New Patient Enrollment Form

Phone: 888-637-9669 | Fax: 888-637-9661 | www.sevamedical.org | enrollments@sevamedical.org

We appreciate your interest in joining Seva Medical and are eager to offer you our full range of healthcare solutions. To expedite your enrollment, kindly fill out the form below with precise information. **After completing the form, kindly collect and submit essential patient documents, such as your medical history, medication list, and any relevant Power of Attorney (POA) documents. You can send these documents via fax to (888) 637-9661 or email them to enrollments@sevamedical.org. Thank you for choosing Seva Medical.**

Once all documents are received, our team will get in touch with you to schedule your first appointment.

Patient Name: ____ SSN: ________________________

DOB (MM/DD/YYYY): ________________________ Gender (assigned at birth): ____ Male ____ Female

Current Gender (If different from assigned): ____

Race: ____________________ Ethnicity: _____________________ Language: ________________

Who will provide consent to treat: ____ Patient ____ Guardian ____ Power of Attorney

If applicable:

Guardian/POA Name: ____

Relationship to Patient: ____

Guardian/POA Address: ____

Phone Number: ___________________________ Email: ___________________________

Patient's full-time residence:

____ Adult Family Home ____ Assisted Living ____ Private Home

____ Memory Care ____ Independent living ____ Other Senior Community

Name of Community (If applicable): ____

Address: ____ Room Number: ________

Residence Phone Number: __________________ Fax Number: ________________________

Caregiver Contact Name: ____

Phone Number: _________________________ Email: ______________________________

Please ensure to email or fax the following documents:

____ Medication Summary ____ Insurance Card ____ POA/Guardian Documents

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Patient Information

Emergency Contact Name: ______________________________ Relationship to Patient: ________________

Phone Number: ________________________________ Email: _______________________________________

Current Pharmacy Name: ____

City: ________________________________ State: _______________ Phone Number: __________________

Current Primary Care Provider: ____

Primary Insurance: _____________________________________ Member ID Number: _________________

Secondary Insurance: ___________________________________ Member ID Number: _________________

Medical History

Allergies: ____ Yes ____No Please list allergies: ____

Smoking: ____ Never smoked ____ Former smoker ____ Current smoker

Alcohol: ____ None ____ Less than 3 per week ____ One a day ____ More than one a day

Marijuana: ____ Never ____ Less than 3 per week ____ Once a day ____ More than once a day

Past Surgeries: ____

Have you ever been diagnosed with any of the following:

____ Alzheimer's Disease	____ COPD	____ Hypothyroidism
____ Anxiety	____ Dementia	____ Liver Disease
____ Asthma	____ Depression	____ Multiple Sclerosis
____ Atrial Fibrillation	____ Diabetes	____ Parkinson's Disease
____ Bipolar Disorder	____ Down Syndrome	____ Schizophrenia
____ Cancer	____ Emphysema	____ Stroke
____ Cerebral Palsy	____ Heart Attack	____ Other: __________
____ Congestive Heart Failure	____ Hypertension	______________________

Does the patient currently use any of the following:

____ Cane	____ Hospital Bed	____ Walker
____ Catheter Supplies	____ Ostomy Supplies	____ Wheelchair
____ Incontinence Supplies	____ Oxygen	____ Other: __________

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Authorization to Release Medical and Pharmacy Records

Patient Name: ________________________________ Date of Birth: __________________

As the undersigned, I hereby provide authorization for the release of the designated information from the medical and/or pharmacy records of the patient mentioned above.

Information to be released or accessed:

____ All of my medical related information

____ My medical related information ONLY related to ____

____ My medical related information from ________________________ to ______________________

____ Prescription history (2 years)

____ Immunization records

____ Prescriber information

____ Other: ____

The above information may be released to:

Seva Medical, PLLC (888) 637-9669
(Provider Group/Provider) Phone Number

From:

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

____
Address

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 longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, 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.

