ Age: _____ Date of Birth: _____ Marital Status: _____

Phone Numbers: Home: _____ Cell: _____ Work: _____

Email: _____ Pharmacy: _____ Phone: _____

Emergency contact (not living with you): Last: _____ First: _____

Relationship to Patient: _____ Phone: _____ Alt: _____

Address: _____

I understand that NYC-Metro Physician Services PC, my treating physicians and their respective designees, will use and disclose my health information for all purposes necessary for treatment, payment and health care operations, including but not limited to release of information requested by my insurance company (or carrier) and any information necessary for discharge planning purposes.

- **ASSIGNMENT OF INSURANCE:** I hereby authorize my insurance benefits to be paid directly to NYC-Metro Physician Services PC. I understand I am financially responsible for non-covered services. I authorize the release of any medical or other information necessary to process insurance claims on my behalf.

- **FINANCIAL LIABILITY:** I have been provided a copy of the NYC-Metro Physician Services PC financial policies and agree to the specified terms. I hereby agree to pay all charges due (or to become due) to NYC-Metro Physician Services PC for care and treatment, including co-payments and deductibles as provided under my plan. Benefits, if any, paid by a third party, will be credited on account. I understand that I will be responsible for any charges if any of the following apply:

    - My health plan requires prior referral by a Primary Care Physician (PCP) before receiving services at NYC-Metro Physician Services PC and I have not obtained such a referral or I receive services in excess of the referral, and/or
    - My health plan determines that the services I receive at NYC-Metro Physician Services PC are not medically necessary and/or not covered by my Insurance plan, and/or
    - My health plan coverage has lapsed or expired at the time I receive services at NYC-Metro Physician Services PC, and/or
    - I have chosen not to use my health plan coverage, and/or
    - The physician I see does not participate with my health care plan.

Responsible party agrees to fill out new form when any of the above information changes. Wrong information may result in incorrect filing and subsequent charges.

PRIMARY INSURANCE:

Insurance Company:_____ **Contact #:** _____

Subscriber ID_____**Name of Insured Card**_____**Signature**_____

SIGN HERE

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Patient Name: _____ Date of Birth: _____

SECONDAY INSURANCE:

Insurance Company:_____ **Contact #:** _____

Subscriber ID_____**Name of Insured Card**_____**Signature**_____ SIGN HERE

TERTIARY INSURANCE:

Insurance Company:_____ **Contact #:** _____

Subscriber ID_____**Name of Insured Card**_____**Signature**_____ SIGN HERE

MEDICARE SIGNATURE ON FILE (Medicare Patients Only): I request that payment of authorized Medicare benefits be made either to me or on my behalf to all providers who treat me or any services furnished to me by those providers. I authorize the holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Patient's Medicare Number_____**Patient**_____**Signature**_____ SIGN HERE

- **ANCILLARY SERVICES:** I understand I may receive certain ancillary medical services while I am at NYC-Metro Physician Services PC; such as, x-rays, imaging services, and laboratory tests. I understand that some physicians may not provide services in my presence, but are actively involved in the course of diagnosis and treatment. I hereby authorize payment directly for these services under the policy(s) or plan(s) issued to me by my insurance carrier. I understand that I may incur additional charges as a result of these ancillary services; I agree to pay all charges due with respect to such services to the extent the charge is due after credit is given for benefits paid on my behalf by any third party payor.

- **PRESCRIPTIONS:** I acknowledge that my treating physician may obtain a prescription history if necessary.

  Preferred Pharmacy / Location:_____ Phone #: _____

- **CANCELED OR NO-SHOW APPOINTMENTS:** I understand that, based on the policy of individual physician offices, I may incur a cancelation fee if I do not provide the required notice of cancelation, or if I do not keep my appointment and have not canceled.

Health Maintenance Organizations (HMO) are those with co-pay per visit. All co-pays are collected at the time of the visit. In order to see you, we must be designated as your PCP with your HMO.

