Welcome Letter & Guide for Our Residents and Families

Welcome to Hartley Health and Wellness Associate, LLC and thank you for choosing us as your provider for primary medical care.

Hartley Health and Wellness is a **Nurse Practitioner Led-Clinic (NPLC)**. Nurse Practitioner Led clinics are an innovative model of delivery of comprehensive primary health care in independent living and assisted living communities and homes. We have three collaborating physicians, Dr. Michelle A. Huggins and Drs. Crispin and Sabine Barlatt.

Our **primary goal** is to provide quality medical care which is easily accessible and responsive to you in your time of need.

Our staff includes a comprehensive interdisciplinary team of professionals who will consistently strive to exceed your expectations to ensure that your experience with us is as comfortable as stress-free as possible.

We Are A Patient Centered Mobile Service

As a **Patient Centered Mobile Service**, our approach is to provide our patients with comprehensive health care, which is focused on all aspects of your health and overall wellbeing, including emotional, family and social concerns. We use a team-based approach to address the physical, emotional, mental and social aspects of patients' health.

A "**Patient Centered Mobile Service**" makes it easier and more comfortable for you to access care on a day to day basis by strengthening your relationship with your primary care provider and the team responsible for your care. With a medical home, your quality of care will be significantly improved, and it will take less time for you to get the care when you need it.

Benefits of A Patient Centered Mobile Service:

- Your medical home team will have an ongoing relationship with you and your family to manage your healthcare needs.
- You will see the same team each visit and they will assist you in coordinating care with other providers, specialists, and community resources if needed.
- Your team will have access to all your health information through electronic records in order to effectively manage your care.

3755 Sixes Road Ste. 203 Canton, Georgia 30114
Office: 678-880-6698 Fax: 470-299-9936

- You will have easy access to care through other methods of communication with your team.
- We can provide interim care (care between visits to your PCP) or we can provide total primary care to you and your love ones.

We look forward to taking care of your medical needs!!!

Sincerely,

Shanda T. Hartley, FNP-C

Shanda T. Hartley, FNP-C

Lead NP/Co—Owner

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In Association with:

Michelle A. Huggins, MD

Crispin Barlatt, MD

Sabine Barlatt, MD

Please complete the attached patient information sheet. Return it with the following:

- Current copy of primary and secondary insurance cards {front and back)
- Current list of Medications (MAR - the facility can provide this for you)
- Copy of POA, DNR, and Advanced Directive paperwork

Please sign the highlighted areas to complete your required paperwork

Please make sure all paperwork is completed and all documents are attached to avoid delay in processing and admission.

You may return this email: admin@hartleyhealthandwellness.org or fax: 470-299-9936.

Please feel free to contact our office at 678-880-6698 with any questions or concerns.

Our Practice accepts Medicare insurance along with all PPO plans, including HMO plans currently.

Thank You,

Danielle K. Hodge
Office Manager

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Personal Information

Telephone Number: (678) 880-6698
Fax Number: (470) 299-9936
Email: admin@hartleyhealthandwellness.org

Full Name:

_____
Last First MI

Address:

_____
Street Address Apartment/Unit #

_____
City State Zip Code

Home Phone: _____ Mobile Phone: _____

Birth Date: _____ Sex: M F Race: _____ SSN: _____

Code Status: Full Code DNR Advanced Directive? Yes No *please attach all paperwork

Medicare #: _____ Is Medicare the Primary? Yes No

Insurance ID#: _____ Group ID# _____

Please circle one: Medical/POA Emergency Contact

Name:	Relationship:
Address (incl. city, state, zip):	
Telephone:	Email:

Please circle one: Medical/POA Emergency Contact (if different from above)

Name:	Relationship:
Address (incl. city, state, zip):	
Telephone:	Email:

Name of Facility you're going to: _____

Date of Admission: _____

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Facility's Pharmacy Information

Pharmacy Name:	
Pharmacy Address (incl. city, state, zip):	
Pharmacy Phone #:	

Health Information and History

Allergies:	Reactions to Allergies:

Past Medical History	Past Surgical History

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Authorization to Release Medical Records

Name of Patient_____ Date(s) of Service_____

Date of Birth_____ Social Security Number_____

I, the undersigned, authorize the release of or request access to the information specified below from the medical record(s) of the above named patient.

PATIENT INFORMATION IS NEEDED FOR:

Continuing Medical Care	Military	Social Security/Disability
Insurance	Personal Use	Other_____
Legal Purposes	School	_____

INFORMATION TO BE RELEASED OR ACCESSED:

History & Physical	Consultation Report	Emergency Room Record(s)
Operative Reports	Discharge/Death Summary	Face Sheet
Lab/Path Reports	X-Ray Reports/Images	Other_____

The above information may be released (specify name and title of the individual or name of the organization to which records are to be released and the appropriate address):

TO: Hartley Health and Wellness Associates, LLC **Office Number: 678-880-6698**

3755 Sixes Road, Ste. 203, Canton, GA 30114 **Office Fax: 470-299-9936**

FROM:

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

_____

_____

Address (incl. city, state, zip)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no later than protected. I understand that the specified information to be released may include but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire six (6) months from the date of my signature unless I revoke the authorization prior to that time.