Patient Signature: ____ Date: __________________

Patient's legal representative signing on behalf of patient:

I, the individual named below, attest that I am the legal representative of the patient named above. I certify that the patient named above is not competent to sign contracts and provide informed consent to treatment. I certify that I am authorized by applicable law to sign contracts and consent to treatment on behalf of the patient.

POA/Guardian Signature: ____ Date: __________________

Print Name: ____________________________________ Relationship to Patient: __________________

Note: POA Documents must be provided if patient is not able to consent for their own care.

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Photo Consent and Release Form

Patient Name: ________________________________ Date of Birth: ___________________

I consent for photographs and/or video to be taken of me by Seva Medical or a representative. I understand the images or videos will be a part of my medical record and may be used for purposes of medical teaching or training or for marketing purposes (website, print, digital or social media).

By consenting to photographs and/or video images I understand I will not be compensated from any party.

Although photographs and/or video images will be used without identifying information such as name, I understand it is possible someone may recognize me.

I further acknowledge that my participation is voluntary and agree that use of any photographs and/or video confers no rights of ownership or royalties whatsoever.

I authorize the use of photographs and/or video images:

_____ For educational purposes (medical teaching or training)

_____ For marketing and advertising purposes (website, print, digital, or social media)

_____ For medical records

By initialing here, I ONLY authorize the usage of photographs and/or video images for medical records, _____

By initialing here, I DO NOT authorize the usage of photographs and/or video images for any reason, _____

I hereby release Seva Medical, its employees, and any third parties involved in the creation of or publication of educational or marketing materials, from liability for any claims by me or any third party in connection with my participation.

By signing this form, I confirm understanding of this consent and unless initialed above, authorize the use of photographs and/or video images for the reasons listed above. If I wish to withdraw my consent in the future, I may do so via written request submitted to Seva Medical or by completion of a new form.

Patient Signature: ____ Date: ___________________

Patient's legal representative signing on behalf of patient:

I, the individual named below, attest that I am the legal representative of the patient named above. I certify that the patient named above is not competent to sign contracts and provide informed consent to treatment. I certify that I am authorized by applicable law to sign contracts and consent to treatment on behalf of the patient.

POA/Guardian Signature: ____ Date: ___________________

Print Name: _____________________________________ Relationship to Patient: ___________________

Note: POA Documents must be provided if patient is not able to consent for their own care.

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Patient Agreements and Informed Consent Forms

Patient Name: ________________________________ Date of Birth: ___________________

Please carefully review all agreements and consents prior to signing. The documents can be accessed at sevamedical.org/enroll, or you can request a copy via email at enrollments@sevamedical.org.

1. Seva Medical Agreements:

By signing below, you acknowledge and accept the following agreements included in this packet, pertaining to the professional services provided by licensed health care providers of Seva Medical, PLLC doing business as Seva Medical:

- Patient Services Agreement
- Patient Financial Agreement

You confirm that you have comprehensively understood both the services offered by Seva Medical and your financial responsibilities for those services.

2. Informed Consent Forms:

Your signature below certifies that you comprehend the descriptions of primary care and telehealth services outlined in the following Informed Consent Forms:

- Informed Consent for Primary Care Services
- Informed Consent for Telemedicine Services

You confirm your understanding of the potential benefits, risks, and alternatives related to these services. You assert your competence to consent to treatment, confirm that you have had the opportunity to ask questions and have received satisfactory answers, and provide consent to receive primary care and telehealth services from Seva Medical and its providers.

3. Chronic Care Management and Remote Patient Monitoring Services:

If your provider deems chronic care management and/or remote patient monitoring services appropriate for your chronic conditions, your signature below indicates your agreement to the following agreements included in this packet concerning these services:

- Chronic Care Management Consent Agreement
- Remote Patient Monitoring Consent Agreement

Chronic care management patients receive comprehensive care plans for multiple conditions, and Seva Medical may suggest remote monitoring for managing these conditions.

4. Acknowledgment of Receipt of Notice of Privacy Practices:

By signing below, you acknowledge that you have received a copy of the Notice of Privacy Practices for Seva Medical included in this packet.