Preferred Provider Plans or Choice Option Plans (PPP, PPO, POS) are plans that allow you to choose your provider. There may be a deductible and/or co-pay collected at the time of the visit. If we are not on your preferred list or are outside the preferred panel the paid benefits may be at a lower percentage (for example 70% instead of 80%). You will be expected to pay the difference at the time of service.

Indemnity plans are those with deductibles, pay a percentage of the bill and allow you to choose your physician. You are responsible for the amount not covered by insurance.

Medicare If you have supplemental GAP coverage, secondary insurance, we will file claims for your services to both carriers. Deductibles, co-payments, and fees for any non-covered services are due at the time of service. All Medicare patients are required to sign a waiver indicating that they understand that they will be responsible for non-covered services denied by Medicare, GAP coverage, or their supplement insurance carrier.

Patient Responsibility:

- You are responsible for all charges resulting from treatment provided by NYC-Metro Physician Services, PC. We bill most insurance carriers. However, primary responsibility for the account is yours.
- Your co-payment is always due at the time of service; if co-pays are not paid at the time of service there is a $10.00 billing fee that will be added to your balance.

PARKER AT YOUR DOOR
PARKER JEWISH INSTITUTE

Patient Name: _____ Date of Birth: _____

- Any remaining balance owed by you is due when you receive your first bill, unless other financial arrangements are made. If you have a delinquent balance, we may ask you to make a payment at the time of your next visit with us. Balances due by patients under $10.00 will not be sent a statement due to cost; these balances will be collected from the patient at the next office visit.

Insurance Billing:

- It is your responsibility, (or that of the financially responsible party), to provide current, accurate insurance billing information. As a courtesy, we will bill your insurance, however, you (or the financially responsible party) are responsible for any amounts that insurance does not pay. If your insurance information changes, please provide the new insurance information prior to receiving additional care. If your insurance coverage is not in effect at the time you receive care, or if your plan does not cover the services that you receive, you will be responsible to pay the charges.
- Medicare: We participate with Medicare. We will bill Medicare as your primary insurer. We will also bill your supplement insurance provider.
- Medicaid: We do not accept Medicaid. All Medicaid patients are required to sign a waiver indicating that they understand that they will be responsible for the non-covered services by Medicaid.
- I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network amounts, usual and customary limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment whenever required.
- I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider is not recognized by insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.
- I understand and agree it is my responsibility to know if my PCP (primary care physician) choice had been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.
- I understand that any account balance that is 90 days past due will be sent to collections and that it is my responsibility to ensure that my insurance and contact information is always current and updated.

Non-Insured Patient Payment:

If you do not have insurance, we will provide your care on cash for services basis. A $100 deposit is due at the time of the visit for all private pay **new patient** visits. A $50 deposit is due at the time of the visit for all **established patient** visits. Patients will be billed for any remaining balance. Services do not include medications, blood draws, lab work, or administration of immunizations).

Check Returned:

It is our office policy to charge a **$20.00** fee for checks that are returned

Delinquent Accounts:

Accounts that become delinquent may be subject to collection activity, and a $20.00 late fee may be added to cover the cost of additional handling required.

Authorization to Release Information:

- In obtaining payment for services, I authorize my healthcare provider, NYC-Metro Physician Services, to furnish information from my medical record to any company that may be responsible for payment of all or part of my provider charges, including my insurance companies and their representatives, and my employer or union if they are involved in processing the claim. For further information regarding disclosure of health information, please refer to the Notice of Privacy Information Practices.
- If I have been referred by, or am being referred to, another healthcare provider, I authorize NYC-Metro Physician Services to release my medical information to this provider for continuing care.
- I also assign NYC-Metro Physician Services all payments to which I am entitled for medical expenses related to the services reported herewith. I understand I am financially responsible for all charges whether covered by insurance or not. I also understand that balances outstanding for more than 90 days may be subject to a processing fee.