Date_____ **Signature**_____ **Relationship to Patient**_____

Print Name_____

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I hereby signed that I received and read the Hartley Health and Wellness Associates, LLC Notice of Privacy Practices (Contact office for copy of privacy practice at 678-880-6698)

Name: _____ Date: _____

Signature: _____

I hereby authorize my insurance company, including Medicare if I am a Medicare Beneficiary, to make payments to Hartley Health and Wellness Associates, LLC for medical or surgical services or items rendered by Hartley Health and Wellness Associates, LLC. Should my insurance carrier deny Hartley Health and Wellness Associates, LLC payment, I understand that I am financially responsible for the charges. I authorize Hartley Health and Wellness Associates, LLC to release any and all of my records to my insurer, or any other third-party payer, legally responsible for the payment of medical expenses. I certify that the information provided or to be provided by me is correct and complete to the best of my knowledge. It is my responsibility to update any all personal, insurance and health information.

Name: _____ Date: _____

Signature: _____

By signing below, I agree that Hartley Health and Wellness Associates, LLC will be assuming responsibility for resident's primary care needs. Visits will be scheduled every 4-6 weeks (quarterly at residents'/POA request)

I hereby authorize Hartley Health and Wellness Associates, LLC to provide medical care services to:

Resident's Name: _____

Name: _____ Date: _____

Signature: _____

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AGREEMENT TO RECEIVE CHRONIC CARE MANAGEMENT SERVICES

Medicare, effective January 2015 covers chronic care management (CCM) services. The professional/practice named below, can provide the CCM services, has informed me that I would benefit from CCM services, including those provided when we are not together in person, and that I meet the clinical eligibility to receive CCM services based on my diagnostic conditions.

The CCM services the professional/practice will provide me under this agreement include the following:

- Access to my care team 24-hours-a-day, 7-days-a-week, including telephone access and other non-face-to-face means of communication (e.g., E-Mail)
- The ability to get successive, routine appointments with my designated primary care provider or member of my care team
- Care management of my chronic conditions, including timely scheduling of all recommended preventive care services, medication reconciliation, and oversight of my medication management
- Creation of a comprehensive plan of care for all my health issues that is specific to me and congruent with my choices and values

Management of my care as I move between and among health care providers and settings including:

- Referrals to other health care providers
- Follow-up after I visit an emergency department
- Follow-up after I am discharged from the hospital or other facility (e.g., skilled nursing facility)
- Coordination with home- and community-based providers of clinical services

My signature below indicates my understanding and agreement to receive CCM services and that I understand

- The professional/practice is designated by me for purposes of providing CCM to me and for submitting claims for payment to Medicare for the CCM services
- I will receive a copy of my comprehensive plan of care
- The professional/practice is authorized to electronically communicate my medical information with other treating providers as part of the care coordination involved in CCM services
- Medicare will only pay one professional/practice for CCM services provided to me during a calendar month
- CCM services are subject to the usual Medicare deductible and coinsurance applied to my Medicare Part B services, and
- I can revoke this agreement at any time (effective at the end of the current calendar month) and can choose to receive these services from another professional/practice or not to receive CCM services at all after the calendar month in which I revoke this agreement

This agreement is effective as of the date below.

Professional/Practice: _____

Patient Name (please print):_____

Patient or Guardian Signature:_____

Date: _____

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AGREEMENT OF FINANCIAL RESPONSIBILITIES

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all our patients and residents. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards and pre- approved insurance for which we are a contracted provider and are the designated Primary Care Provider (PCP), if applicable.
- We participate in most insurance plans, including Medicare. If you do not carry insurance that we do business with, payment in full is expected at each visit. If you are insured by a plan that we do business with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- If we have a contract with your insurance company we will bill your insurance company first, less any co-payment (s) or deductible (s), and then bill you for any amount determined to be your responsibility. The process generally takes 45-60 days from the time claim is received by the insurance company. Failure on our part to collect co- payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
- Please be aware that some - and perhaps all - of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
- All patients must complete our patient information form before seeing the provider. We obtain a copy of your current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
- If your insurance changes, please notify us before your next visit so we can make appropriate changes to help you receive your maximum benefits.
- If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, and you may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, we will only be able to treat on an emergency basis.

Our practice is committed to providing the best treatment to our patients/residents. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read the financial policies contained above, and my signature below services as acknowledgment of a clear understanding of my financial responsibility. I understand that if my insurance denies coverage and/or payment for services provided, I assume financial responsibility and will pay all such charges in full.

Signature of Patient/Responsible Party:_____

Name of Patient/Responsible Party:_____

Relationships to Patient/Resident:_____