BridgeCare
BRIDGECARESPECIALISTS.COM

PATIENT REGISTRATION & CONSENTS

PATIENT FORMS

REQURIMENTS FOR SERVICES

1. I have the capability, either by myself or with support from a family member, to do a prompt telehealth (video conferencing) visit from home? **YES** **NO**

2. Patients can only receive services and prescriptions from providers who are licensed in the state they currently reside in at the time of their appointment. Please write the state in which you will be residing during your appointment. **STATE** ___________
NOTE: As of April 2024, we practice in MI, OH, IN, IL, and WI.

3. **DATE** of Most Recent Discharge ______________ **NAME** of Facility __________________

SERVICE REQUEST & EXISTING PROVIDER INFORMATION

4. **REASONS** for Requesting BridgeCare Discharge Clinic Services (circle all that apply)

Need supervising physicians for Homecare orders
IV Antibiotic Management
Medication Refills and/or Management
Need Referral to Specialists
Wound Care Guidance
Don't have a primary care doctor

Other ____

5. If you have a Primary Care Provider (PCP), please List Their Name. ________________________________

6. List the Next Appointment Date with PCP ____

7. NAME____

8. DATE OF BIRTH _____________________ 8b. BIOLOGICAL SEX AT BIRTH ________________

9. HOME ADDRESS:____

10. OTHER ADDRESSES: ____

11. PHONE NUMBER: _______________________ 11b. SECONDARY PHONE NUMBER:__________________

12. EMAIL:____

13. CHOOSE BEST MEANS OF CONTACT: **PHONE** **TEXT** **EMAIL**

14. INSURANCE ____ POLICY NUMBER _____________________________

15. SECONDARY INSURANCE____________________________ POLICY NUMBER _____________________________

16. AUTO INSURANCE ____
Include auto Insurance's name, claim number, and agent contact information.

Office Phone: 517-258-0344
Fax: 517-879-0374

CONSOLIDATED BRIDGECARE SPECIALISTS' CONSENTS & POLICIES

For full and complete documents, please see website at bridgecarespecialists.com/consents.

Consolidated Consent to Treat

1. Treatment Consent and Scope
I authorize evaluation and treatment by BridgeCare Specialists, including shared medical appointments and telemedicine. This encompasses the use of audio and video devices for diagnosis and safety. Providers may adjust my care as necessary for my health and well-being.

2. Understanding and Referral Process
I understand the practice of medicine is not exact and outcomes cannot be guaranteed. Students and staff may access my medical records for administrative or educational purposes. In the event of a specialist referral, I will be consulted for my preference, with BridgeCare Specialists facilitating the connection.

3. Telehealth Consultation Agreement
I acknowledge that telehealth consultations differ from in-person visits and may involve risks such as interruptions and technical issues. Both my provider and I can discontinue the consultation if necessary. Telehealth is not for emergencies, and I will call 911 in such cases.

4. Information Accuracy and Confidentiality
I understand that my provider may not have access to all technical information during telehealth sessions. To maintain confidentiality, I agree not to share my telehealth appointment link with unauthorized individuals.

Consent for Medical Record Retrieval

I hereby grant permission to MedClubs, the parent organization of BridgeCare, to retrieve my medical records from the National Medical Record Databases. The purpose of these records will be to create my new patient chart and provide my healthcare provider with accurate information about my previous health history. I agree to review this information for accuracy during my first appointment with my provider. If my records are unavailable, I understand that I will be asked to provide a comprehensive health history before my first appointment. By signing below, I consent to the retrieval and review of my medical records for the sole purpose of my medical care by BridgeCare's Specialists Clinic.

By signing below, I hereby authorize disclosure of information in the medical record of the patient identified above which includes information that may be stored in a paper and /or another electronic format. Such records may contain information on demographics; financial/insurance information; general medical care; alcohol and drug abuse treatment; psychiatric treatment; behavioral or mental health treatment; HIV or AIDS; AIDS-related treatment; sexually transmitted diseases or infections venereal disease; tuberculosis; hepatitis. Disclosure shall be limited to the listed entities and the information obtained during treatment.

