Careline Physician Services

Dear Residents and Families,

We are honored to introduce our practice, Careline Physician Services. ***We are different by design***.

We are a specialized group of Physicians, Physician Assistants and Nurse Practitioners. Together, we help patients and their families find solutions to complex care needs. Our model of care is designed specifically for patients residing in independent, assisted, long-term care facilities or skilled facilities. We are a doctor's office without walls; ***we provide care wherever our patients reside.***

What is "Advanced" with Careline's **Advanced Primary Care** services?

- Provides consistent in-person visits based on our patients' needs – same provider
- Telehealth visits when necessary and for urgent needs
- Prompt and proactive medication management & refills minimize costs
- Cross-functional Case Management Team helps patients age in place
- Facility, family and patient portal provides clinical notes and two-way communication with your provider
- Care Advocate assists with advanced care planning and early detection
- 24/7 access to team for urgent needs
- Referrals and oversight for in-home mobile x-ray, labs, home health and hospice

Advanced Primary Care goes beyond an individual clinician; we are a team of coordinated professionals using the latest technology and data to support you or your loved one. Our practice only serves patients with complex care needs which assures our focus is always on you. Aligning the best people with the best tools enables you to ***live with the highest possible quality***.

Our team will work with your insurance plan to ensure you receive the best care possible at the lowest cost. In fact, based on Medicare data, our care model saves the average patient between 17%-22%[1] of what they would spend in a year without Advanced Primary Care.

Please call us with any questions at (800) 865-4098. Our team is ready to help you. **With Careline Physician Services, you can *Expect Exceptional*.**

[1]Based on the CY2020 Center for Medicare & Medicaid Innovation Primary Care First program Total Per Capita Cost data for Careline Physician Services' attributed patient population.

PATIENT CONSENT / ACKNOWLEDGEMENT

Release of Medical Records and Information:
I consent to release my hospital records and physician records to Careline. Also, I consent to the electronic download and review of insurance eligibility, medication history and medical history including claims data and health information exchange data. I understand that Careline will maintain a confidential medical record containing information about me and my medical condition. I authorize Careline to release copies of my medical records as necessary to other health care providers, facilities, or regulatory or accrediting bodies for the purpose of continuing and coordinating my plan of treatment, and for quality assurance, survey, and accreditation purposes.

Consent to Assessment and Rights and Responsibilities:
I voluntarily consent to such care encompassing medical in-person and telehealth assessment, treatment, and diagnostic procedures provided by Careline, and its associated physicians, clinicians, and other personnel as is necessary in his/her professional judgment. I understand the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of treatments or examinations.

Assignment of Medical Insurance Benefits:
I assign to Careline any medical insurance benefits payable to me for services provided by Careline and permit Careline to submit a claim for payment to Medicare or Medicaid or to other third-party payors and/or any appropriate intermediary agency necessary, to bill for services provided by Careline. I choose Careline to act as my representative in claim denial appeals. Subject to applicable laws and the terms and conditions of any applicable contract between Careline and a third-party payor, I understand that I am responsible for fees not reimbursed by my health insurance including, but not limited to, deductibles and/or co-payments.

Medicare / Medicaid Payment Authorization Coverage:
As a Medicare or Medicaid patient, I certify that the information I have provided in applying for payment under Title XVIII and/or Title XIX of the Social Security Act is correct. If Careline believes that I no longer qualify for benefits under Title XVIII and/or Title XIX of the Social Security Act, I will be notified verbally and in writing of any potential payment liability.

Notice of Privacy:
I acknowledge that I have received the Careline Notice of Privacy Practices. I understand that the Notice of Privacy Practices explains how Careline may use and disclose confidential health information that identifies me. I consent to let Careline use and disclose health information about me as described in the Notice of Privacy Practices. In doing so I am consenting to the use and disclosure of health information about substance abuse, psychiatric care, or HIV, if applicable. I consent to the release of health information about me to my insurer, other third-party payers, and any agents or consultants that help Careline get paid or assist in my treatment or its health care operations. I can revoke my consent in writing at any time except to the extent that Careline has already relied on my consent.

Consent to Photography:
I consent for Careline to take pictures of myself, and treatment(s) being provided and consent to the release of those photographs for such uses including but not limited to insurance verification, identification purposes, medical condition assessment, or advertisement or public education regarding physician services.