Patient Signature: ____ Date: ___________________

Patient's legal representative signing on behalf of patient:

I, the individual named below, attest that I am the legal representative of the patient named above. I certify that the patient named above is not competent to sign contracts and provide informed consent to treatment. I certify that I am authorized by applicable law to sign contracts and consent to treatment on behalf of the patient.

POA/Guardian Signature: ____ Date: ___________________

Print Name: ____________________________________ Relationship to Patient: ___________________

Note: POA Documents must be provided if patient is not able to consent for their own care.

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Seva Medical, PLLC

Notice of Privacy Practices

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

Introduction:
This Notice will inform you about the ways Seva Medical, PLLC dba Seva Medical may use and disclose your healthcare information. It describes your rights and certain obligations Seva Medical has regarding the use and disclosure of your healthcare information.

Our Commitment to Your Privacy:
At Seva Medical, PLLC dba Seva Medical, we are committed to maintaining the privacy and security of your personal health information. We are required by law to protect the privacy of your health information and to provide you with this Notice of Privacy Practices.

Uses and Disclosures of Protected Health Information (PHI):
Seva Medical may use and disclose your PHI for treatment, payment, and healthcare operations without your written authorization. Additionally, Seva Medical may use and disclose your PHI for other purposes allowed or required by law, such as public health activities, law enforcement, and court orders.

Disclosures Seva Medical May Make Without Your Authorization:
Seva Medical may use and disclose your healthcare information for providing health care services to you and for billing and collecting payments. Additionally, Seva Medical may use your healthcare information for internal quality assurance purposes.Seva Medical may disclose healthcare information when required or permitted by law, such as in cases of abuse, neglect, or domestic violence, or to avert a serious threat to health or safety.

Disclosures for Which You May Object:
You have the right to direct Seva Medical to share healthcare information with family, close friends, caregivers, or others involved in your care. If you are unable to communicate your preferences to Seva Medical, such as in the case of unconsciousness, Seva Medical may disclose your information to these individuals if deemed to be in your best interest.

Uses and Disclosures Requiring Your Authorization:
Seva Medical will not share your healthcare information for marketing purposes, sale, or psychotherapy notes without your written authorization.

Other Uses and Disclosures:

Uses and disclosures other than those described in this Notice will only be made with your written authorization.

Your Rights Regarding Your PHI:

Right to Inspect and Copy: You have the right to request access to your healthcare information to review and obtain copies. All requests must be made in writing. Seva Medical may deny access under limited circumstances and may charge a reasonable, cost-based fee.

Right to Alternative Communications: You may request to receive healthcare information through alternative means or at alternative locations, and Seva Medical will accommodate reasonable written requests.

Right to Request Restrictions: You can request restrictions on the use or disclosure of your healthcare information for treatment, payment, or healthcare operations. Requests must be made in writing to Dalveer Josan at the provided address. Seva Medical is not obligated to agree to restrictions except in specific circumstances outlined in the notice.

Right to Accounting of Disclosures: Upon written request, you may receive an accounting of disclosures made by Seva Medical in the last six years, subject to restrictions and limitations.

Right to Request Amendment: You have the right to request amendments to your PHI by providing a written explanation. Seva Medical may deny requests under certain circumstances.

Right to Obtain Notice: You may request a paper copy of this Notice at any time by submitting a request to Seva Medical at the provided address.

Right to Receive Notification of a Breach: Seva Medical is required to notify you of any breach of your unsecured PHI according to federal law requirements.

Questions and Complaints:

If you have questions or concerns about your privacy rights, please contact Seva Medical at (888) 637-9669. You may also file a complaint with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Seva Medical will not retaliate against you for filing a complaint.

Effective Date and Changes to this Notice:

This Notice is effective as of April 1, 2023. Seva Medical may change the terms of this Notice at any time, and any revisions will be posted on its website or provided upon request.

New Patient Enrollment Form

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Patient Services Agreement

We appreciate your choice of Seva Medical, PLLC, operating under the name Seva Medical, as your healthcare provider. This document, known as the Patient Services Agreement ("Agreement"), is established between you, the undersigned patient, and Seva Medical. It delineates the professional services ("Services") offered by Seva Medical's licensed providers and clarifies the rights and responsibilities of the patient.