The Purpose for Disclosure: Medical Care, Care Planning, Insurance Verification, Coordination of Care, Referral Purposes
Disclosure Format: Fax, Secure Email, National Medical Record Databases

Authorization is valid only if received within 90 days of being signed and will expire within one year from the date of signature or if services are terminated before the one year or if otherwise specified. Unless otherwise specified in writing: I may revoke this authorization at any time by submitting a written request or through verbal indication. Revocation will not apply to information disclosed prior to receiving notification of revocation. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal and state privacy laws. l has carefully read and understood this authorization, and have had any questions answered to my satisfaction. By signing below, I do hereby expressly and voluntarily authorize the disclosure of the above information regarding my health to BridgeCare Specialists.

Consolidated Financial Policy

I understand BridgeCare bills insurance first, but due to diverse insurance agreements, they can only know patient responsibility after billing insurance. In the event that insurance coverage is insufficient, or claims are denied, I am responsible for the remaining balance. Payments are due upon bill receipt, with arrangements for financial hardship considered. BridgeCare accepts both mailed checks and online payments. It's my responsibility to secure any necessary insurance referrals and understand that if insurance fails to pay within 90 days due to inaccuracies or uncovered services, the payment obligation falls to me. Non-payment may lead to additional charges, and if an account is delinquent for 90 days without prior arrangement, it may be referred to a collection agency, with all associated costs charged to me. Continued non-payment could interrupt or halt treatment until full payment is made. Payment plans can be provided upon request.

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BridgeCare adheres to Michigan's opioid guidelines, renewing medications only if previously prescribed at discharge.

BridgeCare Specialists' virtual care policy for controlled substances is designed to ensure high-quality care and mitigate the risks of misuse, abuse, and dependency by limiting prescriptions to 7-day periods, with a total cap of 4 weeks. This approach, based on provider discretion, guarantees safe prescription quantities and rigorous monitoring. Chronic pain management exceeding this period necessitates an in-person provider consultation. This policy reflects our commitment to patient safety and responsible controlled substance use, directing patients toward appropriate long-term care pathways. Patients must comply with specific conditions, including disclosing any new medications, adhering to treatment recommendations, understanding the prohibition on early refills and replacements for lost or stolen medications (requiring a police report), filling prescriptions at a designated pharmacy, undergoing drug tests for treatments over two weeks, maintaining appointments, and acknowledging the potential for substance use disorders, overdose risks, and legal consequences of improper controlled substance distribution. The full policy also covers safe disposal methods for unused medications to prevent misuse.

Consolidated Clinic Practices and Policies

1. Non-Discrimination
BridgeCare is committed to providing an inclusive environment, free from discrimination based on race, color, national origin, age, disability, or sex, aligning with federal civil rights laws.

2. Form Completion Policy
For efficient processing, we encourage completing all forms during a video visit. A $50 fee applies for form completions outside of these visits, covering FMLA, disability, workers' compensation, school forms, and miscellaneous patient requests.

3. Communication Consent
BridgeCare engages with patients through video, calls, texts, and emails, requiring your consent for sharing protected health information. We emphasize the importance of updating contact details to avoid unauthorized information disclosure.

4. Termination Policy
BridgeCare reserves the right to terminate patient relationships under circumstances like nonadherence to treatment, policy violations, verbal abuse, nonpayment, and inappropriate conduct, ensuring compliance with state, federal, and professional guidelines.

5. HIPAA and Patient Rights
We strictly adhere to HIPAA guidelines, ensuring the confidentiality and security of patient health information. Patients have rights to control disclosures, request information restrictions, specify communication preferences, access and amend PHI, and understand their privacy practices.

Agreement

By signing this document, I consent to receive virtual medical care BridgeCare Specialists. I am aware of my responsibility to review the full forms of the following policies and consents, which are available on BridgeCare Specialists' website:

- Clinic Consents & Policies
- Consent to Treat & Record Retrieval
- Financial Obligations
- Controlled Substance Policy and Michigan's "Opioid Start Talking"

My adherence to these policies is essential for the ongoing provision of my treatment. Failure to comply with these guidelines may result in an interruption of my care or discharge from the practice.

Print the name of the patient: ____ **Date of Birth:** _________________

Signature: ____ **Today's Date:** _________________

Name of Responsible party (if different from the patient) ____

Signature of Responsible party ____ Today's Date: _________________

Upon completion and receipt of this form, BridgeCare staff will call you to schedule your first appointment.

Send Form via Secure **Fax: 517-879-0374** or **Email: contact@bridgecarespecialists.com**