HERITAGE LAKES

Concierge Wellness

We're there when you need us

This Concierge Wellness program is executed by third parties Total Care Medical, PLLC and Fox Rehabilitation Management Services, LLC. This program offers services in coordination with Heritage Lakes staff and is endorsed by the Management of Heritage Lakes. All parties aligned for the joint purpose in delivering a higher caliber of comprehensive care to each resident in a way that was streamlined for the resident and their family. Total Care and Fox Rehab are providing separate services than Heritage Lakes. If you would like to take part in any of the services listed above, please fill out the Intake Form to enroll in our Concierge Wellness Program. We will not take payment directly from any resident, all services are reimbursed by Medicare and Major Insurance Providers.

*Please use the clickable form to fill out your records. After this is complete, please download and email them to **info@tcmedicalhome.com** or print your form and turn it to the Concierge Wellness Director at Heritage Lakes.

ENROLLING NOW

Concierge Wellness Program

Assisted Living and Memory Care

At Total Care our goal is to improve people's daily lives. Our nurses and providers do that by listening to you and your family's needs to customize a Continuity of Care Plan specific to your health and wellness needs. We know how complicated it can be to navigate the healthcare system, so we do the hard parts for you. This allows your time to be relationally focused while we manage the tasks and reporting. Our medical program offers a comprehensive list of services that foster communication between your personal doctors, specialist, and therapist.

List of services offered in the Concierge Wellness Program designed for Heritage Lakes:

- Chronic Care Management – Each resident will have a personal nurse that will help residents coordinate care, appointments, prescription refills, mental health, and referrals.
- Telehealth Services- Residents will have access to telehealth with a health care provider that can coordinate with local doctors and pharmacies to provide the most efficient care possible.
- Remote Patient Monitoring- Our staff will be able to perform remote patient monitoring of vital signs (blood pressure, pulse ox, weight readings, ext). This will provide our care givers with the information they need to deliver the best care possible.
- On-Site Nurse Practitioner- we will have a nurse practitioner on staff making rounds to check in on residents needs in-between doctors' visits.
- Annual Well Visits/ Physicals
- Annual On-Site Flu Shots and Vaccinations - Onsite immunizations, vaccinations, and boosters will be available for those as needed.
- Access to Therapists – We have partnered with Fox Rehabilitation for all your therapy needs.
- Software – As needed, we can provide the family and resident's care staff team with easy-to-use software that will provide access to telehealth, calendar of appointments, healthcare reports and evaluations.

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Total Care Medical Care Intake Form

New Patient Registration Form

Please fill out this form completely. The following information will help us in providing you the best medical care and treatment possible. If you have any questions, please contact the office.

Demographics

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ SSN: _____

Sex: _____ Mailing Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Email Address: _____

Race: _____ Ethnicity: _____ Language: _____

Emergency Contact

Name: _____ Number: _____

Address: _____

Primary Care Provider

Name: _____ Practice: _____

Address: _____

Phone Number: _____ Fax: _____

Insurance

Primary Insurance Type: _____

Policy ID: _____ Group ID: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Policy Holder SSN: _____

Secondary Insurance Type: _____

Policy ID: _____ Group ID: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Policy Holder SSN: _____

Medical History

Please list all medications you are currently taking (including over the counter and vitamins/ supplements): _____

_____

_____

_____

_____

Please list any allergies: _____

_____

_____

_____

_____

Please Check all that apply

- Anxiety
- Arthritis
- Asthma
- Cancer
- Cerebrovascular Disease
- Chronic Kidney Disease
- Chronic Kidney Disease Stage 3,4, or 5
- Chronic Pain
- Chronic Venous Insufficiency
- COPD, Chronic Bronchitis, Emphysema
- Depression
- Diabetes Mellitus Type 1, or Type 2
- Hear Failure
- Hepatic Cirrhosis
- Hyperlipidemia
- Hypertension
- Inflammatory Bowel Disease
- Nephrotic Syndrome
- Overweight or Obese
- Peripheral Artery Disease
- Reduced Mobility