Please initial the following items that you are electing to utilize Careline Physician Services for Care Management

_____ I choose to utilize Careline Physician Services for all my primary care needs while appropriate for in-home care.

_____ I consent to participate in Psychiatric Collaborative Care Management for Behavioral Health Integration Services.

I acknowledge I have discussed Careline Psychiatric Collaborative Care and Behavioral Health Integrated Services including the roles of the Behavioral Health Care Manager and the Psychiatric Consultant with Careline Physician Services.. I have been informed that I may benefit from the program and that I will be responsible for potential cost sharing expenses for both in person and non-face-to-face services. I have agreed to participate in the Careline Behavioral Health Collaborative Care Program and for consultations to be conducted with relevant specialists.

-OR-

_____ I choose to continue to utilize my primary care provider in the community but consent to Careline Physician Services providing care management visits if I am unable to see my provider of choice in a timely manner.

I have read this form and understand its contents at this date.

Patient Name (PRINT PLEASE): _____

Patient or Responsible Party Signature: _____ Date: _____

Reason patient unable to sign: _____

Witness Signature: _____ Date: _____

CARELINE
PHYSICIAN SERVICES

Phone Number: (800) 865-4098
Fax Number: (517) 212-2009

Patient Intake Form

Section 1: Patient Demographics

Completed by: _____ Date: _____

Patient Name: _____ DOB: _____

Facility Name: _____ Apt/Room: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Current Pharmacy: _____ Pharmacy Telephone: _____

Section 2: Responsible Party Demographics

Do you have a DPOA or Guardian? ❑ Y ❑ N *If yes, please include DPOA/Guardianship paperwork*

DPOA or Guardian Name: _____

DPOA or Guardian Address: _____

Primary Phone Number: _____ Alternate Phone Number: _____

Email: _____ Do you want access to our patient portal? ❑ Y ❑ N

Is the Patient, DPOA, or Guardian responsible for bills? ❑ Y ❑ N *If yes, continue to Section 3*

Responsible Party Name: _____ Primary Phone Number: _____

Responsible Party Address: _____

Email: _____ Should bills remain in the patient's name? ❑ Y ❑ N

Section 3: Billing and Insurance Information

Social Security Number: _____-_____-_____

Primary Insurance: _____ Plan Number: _____

Secondary Insurance: _____ Plan Number: _____

Section 4: Current Services

❑ Physician Specialist ❑ Homecare ❑ Hospice ❑ Aide services ❑ Other: _____

Provider: _____ Specialty: _____

Provider: _____ Specialty: _____

Provider: _____ Specialty: _____

Section 5: Medication List

Please attach a copy of facility Medication Administration Record (MAR) or current medication sheet, history and physical.

Chief Complaint for First Visit

Reason for visit:

Allergies

Drug allergies:
Other allergies (food/environmental):

Activities of Daily Living History

Bed bound? ❑Y ❑N	Is patient able to walk? ❑Y ❑N	Walking aide: ❑Walker ❑Cane ❑Crutch ❑WC
Control of bladder? ❑Y ❑N	Does patient have control of bowel? ❑Y ❑N	
Does the patient utilize: ❑ Catheter ❑ Ostomy	Independently able ❑ Groom ❑ Bath ❑ Dress ❑N	
Patient's weight and height _____Lbs. and _____'____" height		

Social History

Marital Status	❑Married	❑Single	❑Widowed	❑Divorced
Smoking Status	❑Never	❑Currently	❑Quit	
Alcohol Usage	❑Never	❑Currently	❑Quit	
History of Substance or Narcotics Use ❑Y ❑N				
Oxygen Used in the Home ❑Y ❑N If yes: _____ Liters ❑Continuous ❑PRN				
Gender:	Ethnicity:	Language:	Race:	

Family Medical History

Heart Disease: ❑Mother ❑Father ❑Other	Cancer: ❑Mother ❑Father ❑Other
Diabetes: ❑Mother ❑Father ❑Other	Dementia/Alzheimer: ❑Mother ❑Father ❑Other

Past Medical History

CHF ❑Y ❑N	COPD ❑Y ❑N	Heart Attack ❑Y ❑N	Stroke ❑Y ❑N
Cancer ❑Y ❑N	Dementia ❑Y ❑N	Pacemaker ❑Y ❑N	Depression ❑Y ❑N
Hypertension ❑Y ❑N	Hypothyroid ❑Y ❑N	Diabetes ❑Y ❑N	Other: _____
Blood Clots ❑Y ❑N If yes, is the patient utilizing a blood thinner? ❑Y ❑N			
❑ Coumadin ❑ Xarelto ❑ Pradaxa ❑ Eliquis If yes, who manages:			