Services:
The services rendered by Seva Medical encompass primary care services delivered to you within specific healthcare facilities situated in your vicinity. These services are administered through in-person appointments or by means of telecommunication technology ("Telehealth").

Cancellation Policy:
You are entitled to cancel your visit at any time by contacting Seva Medical at (888) 637 9669.

Accuracy of Information:
You are obligated to provide Seva Medical with accurate and thorough information concerning your medical history, condition(s), symptoms, physical well-being, and insurance details. Any inaccuracies or omissions in the information provided may impact the services rendered. By providing incomplete or inaccurate information, you assume all associated risks and absolve Seva Medical and its providers from any liability for personal injury, death, or damages resulting from the inaccurate or incomplete information provided.

Confidentiality of Health Information:
Seva Medical and its providers will utilize and disclose your health information in compliance with the Notice of Privacy Practices, accessible to you in both paper and electronic formats.

Communication:
Outside of agreed-upon visits, Seva Medical can be accessed by fax, phone or email. Emails may only be used to clarify issues discussed in prior visits. They may not be used to address new concerns. By your signature to this Agreement, you understand and agree that: (1) there is some level of risk that the information in unencrypted electronic communications, including email and text messaging, could be read by a third party, and (2) you consent to Seva Medical’s use of unencrypted electronic communications, including email and text messaging, to communicate with you.

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Patient Financial Agreement

We appreciate your choice of Seva Medical, PLLC, operating under the name Seva Medical, as your healthcare provider. This document, known as the Financial Services Agreement ("Agreement"), is established between you, the undersigned patient, and Seva Medical. It delineates the professional services ("Services") offered by Seva Medical's licensed providers and clarifies your rights and responsibilities.

Medical Insurance Billing:
For your convenience, Seva Medical will handle billing your medical insurance company for the professional services provided by our team. It's important that you provide us with accurate and current information about your medical insurance coverage. If there are any changes to your coverage, please inform us immediately. By signing below, you authorize the payment of authorized medical insurance benefits to Seva Medical for the services provided to you by our team.

Medicare:
Seva Medical is a participating Medicare provider. If you are a Medicare beneficiary, provide your Medicare enrollment details to Seva Medical before or during your initial visit. By signing below, you authorize payment of authorized Medicare benefits to Seva Medical for services provided by us and our providers. You also grant permission for any party holding medical information about you to release necessary information to the Centers for Medicare and Medicaid Services and its agents for benefit determination. Seva Medical acknowledges the Medicare carrier's charge determination as the full charge, and you are accountable solely for deductibles, co-insurance, copayments, and amounts for services not covered.

Medigap:
If you have a Medicare Part B supplemental plan (e.g., Medigap), please provide your enrollment information to Seva Medical before or during your initial visit. By signing below, you authorize Seva Medical to disclose any necessary information to determine these benefits. You also request that authorized Medicare supplemental benefits be paid to Seva Medical, if feasible, or otherwise to you.

Your Responsibility:
You are responsible for all deductibles, co-insurance, co-payments, and charges for services not covered by your medical insurance at the time the services are provided. Following billing to your medical insurance, you will receive monthly statements indicating any outstanding balances. If you lack insurance coverage or your insurer does not cover Seva Medical’s services, your account will be considered self-pay. In this case, you agree to settle the full balance of services rendered at the time of service. Pursuant to applicable law, we reserve the right to transfer your account to a collections agency if it becomes past due.

Payment Methods:
Seva Medical accepts check and credit cards (Visa, MasterCard, Discover, and American Express). Accounts can be set up on payment plans, if necessary, at no additional cost.

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Informed Consent for Primary Services

This form outlines the primary care services available to you, the undersigned patient. Please review it carefully.