Type of Cancer: _____

Other:

_____

_____

Social History

Do you smoke: _____ How many cigarettes a day: _____

Any other forms of tobacco: _____

Do you drink alcohol: _____ How Often: _____

Do you use illicit drugs? _____

Family History

Does anyone in your family (living or deceased) have the following: CHECK ALL THAT APPLY

- o High Blood Pressure
- o High Cholesterol
- o Cancer
- o Stroke
- o Heart Disease
- o Diabetes
- o Depression
- o Mental Illness
- o Hyperthyroidism
- o Other
  _____
  _____
  _____
  _____
  _____
  _____
  _____
  _____

Surgical History

- o Appendix
- o Tonsils
- o Adenoids
- o Hysterectomy
- o Gallbladder
- o C-Section
- o Heart
- o Other:
  _____
  _____
  _____
  _____
  _____
  _____
  _____

Pharmacy

Name: _____ Phone Number: _____

Pharmacy Address: _____

Back-Up Pharmacy: _____

Back-Up Pharmacy Phone Number: _____

Back-Up Pharmacy Address: _____

Telehealth Consent

Nature of Telehealth Consent

During the Telehealth consultation: Details of your medical history, examinations and tests will be discussed using interactive video and/or audio, A virtual examination may take place, Other medical professionals such as Medical Assistants and/or Scribes may be present during the visit to assist the provider and Photographs may be taken of you during the service. In an emergency, it is the responsibility of the Telehealth provider to direct the patient to emergency medical services, such as an emergency room. The Telehealth provider may also discuss and advise with the patient's local provider (if applicable). The Telehealth providers responsibility will end upon the termination of the Telehealth connection.

Possible Risks

As with any medical procedure, there are potential risks associated with the use of Telehealth. These risks include but may not be limited to: In rare cases, information transmitted may not be sufficient (e.g., poor resolution of images) to allow for appropriate medical decision making by the provider. There are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. The session may be discontinued by the patient and/or the provider if the video conference connection is not adequate for the situation.

Your Rights

You may withhold or withdraw consent to the Telehealth consultation at any time without affecting your right to future care or treatment or risking the loss or withdraw of any program benefits to which you would otherwise be entitled.

Billing and Payment

Total Care participates with many, but not all insurance plans. It is your responsibility to contact your insurance company to verify that we participate with your plan and the physician you will be seeing is in network with them. It is also your responsibility to provide accurate insurance information prior to the service. If you do not have your up-to-date insurance information, we will reschedule your appointment or classify your appointment as self-pay. Telehealth services may not be covered by all insurance plans. If your insurance does not cover the Telehealth visit, you will be considered self-pay and our published self-pay fee will apply. Non-covered Telehealth visits will be the patient's responsibility.

I Agree and Consent to Telehealth:

Signature: _____ Date: _____

Printed Name: _____

INSURANCE RELEASE INFO:

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGE FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT. I authorize the release of any medical information necessary to determine liability for the payment and to obtain reimbursement of any claim. I request that payment of authorized benefits be made on my behalf. I assign that benefits payable for all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and other agency reimbursements to this center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as vailed as an original. I understand I am financially responsible for all charges whether paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

HIPAA NOTICE OF PRIVACY PRACTICES

SUMMARY: To provide you with benefits, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides that if Total Care receives personal information about health, from you, your physician, hospitals, and other provide you with health care services we are required to keep this information confidential. This notice of our privacy practices is intended to inform you of the ways we may use your information and the occasion on which we may disclose this information to others. FOR THE FULL HIPAA NOTICE PLEASE SEE THE FRONT DESK AND THEY WILL MAKE IT AVAILABILITY FOR YOU.

Signature: _____ Date: _____

Printed Name: _____

Please send attached ID and Insurance Cards