Past Surgical History

Appendix ❑Y ❑N	Cataracts ❑Y ❑N	Gall Bladder ❑Y ❑N
Knee ❑L ❑R	Hip ❑L ❑R	Other Major Surgeries:

Active Patient Specialist

Specialist Name:	
Phone Number:	Specialty:

Additional Information

RETURN TO INTAKE VIA FAX (517) 212-2009
OR EMAIL INTAKE@CARELINEHEALTHGROUP.COM

CareConnectMD at Home

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Confirmation of Main Doctor or Other Healthcare Professional Form

1. CONFIRM

By signing below, I am confirming that my main doctor or other healthcare professional – or the main place I go to for routine medical care – is:

Provider Name and/or Medical Group _____

Beneficiary Name _____

X	
Signature	**Date (Required)**

Printed Name of Signatory

Medicare Number

Note: If the names listed above and in the attached letter are incorrect do not sign this form. If you would like to receive a new form with a different doctor, other healthcare professional or practice listed, please call CareConnectMD at Home at 888-874-0818.

2. RETURN

Return this form to our practice via secure fax or mail to:

CareConnectMD at Home
3090 Bristol St Ste 200
Costa Mesa, CA 92626

FAX:
877-738-0868

Note: Completing and returning this form is voluntary. It won't affect your Medicare benefits. This form is not valid unless it includes both a signature and date.

Rev Jan 2024

CARELINE
PHYSICIAN SERVICES

Agreement to Receive Chronic Care Management Services

Medicare, effective January 2015 covers chronic care management (CCM) services. Careline Physician Services is able to 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 Careline Physician Services will provide me under this agreement include the following:

- Access to my care team 24-hour-a-day, 7-days-a-week, including telephone access, and other non-face-to-face means of communication,
- The ability to get successive, routine appointments with my designated primary care provider,
- Care management of my chronic conditions, including timely scheduling of all recommended preventative 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 transition between and health care providers and settings, including:
    - Referrals to other health care providers,
    - Follow-up after I visit any emergency department setting,
    - Follow-up after I am discharged from the hospital or other skill-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:

- Careline Physician Services is designated by me for purposes of providing CCM to me and for submitted claims for payment to Medicare for the CCM services,
- I will receive a copy of my comprehensive care plan,
- Careline Physician Services 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 practice for CCM services provided to me during the calendar month,
- CCM services are subject to the usual Medicare deductible and coinsurance applied to my Medicare Part B services, and
- I can revoke the agreement at any time (effective at the end of the current calendar month) and can choose to receive these services from another practice or not to receive CCM services at all after the calendar month in which I revoke the agreement.

Date: _____ Patient Name: _____

Patient or Guardian Signature: _____

CARELINE
PHYSICIAN SERVICES

Pain and Symptom Management Medical Agreement

In order to receive care and services from Careline Physician Services, I _____, agree to follow the stipulations with respect to the medication prescribed and dispensed to me and the treatment plan set forth by the interdisciplinary team at Careline Physician Services for the control of my pain and symptoms.

1. Only my attending primary care clinician, _____, may prescribe pain and symptom medications unless expressly agreed to in writing by my attending clinician.
2. I will only have prescriptions filled for pain and symptom medication at _____ pharmacy.
3. I will take my medication exactly as it is prescribed for me by my clinician and explained to me. If asked, I will document all doses that I have taken and the times that I take them.
4. If I do not have enough medication to last until the next scheduled prescription, I will notify Careline Physician Services who will contact the above listed clinician for orders. I will not go to any other physician or pharmacy to obtain additional medication. If I have a crisis where I need to go to an emergency room or other health care facility for treatment, if possible, I will notify Careline Physician Services prior to going.
5. I will take responsibility for maintaining the security of all medications prescribed and dispensed to me so that they are not likely to be lost, destroyed or taken by someone else. If the medication is stolen, I agree to file a police report and provide a copy of the report to Careline Physician Services.
6. I will follow the plan of care for the management of my symptoms including any recommendations for non-medicine treatments and consultation with the social worker, home health agency or any other team member or health care provider that is recommended.
7. I will provide urine and or saliva samples as asked for toxicology screens.
8. I understand that if I do not follow these stipulations, at the discretion of Careline Physician Services and my clinician, I will be discharged from Careline Physician Services.

I agree to follow the above stipulations:

Print Name: _____ Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact our Privacy Officer (contact information provided below).