PARKER AT YOUR DOOR
PARKER JEWISH INSTITUTE

Patient Name: _____ Date of Birth: _____

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any medical service or visit, preventive exam or physical, lab testing, x-ray, EKG, and any other screening service or diagnostic testing ordered by the physician or the physician's staff. I further agree to pay the balance of the charges not paid by my insurance. Any balance that is not paid within 45 days will also be my responsibility. I hereby authorize the release of any information necessary to secure payment of benefits. I also authorize the use of this signature on all insurance submissions. If the patient is a minor, I as a legal guardian give consent for treatment for this and future services rendered. I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure the payment of services.

I have been provided the NYC-Metro Physician Services PC Patient Financial Policies. I understand the information listed above which has been fully explained to me.

SIGN HERE

_____ _____
Patient Signature **Date**

Responsible Party Name: _____
(Please print name of Responsible Party if different from Patient)

_____ _____
Responsible Party Signature **Date**

PARKER AT YOUR DOOR
PARKER JEWISH INSTITUTE

NYC –Metro Physician Services PC

I have received a copy of the

- Patient Rights
- Patient Responsibilities
- Advanced Directive
    - Including Health Care Proxy and Living Will
- Notice of Privacy Practices
- Summary of Financial Policies
- Consent for Treatment

Print First and Last Name

SIGN HERE

Signature of Client/Representative

PARKER AT YOUR DOOR
PARKER JEWISH INSTITUTE

NYC-Metro Physician Services, PC

NOTICE OF AUTHORIZATIONS AND ASSIGNMENT OF BENEFITS

Patient Name_____ _____ ____

Date of Birth_____ Date: _____

ASSIGNMENT OF INSURANCE BENEFITS:
I HEREBY AUTHORIZE DIRECT PAYMENT OF INSURANCE BENEFITS TO NYC-METRO PHYSICIAN SERVICES, PC or the physician individually for services rendered to my dependents, or me, by the physician or those under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that NYC-METRO PHYSICIAN SERVICES, PC is unable to collect from my insurance carrier for whatever reason.

AUTHORIZATION TO RELEASE NON-PUBLIC INFORMATION:
I certify that I have read and been offered a copy of the NYC-METRO PHYSICIAN SERVICES, PC "Notice of Privacy Practices". I hereby authorize NYC-METRO PHYSICIAN SERVICES, PC and/or the physician individually to release any of my or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

MEDICARE / MEDICAID INSURANCE:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to NYC-METRO PHYSICIAN SERVICES, PC or the physician on my behalf.

LAB/X-RAY/DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balances due for these services if they are not reimbursed by my insurance for whatever reason.

PRESCRIPTIONS:
I acknowledge that my treating physician may obtain a prescription history if necessary.

Preferred Pharmacy / Location:__ _ Phone #: _____ _____

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing, and treatment as directed by my NYC-METRO PHYSICIAN SERVICES, PC physician or those under his/her supervision.

I have read and agree to all of the above information:

PATIENT SIGNATURE: __ _____DATE: _____ *SIGN HERE*

GUARANTOR SIGNATURE:_____DATE: _____
(If different from patient)

GUARANTOR NAME (Please Print):

PARKER AT YOUR DOOR
PARKER JEWISH INSTITUTE

NYC–Metro Physician Services PC
NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

NYC –Metro Physician Services PC (Parker at Your Door) Notice of Privacy Practices provides information about how we may use and disclose health information about you. We encourage you to review it carefully.

I acknowledge that I have received the Notice of Privacy Practices

SIGN HERE

Signature of Patient or Patient's Representative Date

Print Name of Patient

Print Name of Representative (if applicable)

Representatives Relationship

Inability to Obtain Acknowledgement (to be completed by staff)
If it is not possible to obtain the individual's acknowledgement, please document your efforts to obtain acknowledgement and the reason why it was not obtained.