Services:
Seva Medical, PLLC, operating as Seva Medical, provides a range of primary care services tailored for geriatric patients, encompassing chronic condition and medication management. Additionally, Seva Medical coordinates care among specialists and other providers as necessary. Our providers will discuss with you the suitability of these services based on your specific health condition(s) and collaborate with you to develop a personalized care plan aligned with your health objectives and needs.

Anticipated Benefits:
Receiving the primary care services outlined above may potentially result in various benefits for you, including enhanced wellness, health improvement, increased functional capacity, pain alleviation, aid in injury and disease recovery, and disease prevention or progression mitigation, among other potential advantages. However, you acknowledge that no assurances or guarantees regarding the outcomes of any primary care services provided by Seva Medical and its providers have been made to you.

Potential Risks:
The potential risks associated with receiving the primary care services described above include, but are not restricted to, medication side effects prescribed by Seva Medical’s providers, exacerbation of pre-existing symptoms, discomfort, pain, infection, burns, nausea, dizziness, lifestyle changes inconvenience, procedural or treatment-related injuries, and, in rare instances, severe injuries including death. If you experience any adverse symptoms possibly stemming from the primary care services provided to you, please inform Seva Medical and/or seek assistance from emergency providers as necessary.

Alternatives:
You have the option to seek primary care services from providers other than those at Seva Medical. However, it's important to note that Seva Medical’s providers may possess varying expertise, experience, and specialized areas compared to alternative providers. Another alternative is to forgo primary care services altogether, though this decision could potentially exacerbate your health condition(s).

New Patient Enrollment Form

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Informed Consent for Telemedicine Services

Seva Medical, PLLC, operating as Seva Medical, is committed to meeting your healthcare needs, even when in-person visits with Seva Medical's providers impractical or inconvenient. This form outlines the telemedicine services available to you, the undersigned patient. Please review it carefully.

Services:

"Telemedicine" refers to healthcare services provided via two-way interactive video and audio communications. During Telemedicine sessions, you should be able to see and hear your Seva Medical provider, and vice versa. These sessions may involve evaluation, diagnosis, care management, follow-up, and education, among other purposes, as deemed appropriate based on your individual condition(s) and health needs.

Important Considerations:

1. Prior to your telemedicine session, you will receive a link and/or phone number that you can use to join the session at the scheduled time. Seva Medical will send you this information by fax, email or text message using the contact information that you provide.
2. Your Seva Medical provider will always conduct telemedicine services from a secure and private location. It is your responsibility to ensure privacy during the session by choosing a suitable location where your conversations cannot be overheard.
3. You must connect to the session using either a cellular data plan or a secure Wi-Fi network. It is recommended to use a Wi-Fi network with a password that is not publicly available to protect the privacy and security of your health information.
4. By engaging in telemedicine services, you release Seva Medical and your Seva Medical provider from any claims, damages, losses, or expenses resulting from your failure to maintain privacy and security during the session, including the use of unsecured Wi-Fi connections.
5. Standard data and message rates will apply for telemedicine services, and Seva Medical will not reimburse you for any associated costs.
6. Seva Medical cannot guarantee the availability of telehealth sessions due to potential technical issues or network failures.

Anticipated Results and Benefits of Telemedicine:

Telemedicine services aim to assist you effectively and efficiently with the care, management, and treatment of your health condition(s) while minimizing exposure to contagious conditions and travel-related risks.

Potential Risks:

Potential risks with telemedicine include technology failures jeopardizing privacy/security and delays in evaluation/care. Depending on your health condition(s), your provider may deem telehealth unsuitable, requiring an in-person visit.

Alternatives:

If telemedicine is not suitable, you may schedule an in-person visit with your Seva Medical provider. However, immediate availability for in-person visits may not always be possible, leading to delays in your care. Another alternative is to forego any care or treatment, though this decision may worsen your health condition(s).

Text and Phone Call Consent:

By signing below, you consent to Seva Medical's transmission of scheduling information related to telemedicine sessions via telephone calls and unencrypted text messages to the provided number, as well as via unencrypted email messages to the provided email address. You acknowledge the risks associated with unencrypted communications and expressly consent to receive electronic communications containing your personal information from Seva Medical as described in this Consent.