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by aiding with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services, we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our privacy officer to request that these materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Disease: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the food and drug administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that

death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are armed forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the president or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgement, determine whether the disclosure is in your best interest.

Others Involved in Your Health Care or Payment for Your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice use for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this notice of privacy practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

We are not required to agree to a restriction that you may request. If we do agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Please discuss any restriction you wish to request with your physician and contact the privacy officer for more information. You may request a restriction by contacting the privacy officer in writing.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our privacy officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this notice of privacy practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur within the last 6 years. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer at, **(517) 212-9000 or** PrivacyOfficer@carelinehealthgroup.com for further information about the complaint process.

This notice was published and becomes effective on **February 1, 2019**.

CARELINE
PHYSICIAN SERVICES

Patient Information

- **<u>In Home Support</u>**: Careline Physician Services employs only exceptional physicians, physician assistants, and nurse practitioners as part of your care team. Your nurse practitioner or physician assistant is always overseen and collaborates with a Michigan licensed physician.
  - We request that you call the office if you need to go to the Emergency Room or are admitted to the hospital so that we can coordinate a visit when you return home. Call us anytime at (800) 865-4098.

- **<u>Office Structure</u>**: Our clinicians are not physically in the office every day due to the nature of seeing patients where they call home.
  - Our support staff is in the office from 8:00am to 5:00pm on weekdays. The support staff answers the phones and relays information to the clinicians. Please provide the staff with details you want to discuss with the clinician.
  - *<u>Office Hours</u>*: 8:00am to 5:00pm Monday through Friday.
  - *<u>After Hours</u>*: If you have an urgent after-hours need, please call us at (800) 865-4098. **Our dedicated staff are always ready to assist you, 24 hours a day, 7 days a week.**

- **Scheduling** is based on level of medical complexity and geography
  - If you have an urgent medical need, we will try to accommodate a visit as soon as possible with our telehealth program.

- **Medication Management and Refills**: Your medication will be reviewed at every visit: pills, tablets, vitamins, eye drops, topical creams, and insulin or other injectables including over-the-counter medications such as Aspirin or Tylenol.
  - **Refills will only be processed during normal business hours**
    - By reviewing your medications at every visit, we try to avoid having you call for refills.
    - We request that you call the office when you have a 7 to 10-day supply left of your medication.
    - We will confirm the pharmacy name that we have on file.
    - Please indicate if you need a mail-in prescription for mailing (generally a 3-month supply).

- **Follow Up Visit Appointment**: At the end of every visit, the clinician will tell you when to expect the next visit – this will be an approximate number of weeks (generally every 4-6 weeks).
  - Exact dates and times cannot be guaranteed.
  - You or your assisted living facility clinical staff will receive a phone call 1 business day before the next visit date.
  - Your visit time will be given via a block of time due to the nature of seeing patients wherever they call home.

- **Preparation for Each Appointment**: It is not necessary to clean the house, dress-up, or go to any trouble to prepare for the visit. We are here to serve you and your medical needs wherever you call home.

If you are unsure about needing an ER visit, please call our office at (800) 865-4098 first – <u>we are here to help you!</u>

It may be possible to avoid an ER visit with an urgent visit from our staff.

CARELINE
PHYSICIAN SERVICES

Patient Responsibilities

To ensure productive, safe home visits, Careline expects that:

1. Staff are treated with respect and courtesy by patients and their families/caregivers in all interactions.

2. Patients and/or family/caregivers maintain a safe, sanitary, smoke-free, alcohol/drug-free, and weapons free home ***during*** all home visits. This may include securing pets during a home visit, if requested.

3. Patients (and if appropriate, family and/or caregiver) will be present in their homes for all scheduled home visits unless reasonable notice has been provided.

4. Patients (and if appropriate, family and/or caregiver) participate in developing the care plan, including providing complete, accurate information about all matters related to your health and sharing expectations of care.

5. Patients (and if appropriate, family and/or caregiver) are compliant with care plan directives to the best of their ability or request assistance and/or explanation. Patients (and if appropriate, family and/or caregiver) must acknowledge and accept that there may be consequences for noncompliance

6. Patients (and their guarantor, if appropriate) must meet any financial obligations agreed to with **Careline**. Patients in certain programs will be required to supply credit card information at the time of registration. We charge the credit card on file only if there is an unpaid balance after billing your insurance with your consent.

Patients understand that receiving medical care and related support services in the home is a privilege, not a right and accept that failure to follow these guidelines may result in discharge from Careline.