- ☐ Patient Unable to Sign
- ☐ Patient Refused to Sign
- ☐ Notice of Privacy and Acknowledgement Mailed to Patient and was not returned
- ☐ Other reason (specify below)

SIGN HERE

Signature of NYC-Metro Physician Sevices, PC Representative Date

NYC-Metro Physician Services, PC

PARKER AT YOUR DOOR
PARKER JEWISH INSTITUTE

VERBAL DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name_____

Date of Birth_____Medical Record Number_____

HIPAA (The Health Insurance Portability and Accountability Act) gives you the right to request that we communicate financial and or medical information to you in confidence by a particular method. In order to protect the privacy and confidentiality of your information, please complete the following. This form will tell us how you wish to be contacted and with whom we may discuss your healthcare, insurance and billing questions.

I give permission for (check all that applies):

☐ Correspondence from NYC-Metro Physician Services may be sent to my attention in a sealed envelope marked "CONFIDENTIAL."

☐ Confidential messages (such as appointment reminders, normal test results) may be left on my home answering machine or voicemail. HOME PHONE #_____

☐ Confidential messages (such as appointment reminders, normal test results) may be left on my work voicemail. WORK PHONE # _____

☐ Confidential messages (such as appointment reminders, normal test results) may be left on my cell phone voicemail. CELL PHONE # _____

I hereby authorize NYC-Metro Physician Services to release PHI to the person(s) listed below: (i.e. spouse, family members, friends, caregiver, etc.).

Name	Phone Number	Relationship to Patient
Name	Phone Number	Relationship to Patient
Name	Phone Number	Relationship to Patient

I understand that I may revoke this authorization at any time by notifying Creekside Medical in writing and the revocation will be effective on the date noted, except to the extent action has already been taken in reliance upon it.

I understand that information used or disclosed pursuant to this authorization may be subject to re- disclosure by the recipient and may no longer be protected by federal or state privacy regulations.

SIGN HERE

Patient or legally authorized individual signature Date Time

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

NYC – Metro Physician Services PC

COMMONWELL/CARE QUALITY ENROLLMENT CONSENT FORM

Thank you for choosing NYC-Metro Physician Services, PC (Parker at Your Door). Our goal is for you to receive the best care possible so you can return to optimal health. As part of your continuum of care, NYC-Metro Physician Services participates in CommonWell. This service allows the network of participants to securely identify, send, and receive your accurate and approved medical information. This free service is offered so that your health information may be quickly and securely available to your doctors who participate in the CommonWell/Care Quality network. With your consent, your protected health information will be available to participants of CommonWell. Your enrollment will bring you better care with fewer delays and hassles and, in turn, greater peace of mind. With timely access to information from other doctors you have seen, your doctors can make the best decisions possible to optimize your health.

Authorization for Release of Protected Health Information

I authorize NYC-Metro Physician Services to disclose information related to my visit to the CommonWell network with this consent. I understand that the purpose of this disclosure is for continuity of care. Furthermore, I understand that this authorization is revocable by me at any time if I provide a written, signed notice except to the extent that action has been taken on this release.

☐ (Please check if this applies.) I want to participate in the CommonWell/Care Quality Program

☐ (Please check if this applies.) I choose not to participate in the CommonWell/Care Quality Program

_____ Patient Name (Print.)

_____ Patient Signature | Date/Time

_____ Witness Signature| Date/Time

_____ Parent/Legal Guardian, or Authorized Representative Signature

NYC-Metro Physician Services, PC

Patient Portal Authorization Form

Purpose of this Form:

The Patient Portal is designed to improve physician and patient communication. Once you are registered as a patient and have provided us with your secure email you will be assigned a username and password. After you registered with the Patient Portal you will be allowed the following:

- Update your contact information
- Request your own appointments
- Communication of laboratory results from staff to patient
- Request prescription refills
- View your medical summary, medication list, treatment history and visitation dates
- Receive reminders through your email
- View current and past statements

The following will **NOT** be accepted through Patient Portal:

- Receiving advice on the best course of treatment for your medical problem. All diagnosis will be made by your provider when your are seen for an office visit.
- Request for narcotics/controlled medications.
- Request for refill for medication not currently being prescribed by a NYC-Metro Physician Services Medical Provider

Online communications should never be used for life threatening, emergency communications or urgent requests. If you have an emergency or an urgent request, you should contact 911 or your physician via telephone.

