Patient Enrollment Packet

Enrollment Instructions

Option 1 – Online Enrollment

1. Take a picture of this QR code or visit our website www.greenwellhealth.com/enrollment and click on the 'Digital Enrollment, Enroll Here" button to start the webform.

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2. Complete the webform as accurately as possible.
3. Collect necessary documentation – you will have the option to upload these documents
    a. Copy of Insurance Card(s)
    b. Current Medication List
    c. Legal POA/Guardianship Documents

Option 2 – Complete & Return This Enrollment Packet

1. Complete this Enrollment Packet.
2. Friendly Reminder:
    a. All documents must be filled out as accurately as possible.
    b. Sign where indicated.
    c. Print out forms and complete if necessary.
3. Collect necessary documentation – ALL the following documents must be provided:
    a. Copy of Insurance Card(s)
    b. Current Medication List
    c. Legal POA/Guardianship Documents
4. Return ALL forms and documents to GreenWell Health by (pick a method):
    a. Upload Enrollment Forms, Insurance Card(s), Medication List, and Legal POA/Guardianship Documents using the 'Upload Documents' button on the Enrollment Page: www.greenwellhealth.com/enrollment , look for the "Upload" button to start.
    b. Email completed packet and all documents to enrollment@greenwellhealth.com.
    c. Fax completed packet and all documents to 480-847-2271.
    d. Mail completed packet and all documents to:
        4705 E. Carefree Hwy
        Suite 131
        Cave Creek, AZ 85331

Please Note:

- The enrollment process typically takes 1-2 business days but may take longer if forms are not completed, documentation is not provided in a timely manner, or additional information is required during the process.
- Once enrollment is completed, GreenWell Health will reach out to schedule the patient to be seen at the provider's next visit to the community or residential area.
- If a patient has an "URGENT" need to be seen, please indicate that at the top of the enrollment form. Criteria for needing an urgent visit would include problems that can't wait longer than 24-48 hours but are not life threatening. (Dial 911 for all emergent or life-threatening situations.)
- The patient should continue with their current primary care provider until seen by GreenWell Health.

Welcome to GreenWell Health, your comprehensive at-home primary care provider! Please complete the following form as completely as possible so that we may process your enrollment quickly. Once complete, you will need to submit important patient documents including medical history, medication list, insurance card(s), and POA/Guardianship documents via email or the upload on our webpage (www.greenwellhealth.com/enrollment). We will review all forms and documentation, and once verified will contact you to schedule your first appointment.

☐ **URGENT VISIT** (An urgent visit would include problems that can't wait longer than 24-48 hours but are not life threatening)

Patient Information

Patient Name: _____ SSN: _____

DOB (MM/DD/YYYY): _____ Sex at birth: ◯ Male ◯ Female

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Legally Separated ◯ Widowed/Widower

Who will provide consent to treat? ◯ Patient ◯ POA* ◯ Guardian*

Facility Information

Name of facility/residence: _____ Phone: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Fax: _____

Primary contact or caregiver: _____ Contact phone: _____

Contact email: _____

POA/Guardian Information

Name: _____ Relationship: _____

Phone: _____ Email: _____

I authorize GreenWell Health to leave a message with protected health information at this number ◯ Yes ◯ No

Address: _____ City: _____

State: _____ Zip Code: _____

*Note: POA/Guardian must provide legal documentation establishing the authority to act on the patient's behalf prior to signing consent and authorizations.

Insurance Information

Primary insurance carrier: _____ Policy ID Number: _____

Group #: _____ Subscriber name: _____

Secondary insurance carrier: _____ Policy ID Number: _____

Group #: _____ Subscriber name: _____

Please include a copy of all Insurance Cards

Enrollment Checklist

☐ **Completed Enrollment Form**

☐ **Insurance Cards**

☐ **Medication List**

☐ **POA/Guardianship Documents**

Patient: _____ **DOB:** _____

Name of facility/residence: _____

Consent to Treatment and Acknowledgement of Services

1. Authorization for Disclosure of Health Information

I hereby authorize my previous doctor's office: _____to release my medical information. To be disclosed to: GreenWell Health Medical House Call Service – 4705 E. Carefee Hwy. Cave Creek, AZ 85331. I authorize GreenWell Health to collect all my medical information to help complete the enrollment process.

