Above & Beyond Healthcare, LLC
dba Beyond Health Group

Please complete the attached patient information sheet along with current copy of Primary and Secondary Insurance cards (front and back) and return:

By email:

info@beyondhealthgroup.com

By Mail to:

430 Northside Drive E
Ste 160
Statesboro, GA 30458-4929

By Fax:
800 – 859 -1297

Please feel free to contact our office with any questions.

Thank you,

Beyond Health Group

Above & Beyond Healthcare, LLC
dba Beyond Health Group
Telephone: 912-225-3220
Fax: 800 -859 -1297
www.beyondhealthgroup.com

Personal Information

Full Name: _____ **M / F**
Last *First* *M.I.* Date of Birth Sex

Billing Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email address _____

Do you currently (or plan to) reside in an Assited Living Community? Y/N

If Yes where? _____

POA Contact Information (if applicable) _____

Insurance Information

Medicare Policy #: _____ Is Medicare the Primary Insurance? Y/N

Other Insurance Name and D #: _____ Group ID # _____

Health History

Allergies:	**Reactions to Allergen:**
Past Medical History:	
Past Surgical History:	
Family History	

AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE

Patient Name: _____ **D. O. B.** _____

I hereby authorize:

_____

To release visit notes, laboratory results, radiographic findings and all important information pertaining to my medical care to:

Above & Beyond Healthcare, LLC
dba Beyond Health Group

430 Northside Drive E Ste 160

Statesboro, GA 30458-4929

(T) 912-225-3220 (Fax) 800 -859 -1297

Specify Dates (or date ranges) if necessary:

_____

This request is for the purpose of: establishing medical care

_____

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization. Unless otherwise revoked this authorization will expire in six months or on this date listed _____.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorization is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that the information in my health record may include information pertaining to treatment of drug and alcohol abuse, mental health, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis information or genetics. THIS INFORMATION WILL ALSO BE RELEASED UNLESS YOU INDICATE: _____DO NOT RELEASE (Indicate Check Mark)

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records.

_____ _____

Signature of Patient or Authorized Representative **Date**

_____ _____

Representative Authority to Act on Behalf of Patient **Signature of Witness**

I hereby signed that I received and read the **Above & Beyond Healthcare, LLC dba Beyond Health Group** Notice of Privacy Practices (copy can be found on beyondhealthgroup.com)

Name:_____Date: _____

Signature:_____

I hereby authorize my insurance company, including Medicare if I am a Medicare Beneficiary, to make payments to **Above & Beyond Healthcare, LLC dba Beyond Health Group** for medical or surgical services or items rendered by **Above & Beyond Healthcare, LLC dba Beyond Health Group**. Should my insurance carrier deny **Above & Beyond Healthcare, LLC dba Beyond Health Group** payment, I understand that I am financially responsible for the charges. I authorize **Above & Beyond Healthcare, LLC dba Beyond Health Group** 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 and all personal, insurance and health information.**

Name:_____Date: _____

Signature:_____

ATTENTION Humana Insured Patients

HUMANA REQUIRES YOU TO GIVE AUTHROIZATION FOR PRIMARY CARE SERVICES. PLEASE BE SURE TO CONTACT HUMANA AND PROVIDE PERMISSION TO RECEIVE SERVICES FROM BEYOND HEALTH GROUP

I give permission (as a Humana Insured Patient) to receive primary care services by **Above & Beyond Healthcare, LLC dba Beyond Health Group, and to bill Human for services**

Name:_____Date: _____

Signature:_____

I hereby authorize **Above & Beyond Healthcare, LLC dba Beyond Health Group** to provide medical care services to

Name:_____Date: _____

Signature:_____

CHRONIC CARE MANAGEMENT AND REMOTE PATIENT MONITORING CONSENT FORM

Dear Medicare Patient and/or Family Member,

We appreciate the opportunity to provide you with comprehensive primary care. In addition to our regular services, Beyond Health Group provides Chronic Care Management and Remote Patient Monitoring Services.

Medicare has identified the care of chronic health conditions as an important goal. Chronic conditions are ongoing medical problems that must be managed effectively in a partnership between the health care team, caregivers, and the patient to maintain the best possible health outcome. Examples include diabetes, high blood pressure, heart disease, depression, and others. Federal regulations enable Medicare to pay for chronic care management and remote patient monitoring.

WHAT ARE THE BENEFITS OF SIGNING UP FOR CHRONIC CARE MANAGEMENT AND REMOTE PATIENT MONITORING?

- Coordinate of care with physician and care team with other providers such as specialists' offices, other healthcare facilities, or your home
- Assistance with medication management
- Personalized, comprehensive plan of care for all your health issues
- Management of chronic conditions and scheduling of recommended preventative care services
- Monitoring device(s) supplied for use at home to review important vitals (e.g., weight, blood pressure, blood glucose) with your physician and care team monthly
- 24/7 communication with your care team via telephone and other non-face-to-face means of communications (email)

WHAT DO YOU NEED TO KNOW BEFORE SIGNING UP?

Understand that this care is subject to Medicare coinsurance (approximately $8 to $20) billed by Beyond Health Group.

each month that you receive services. Patients who are dual eligible (Medicare + Medicaid) are exempt from cost sharing. Additionally, Medigap and supplemental insurances often cover the co-insurance. This service is subject to your annual Medicare deductible.

YOU HAVE A RIGHT TO:

Discontinue this service at any time for any reason. Your signature is required to end your chronic care management or remote patient monitoring services; therefore, please notify us in writing if you wish to terminate your services. The provider will continue providing services until the end of the month and may bill Medicare for those services. At the end of the month, the provider will discontinue services and no longer bill for those services to Medicare.

- Our practice is compliant with HIPAA and all laws related to the privacy and security of Protected Health Information (PHI). As part of this program, your PHI may be shared between caregivers directly involved with your health.

Note: you must sign this agreement to receive chronic care management and remote patient monitoring services. **Only one physician can bill for this service for you.** Please let us know if you have entered into a similar agreement with another physician/practice.

Our goal is to make sure you get the best care possible from everyone that is involved with your health.

Patient Name: _____ DOB: _____

❒ *I agree to participate in the chronic care management and remote patient monitoring program.*

Print Name: _____ Relation to Patient: _____

Signature: _____ Date: _____