Reminders for Patient Portal:

- You will have 10 failed log in attempts before the account is locked
- You will be receiving reminders via email from reminders@eclinicalmail.com regarding your appointments, test results posting etc. Please make security adjustments to your email or computer to receive our emails.
- You will not be able to reply to our email reminders from reminders@eclinicalmail.com. If you have any questions regarding these emails please send us a message via Patient Portal.
- If you forget your password you may request another one through Patient Portal by clicking on the"Forgot Password" link.
- After you are finished accessing Patient Portal be sure to logout and close your browser. This reduces the risk of someone else accessing your private information.
- Avoid using a public computer to access Patient Portal.
- Patient Portal is provided as a courtesy service for our patients. There is no service fee. However if the patient abuses or misuses Patient Portal we reserve the right to terminate the patient's account.
- Our hours of operation are 8:30 am - 4:30 pm Monday-Friday. We encourage you to use the web site at any time; however messages are held for us until we return the next business day. Messages are typically handled within 2 business days. If your doctor is out of the office, your request may be held until your doctor returns to the office.
- We reserve the right to suspend or terminate the patient portal at any time and for any reason.

How the Secure Patient Portal Works:

A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computer and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

Protecting Your Private Health Information and Risks:

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect. We will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors:

1) The secure message must reach the correct email address, and
2) Only the correct individual (or someone authorized by that individual) must be able to have access to the message.

Only you can make sure these two factors are present. **It is imperative that our practice has your correct e-mail address and that you inform us of any changes to your e-mail address.**

You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us. You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, including the Policies and Procedures set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. I understand and agree with the information that I have been provided.

Secure Email Address: _____

Print name: _____ DOB: _____

Patient Signature: _____ Date: _____ SIGN HERE

Complete the following if the email address does not belong to the patient: Please note portal access is not available for patients aged 13-18 years.

Name of Health Care Proxy/Guardian requesting access:

_____

Last Name Middle Initial First Name

_____

Relationship to the Patient Date

Patient Portal URL's:

PARKER AT YOUR DOOR
PARKER JEWISH INSTITUTE

Authorization for Storage and Ongoing Credit Card Charges

Authorization

As a service to our patients we now have the ability to securely store your credit card(s) in our system. This will speed up your check-in process in the office and allow you to pay for your visit if you do not have your credit card with you. Your full credit card number(s) will never be viewable or accessible to staff. We will also never charge for any services that you do not authorize.

I authorize NYC-Metro Physician Services PC to store my credit card information and bill the credit card on file for services I receive at NYC-Metro Physician Services PC. I understand that NYC-Metro Physician Services PC will only charge this credit card for amounts authorized by me and that upon your request a receipt will be provided for all charges processed. I will notify NYC-Metro Physician Services PC in writing if I no longer want my credit card information maintained or automatically billed. I understand that if I do not want my credit card billed for this purpose, I am still responsible for these fees and will be billed accordingly.

Patient Name _____

Print Name (as it appears on credit card): _____

Credit Card #: _____

Expiration Date:_____ CVV: _____

SIGN HERE

Signature of Cardholder: _____

Date: _____

PARKER AT YOUR DOOR
PARKER JEWISH INSTITUTE

NYC – Metro Physician Services PC

Dear Patient,

As a patient with two or more chronic conditions, you may benefit from a new program that NYC-Metro Physician Services offers all Medicare patients. Our goal is to make sure you get the best care possible from everyone that is involved with your care. We can help coordinate your visits with other doctors, facilities, lab, radiology, or other testing; we can talk to you on the phone about your symptoms; we can help you with the management of your medications; and we will provide you with a comprehensive care plan. Medicare will allow us to bill for these services during any month that we have provided at least 20 minutes of non-face-to-face care of you and your conditions. You must provide your consent to participate once a year.