2. Authorization to Treat Patient Statement

Be it known that I have chosen **GREENWELL HEALTH** to provide my primary medical care. I live at the address above, intend to, or have lived at this location for longer than six months, and I have no other place that is my home. Further, I hereby authorize other medical and mental health professionals and institutions to release to GreenWell Health copies of all records deemed necessary to provide me with medical care. I give specific consent to release information relating to drug and alcohol abuse, mental health and psychiatric disorders, STDs and HIV or AIDS virus. Further, I authorize Greenwell Health to release copies of my medical records to other medical and mental health professionals when appropriate and related to the matter at hand. This release includes the use of an electronic medical record to other sources of medical care, such as pharmacies, etc. Patient information is regulated and protected by HIPAA standards. The signature below authorizes GreenWell Health to treat me.

I certify that I am competent to make this choice and sign these authorizations. I also certify that all the information I provided in this document is true and correct as of the date below. If I am not the patient, then my signature below certifies that I am the legally appointed guardian of the individual named on this document and I make this choice and these authorizations on his or her behalf. More information about this policy can be found at: http://www.greenwellhealth.com/disclosures

3. Financial Responsibility Agreement to Pay

I accept FULL FINANCIAL responsibility for my **GREENWELL HEALTH** home visits and other services provided by GreenWell Health. Should my insurance company deny a visit or service, or only pay for a portion of a visit or service, I understand that I will be required to pay for these services IN FULL. More information about this policy can be found at: http://www.greenwellhealth.com/disclosures

4. Acknowledgement of Receipt of Privacy Practices Statement

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting GreenWell Health at 480-847-2273. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. More information about this policy can be found at: http://www.greenwellhealth.com/disclosures

5. Consent Agreement for Chronic Care Management

By signing this Agreement, you consent to **GREENWELL HEALTH** (referred to as "Provider"), providing Chronic Care Management services (referred to as "CCM Services") to you as more fully described below. CCM Services include: 24-hours-a-day, 7-days-a-week access to a health care provider in Provider's practice to address chronic care needs; systematic assessment of your health care needs; processes to assure that you receive timely preventative care services; medication reviews and oversight; a plan of care covering your health issues; and management of care transitions among health care providers and settings. More information about this policy can be found at: http://www.greenwellhealth.com/disclosures

Patient: _____ **DOB:** _____

Name of facility/residence: _____

6. Consent Agreement for Remote Patient Monitoring

By signing this Agreement, you consent to **GREENWELL HEALTH** (referred to as "Provider"), providing Remote Patient Monitoring services (referred to as "RPM Services") to you as more fully described below. RPM Services may be recommended as applicable to provide clinical data related to the management of one or more chronic conditions. More information about this policy can be found at: http://www.greenwellhealth.com/disclosures

7. Consent Agreement for Telehealth Services

By signing this Agreement, you consent to **GREENWELL HEALTH** (referred to as "Provider"), providing Telehealth services to you as described. You certify that you understand the potential benefits and risks to you of receiving such services, and the possible alternatives. You certify that you are competent to consent to treatment, have had the opportunity to ask questions and have them answered, and that you consent to receive telehealth services from GreenWell Health and its providers. More information about this policy can be found at: http://www.greenwellhealth.com/disclosures

Patient Sign Here* (if no POA/Guardian)

Signature: _____

Print Name: _____

Date: _____

POA/Guardian Sign Here**

Signature: _____

Print Name: _____

Date: _____

* If Patient has a diagnosis of Alzheimer's Disease, Dementia, or other Altered Mental Status, this form MUST be signed by a Power of Attorney (POA) or Legal Guardian.