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Chronic Care Management Consent Agreement

Medicare offers a benefit for Medicare beneficiaries to assist with multiple chronic conditions. This document, known as the Chronic Care Management Consent Agreement ("Agreement") is established between you, the undersigned patient, and Seva Medical. It delineates the chronic care management services ("CCM Services") offered by Seva Medical's licensed providers and clarifies your rights and responsibilities.

CCM Services are only available to patients with two or more chronic conditions. Medicare defines a chronic condition as a condition that is expected to last for at least 12 months and increases the risk of death, acute exacerbation of disease, or a decline in function.

Benefits of CCM Services:

- Access to a care provider to assist with your chronic healthcare needs.
- A comprehensive plan of care for health needs, available on paper or electronically.
- Coordination with both home and community-based service providers.
- Medication oversight and management.
- Use of a certified electronic health record (EHR) as mandated by Medicare.
- Transition management among healthcare providers, including referrals and follow-up after dischargers from hospitals, skilled nursing facilities, or other health care facilities.

Should you desire to receive CCM services through Seva Medical, we will only bill Medicare for CCM services once per 30-day billing cycle. Furthermore, your provider agrees only to bill Medicare for CCM Services if you have more than one chronic condition.

By signing this agreement, you agree to the following:

- You consent to Seva Medical providing CCM Services to you.
- You certify that your Seva Medical provider has fully explained the scope of CCM services to you.
- You acknowledge that only one practitioner can furnish and be paid for CCM Services during a calendar month.
- You authorize electronic communication of your medical information between treating providers as part of your care.
- You understand that CCM Services are subject to Medicare cost-sharing requirements, and so you may be billed for a portion of the CCM Services.

You have the right to discontinue CCM Services at any time by revoking this Agreement, effective at the end of the current thirty (30)-day service period. Revocation can be done verbally by calling 888-637-9669 or in writing to Seva Medical at 11120 NE 33rd Pl, Suite 202, Bellevue, WA 98004.

New Patient Enrollment Form

Phone: 888-637-9669 | Fax: 888-637-9661 | www.sevamedical.org | enrollments@sevamedical.org

Remote Patient Monitoring Consent Agreement

Medicare offers a benefit for Medicare beneficiaries to assist with the remote monitoring of their healthcare conditions by medical providers. This document, known as the Remote Patient Monitoring Consent Agreement ("Agreement") is established between you, the undersigned patient, and Seva Medical. It delineates the remote patient monitoring services ("RPM Services") offered by Seva Medical's licensed providers and clarifies your rights and responsibilities.

RPM Services are only available to patients with one or more chronic conditions. Medicare defines a chronic condition as a condition that is expected to last for at least 12 months and increases the risk of death, acute exacerbation of disease, or a decline in function.

Benefits of RPM Services:

- Ensure convenient access to data regarding your chronic condition(s).
- Facilitate monitoring of critical indicators related to your chronic condition(s).
- Empower you to take a more active role in your medical care.

To receive RPM Services and assess their suitability for managing your care, consult with your Seva Medical provider. Your provider may recommend RPM Services to you based on your current care plan.

By signing this agreement, you agree to the following:

- You consent to Seva Medical providing RPM Services to you.
- You agree to be the sole user of the remote monitoring equipment as instructed, solely for personal health monitoring, and you will not tamper with the equipment.
- You commit to returning any Seva Medical equipment upon completion of the RPM Services.
- You certify that your Seva Medical provider has thoroughly explained the scope of RPM Services to you.
- You acknowledge that only one provider can furnish and be paid for RPM Services during a calendar month.
- You authorize electronic communication of your medical information between treating providers as part of your care.
- You understand that RPM Services are subject to Medicare cost-sharing requirements, and so you may be billed for a portion of the RPM Services.

You have the right to discontinue RPM Services at any time by revoking this Agreement, effective at the end of the current thirty (30)-day service period. Revocation can be done verbally by calling 888-637-9669 or in writing to Seva Medical at 11120 NE 33rd Pl, Suite 202, Bellevue, WA 98004.