Sometimes other staff from our practice will talk to you or handle issues related to your care, but please know that your assigned clinician will supervise all care provided by our staff or clinicians who may be involved in your care.

You agree and consent to the following:

- As needed, we will share your health information electronically with others involved in your care. Please rest assured that we continue to comply with all laws related to the privacy and security of your health information.

- We will bill Medicare for this chronic care management for you once a month. The fee for this service allowed by Medicare is between $49.74 and $94.68 of which your portion will be 20% or approximately $18.94. This amount may be covered by your secondary insurance provider. Although you may or may not come into the office every month, your account will reflect this charge and you will be responsible for payment. Our office will have a record of our time spent managing your care if you ever have a question about what we did each month.

- Only one physician can bill for this service for you. Therefore, if another one of your physicians has offered to provide you with this service, you will have to choose which physician is best able to treat you and all of your conditions. Please let your physician or our staff know if you have entered into a similar agreement with another physician/practice.

- A Comprehensive Care Plan from our practice to help you understand how to care for your conditions so that you can be as healthy as possible.

- Discontinue this service at any time for any reason. Because your signature is required to end your chronic care management services, please ask any of our staff members for the CCM termination form.

PARKER AT YOUR DOOR
PARKER JEWISH INSTITUTE

NYC – Metro Physician Services PC

Dear Patient:

Congratulations for taking a step toward managing your health by participating in the NYC – Metro Physician Services PC Chronic Care Management (CCM) program. CCM is a new model of care designed to improve the coordination of your health care with an emphasis on your overall well-being.

We believe that to achieve this goal there must be a partnership between the patient and their medical provider. By remaining involved in the decisions regarding your health, health care and lifestyle, we can develop a stronger relationship with you.

BEFORE YOUR NEXT CCM ASSESSMENT CALL PLEASE USE THIS HANDY CHECKLIST

- ☐ Make a list of any questions you have about your health including questions about dietary recommendations and lifestyle.
- ☐ Inform the CCM nurse of any other health care providers that you have visited in the last month and the reason why you visited them. This includes urgent care or the ER.
- ☐ Have a list of all of your prescribed medications ready, over-the counter, herbal and dietary supplements. Inform the CCM nurse of any refills that you require.
- ☐ Inform the CCM nurse of any new problems that may have developed in the last month.
- ☐ Confirm the date of your next CCM nurse assessment call as well as the date of your next office visit with us.
- ☐ As a reminder, please use the dedicated phone number that was provided to you during your first CCM nurse assessment call so you can call us after hours if necessary, this provides you 24/7 access to your physician or to the covering physician partner.
- ☐ Register for our patient portal. This is a good way to communicate with your doctor and CCM nurse as well as to view your care plan.
- ☐ If you want to designate a caregiver to have access to your record, please ask our office for the forms to sign. With continued partnership in the CCM program, we hope to optimize your health, increase your quality of life and prevent hospitalization. We look forward to continuing to serve you.

Sincerely,

Parker at Your Door

PARKER AT YOUR DOOR
PARKER JEWISH INSTITUTE

NYC – Metro Physician Services PC

Our goal is to provide you with the best care possible, to keep you out of the hospital, and to minimize costs and inconvenience to you due to unnecessary visits to doctors, emergency rooms, labs, or hospitals. We know your time and your health is valuable and we hope that you will consider participation in the program with our practice.

Please feel free to call us if you have any questions!

The number to reach Parker at Your Door is (718) 289-2606

I agree to participate in the Chronic Care Management program. Yes ☐ No ☐

_____ _____

Patient Signature Date