** Signee must submit Power of Attorney (POA) or Legal Guardianship documents with the Enrollment Packet

Enrollment Checklist

- ☐ **Completed Enrollment Form**
- ☐ **Copies of Insurance Cards**
- ☐ **Medication List**
- ☐ **POA/Guardianship Documents**

Patient: _____ **DOB:** _____

Patient Health Information

Allergies: _____

Pharmacy: _____ **Pharmacy phone:** _____

RX Prescription Drug Plan: Name (if available):_____, BIN_____, PCN_____, GRP_____

Emergency Contact: _____ **Relationship:** _____

Emergency Contact Phone: _____ **Emergency Contact Email:** _____

Smoking status:

- ◯ Never smoked/vaped
- ◯ Former smoker/vaping
- ◯ Current smoker/vaping
  - Occasional
  - Daily
  - Heavy
- ◯ Smokeless Tobacco

Alcohol use:

- ◯ None
- ◯ Less than 3 per week
- ◯ One per day
- ◯ More than one per day
- ◯ Prior use

Health Bio:

Height:_____Weight:_____

PT/INR (blood thinners) Y / N (circle)

Are you on Home Health/Hospice?

Y / N (circle)

If yes, what are the names of those service providers:_____
_____

Recreational drug use:

- ◯ None
- ◯ Marijuana
- ◯ Other: _____
- ◯ Prior use

Medications and dosage (or provide list):

- _____
- _____
- _____
- _____

Surgical history (Procedure and Date):

- _____
- _____
- _____
- _____

Medical History:

- ◯ Alcohol/Substance Abuse
- ◯ Alzheimer's Disease
- ◯ Anxiety
- ◯ Arthritis
- ◯ Asthma
- ◯ Atrial Fibrillation
- ◯ Bipolar Disorder
- ◯ Blood Clots
- ◯ Cancer
- ◯ Cerebral Palsy
- ◯ Circulation (PAD/PVD)
- ◯ Chest Pain
- ◯ Congestive Heart Failure
- ◯ Constipation
- ◯ COPD
- ◯ Dementia
- ◯ Depression
- ◯ Diabetes
- ◯ Diarrhea
- ◯ Down Syndrome
- ◯ Emphysema
- ◯ GERD/Heartburn
- ◯ Heart Attack
- ◯ Heart Problems
- ◯ High Blood Pressure
- ◯ Kidney Disease
- ◯ Liver Disease
- ◯ Lower Extremity Edema
- ◯ Migraines
- ◯ Multiple Sclerosis
- ◯ Neuropathy
- ◯ Parkinson's Disease
- ◯ Schizophrenia
- ◯ Stroke/TIAs
- ◯ Thyroid Disorder
- ◯ UTIs
- ◯ Vomiting
- ◯ Other: _____

Patient: _____ **DOB:** _____

General Problems:

- ○ Sleep
- ○ Vision
- ○ Hearing
- ○ Mouth/swallowing
- ○ Nose
- ○ Neck
- ○ Skin
- ○ Back
- ○ Legs and feet
- ○ Arms
- ○ Other:

Devices or other products in use:

- ○ Wheelchair
- ○ Walker/Cane
- ○ Hospital bed
- ○ Oxygen
- ○ Nebulizer
- ○ Catheter Supplies
- ○ Ostomy Supplies
- ○ Dentures
- ○ CPAP/BIPAP
- ○ Glucometer
- ○ Incontinence Supplies

Family History:

ILLNESS/DISEASE	FATHER	MOTHER	BROTHER	SISTER	SON	DAUGHTER	GRANDPARENTS	NONE
Cancer (specify type(s))								
Heart Disease								
Diabetes								
Stroke/TIA								
High Blood Pressure (HBP)								
High Cholesterol/Triglycerides								
Liver Disease								
Alcohol/Drug Abuse								
Anxiety, Depression, or other Psychiatric Illness								
Tuberculosis								
Anesthesia Complications								
Genetic Disorder (specify type)								
Other:								

Other Healthcare notes: