



Welcome to Bluestone Physician Services.
Our goal is to provide high quality, personalized primary medical care to our patients.
Thank you for giving us the opportunity to care for your loved one.

**Please complete the following checklist and return to Bluestone Physician Services
with your completed enrollment forms:**

- Patient Enrollment Form.** *Please print clearly.*
- Include front and back copies of all medical insurance cards.**
- Consent to Treat & Notice of Privacy.** *Must have two signatures.*
- Release of Medical Records.** *It is your responsibility to request records from patient's previous clinic.
We are unable to request records should the form be returned to us.*
- A copy of patient's most current medication list**
- Register on the Bluestone portal in order to receive communications from our providers.**
www.bluestonemd.com

Your loved one will be seen one time per month by their Bluestone team. Frequency of psychiatry and neurology services will vary. Thank you once again for choosing Bluestone Physician Services.

Please fax completed forms to: 651.342.1428
Or email to: Enrollment@bluestonemd.com

Please contact Jill Volkert for questions or concerns regarding your enrollment paperwork,
enrollment@bluestonemd.com

I understand that all of the above information is required in order for Bluestone Physician Services to enroll, evaluate and treat my loved one. Without the above information, my loved one will not be enrolled for services until this paperwork has been completed and received by Bluestone Physician Services.

Signature: X Date: __/__/__

**Bluestone Physician Services
Patient Enrollment Form**

PATIENT'S FULL NAME: _____
FACILITY: _____ Memory Care Assisted Living
SOCIAL SECURITY #: _____ - _____ - _____ DATE OF BIRTH: ____/____/____
RACE: _____ PRIMARY LANGUAGE SPOKEN: _____ Male Female

INSURANCE *Please include front & back copies*

PRIMARY: _____
SECONDARY: _____
MEDICARE #: _____

LEGAL REPRESENTATIVE

POA, Conservator or Guardianship documents are on file at facility.
Name: _____ Relationship to Patient: _____
Primary Phone#: _____ Secondary Phone #: _____
E-Mail Address: _____
 No Legal Representative or Medical POA

BILLING CONTACT

Name: _____ Relationship to Patient: _____
Primary Phone#: _____ Secondary Phone #: _____
Billing Address: _____
City: _____ State: _____ Zip: _____

EMERGENCY CONTACT *Check if same as billing contact*

Name: _____ Relationship to Patient: _____
Primary Phone#: _____ Secondary Phone #: _____

IMMUNIZATIONS *Please provide last approximate date of the following vaccinations*

Pneumonia: _____ Flu: _____

MEDICATION ALLERGIES _____

Please include a copy of patient's most current medication list.

NAME OF PERSON COMPLETING THIS FORM: _____
RELATIONSHIP TO PATIENT: _____ **PHONE #:** _____ **DATE:** _____

Please be sure to register for communication access on the Bluestone Portal.

www.Bluestonemd.com

Bluestone Physician Services Consent to Treat

Patient's Full Name: _____ Facility: _____

I give my consent for Bluestone Physician Services and health care workers to perform exams, treatments, x-rays, lab tests, scheduled immunizations, operations, and to give me medicine that they believe to be necessary to my health.

I authorize and acknowledge consent to participate in Health Care Home.

I authorize payment from Medicare, Medicaid, insurance and any other funds be paid directly to Bluestone Physician Services for my care and treatment. I understand that it is my responsibility to comply with the requirements of my insurance policies. I request that payment of authorized Medicare benefits be made on my behalf to Bluestone Physician Services for any services furnished to me by a Bluestone Physician Services provider and/or in a bluestone Physician Services facility. I authorize any holder of medical or other information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agent any information needed to determine these benefits or related benefits for related services.

If I am signing as Authorized Representative of the patient, I am:

___ Power of Attorney ___ Court appointed guardian/conservator ___ Other: _____

X _____
Signature (patient or authorized representative) _____ Date

Notice of Privacy

Bluestone Physician Services respects your right to privacy. Under the following conditions, your health information will only be released with your consent.

I authorize Bluestone Physician Services to release my medical records to my doctors, their health care providers, my Health Care Home team and anyone else Bluestone Physician Services believes to be involved in my care and treatment. This includes source documents (such as x-rays), behavioral health, and chemical dependency information.

I authorize Bluestone Physician Services to release my protected information to insurance companies, government programs, and other parties responsible for payment of my bill, fraud investigation, and quality improvement. This includes behavioral health and chemical dependency information. Bluestone Physician Services may also release my protected health information to suppliers of medical equipment, special transportation, or other health services so they can request payment from my insurance or other payer. I also authorize Bluestone Physician Services to release my protected health information to organ procurement organizations to facilitate donations.

I authorize Bluestone Physician Services to release information from my medical records as needed by Federal Drug Administration (FDA) or manufacturers of drugs or medical devices to contact me about defects or recalls; or to emergency service providers involved in my care before and during transport to Bluestone Physician Services, for quality improvement.

I authorize Bluestone Physician Services to release information from my medical records and source data needed to accrediting organizations and to legally authorized agencies to oversee healthcare activities and to physical specialty boards for board certification/recertification of physicians.

I authorize Bluestone Physician Services to release information from my medical records for scientific research to improve patient care. I may object at any time to release of my protected health information for scientific research.

I agree to the presence of students, observers from other health care facilities, healthcare consultants and approved representatives of medical service providers during tests, exams, medical treatments and other services at Bluestone Physician Services. I understand that Bluestone Physician Services will also seek my oral permission to have non-Bluestone Physician Services persons present during any services.

- I understand that I may revoke this permission at any time by notifying Bluestone Physician Services in writing. NO further release of information will take place after the date notified.
- I understand that other parties may use or disclose health information received from Bluestone Physician Services.
- I understand that Bluestone Physician Services will treat me whether I sign this agreement or not.
- I understand that the expiration date of this authorization is one year.
- I understand I have a right to receive a copy of this form after I have signed it.

If I am signing as Authorized Representative of the patient, I am:

___ Power of Attorney ___ Court appointed guardian/conservator ___ Other: _____

X _____
Signature (patient or authorized representative) _____ Date

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Full Name (print): _____ DOB: _____ Facility: _____

INFORMATION TO BE RELEASED FROM:

Name of healthcare provider or facility: _____

Address: _____ City, State & Zip Code: _____

INFORMATION TO BE SENT TO: Bluestone Physician Services

Mail:
Bluestone Physician Services Attn: _____
270 Main Street North, Suite 300
Stillwater, MN 55082

Fax:
651.342.1428

INFORMATION TO BE RELEASED:

The most recent two years of pertinent information (chart notes, labs, x-rays, immunization records including **influenza, pneumovax and tetanus**).

Other specific information (i.e. consult notes, psych notes) please Specify:

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE: (please check one)

Doctor Attorney Insurance Personal

PATIENT AUTHORIZATION:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

***EXCLUDE** the following information from the records released (please initial):

_____ Drug/Alcohol abuse/treatment & diagnosis _____ Sexually transmitted disease

_____ HIV/AIDS diagnosis/treatment/testing _____ Mental illness, Psych diagnosis/treatment

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization, in writing, at any time. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws. I understand that there may be a copy fee associated with the medical record release. I understand the expiration of this authorization is one year from the date signed.

X _____ / /

Signature (Patient, legal guardian, or Authorized representative)

Patient is responsible for completing and forwarding this document to previous clinic or provider. If you are signing as a legal representative, include supporting documentation so medical records can be sent without delays.



Disclosure Statement

For the purpose of responsible business practices and full disclosure, it is important to Bluestone Physician Services as a corporate entity to make known to all patients, families, facilities, vendors and other corporations with whom we conduct business, all relationships we have individually and as a group which may reflect additional affiliations and affinities outside of Bluestone Physician Services. In addition, we are required by law to disclose relationships with such companies.

Dr. Todd Stivland, CEO and owner of Bluestone Physician Services, serves as the Chief Medical Officer of St. Jude's Hospice and holds a position on its Board of Directors as a minority shareholder. In addition, Dr. Stivland is an Associate Faculty member of the University of Minnesota Medical School and Augsburg Physician Assistant program without a financial affiliation.

Dr. Matthew Logan serves as Medical Directors for St. Jude's Hospice and Interim Health Care Company. He is also an Associate Faculty member of the University Of Minnesota Medical School without a financial affiliation.

Dr. Rebecca Meyerson works as an Acute Care Neurologist for MeritCare in Fargo, ND and in that role serves an Associate Faculty member for the University Of North Dakota Medical School. In addition, she functions as an Associate Faculty member for the University of Minnesota-Duluth Medical School with teaching responsibilities to the Neuroscience Clinical Correlations course.

Dr. Todd Holm serves as an Adjunct Faculty member of the University Of Minnesota Medical School without financial affiliation.

Dr. David Gish works as an on-call psychiatrist for St. Luke's Hospital in Duluth, MN. He also is the consulting psychiatrist for Ecumen Parmlly Life Pointes' Awakenings program.



Health Care Home Information

What is Health Care Home?

“Health Care Home” is program sponsored by the State of Minnesota in which primary care clinics such as Bluestone are certified as “Health Care Homes”. This means the clinics takes an active role in managing care for the whole person.

Some parts of Health Care Home involve the clinic doing special projects for the entire clinic. For example, this could be projects which focus on disease management or improving our communications.

Other parts of Health Care Home involve direct Care Coordination. This is appropriate for patients who are not receiving care coordination from another organization, such as a county or Health Plan.

We will help your determine if it is appropriate for you or your loved one to receive care coordination from Bluestone when you enroll.

If you have questions about Health Care Home please call our office at 651-342-1039.

Purposes and Services of the Health Care Home

- Facilitate consistent and ongoing communication among the Health Care Home team and the patient and/or family.
- Provide the patient and/or family with continuous access to the Health Care Home.
- Use an electronic, searchable patient registry that enables the Health Care Home team to manage health care services, provide appropriate follow up, and identify gaps in patient care.
- Provide care coordination that focuses on patient and family-centered care.
- Create a care plan for appropriate patient’s that includes the patient and/or patient’s family in the care planning process.
- Encourage active participation by patient/family in their health care by assessing barriers and creating goals in care plan.

Responsibilities of the Health Care Home Team

- Personal Clinician: This could be a physician, physician’s assistant, or nurse practitioner who’s responsibility is to provide overall and ongoing comprehensive medical care. This includes preventive care, treatment of acute and chronic medical conditions, and end-of-life care when appropriate. The patient will be provided the name and contact number of their personal clinician, along with access via our Communication Portal.
- Care Coordinator: Mid Level Practitioner who has the primary responsibility to organize and coordinate care with the participant in a health care home. Specifically the care coordinator will manage referrals for specialty care, ensure lab and test results are obtained and communicated, be involved in hospital admissions to include appropriate discharge planning and follow up, communicate with participant’s pharmacy regarding use of medication and medication reconciliation, and ensure that all other aspect of the participant’s health care needs are being met. The patient will be provided the name and contact number of their care coordinator along with access via our Communication Portal.
- Family: Whenever applicable, the participant’s family is included in all aspects of care. Definition of family includes: any person(s) identified by participant as a family member, legal guardian, health care agent, or spouse.

- Contracted facility nurse or representative: Nurse or representative that is employed by the facility that the participant lives in. This person has direct and often times daily contact with the participant and, when appropriate, would be considered the primary means of communication between participant and Health Care Home. Communication may be face to face, via the Bluestone Communication Portal, or via telephone.

Referral Coordination Services and Sources

- A referral means a written document is given to a participant recommending that the participant receive a consultation for evaluation, treatment, or services from a provider outside of the health care home. Participant may choose a specialty care resource without regard to whether a specialist is a member of the same provider group or network as the participant's health care home, and that the participant is then responsible for determining whether specialty care resources are covered by the participant's insurance.

Clinic Office Hours and After Hours Access

- Bluestone Physician Services does not have a traditional clinic setting where patients actually come into the clinic to see their doctor. All of the clinicians employed by Bluestone Physician Services are out at facilities or group homes seeing patients in their home, which makes contacting your physician somewhat unique. When appropriate, the facility nurse or representative may be the person responsible to facilitate communication between participant and Health Care Home, depending on cognitive ability of participant. Regardless of whom is representing the participant in terms of communication, the following protocol will be used:
 - The care coordinator (Nurse Practitioner or Physician Assistant) can be contacted via phone or Bluestone Communication Portal Monday through Friday from 8am to 5pm.
 - Physicians can be contacted 24 hours a day, seven days a week via phone or Bluestone Communication Portal.
 - All phone calls will be returned within 2 hours.
 - There will be a backup physician assigned to cover call for all providers at all times in the event the primary provider cannot be reached.

What is Different from Care Coordination Previously Received?

- The care coordinator assigned to you is employed directly by your physician, which makes it much easier for your care coordinator to be in direct contact with your physician in times of need.
- The care coordinator will encourage participants to take an active role in managing their health care by helping to identify and address barriers to comprehensive health care.
- The Health Care Home provides 24 hour access.
- The HCH will provide reminders of when the physician or midlevel will be in each facility to both the facility and the families via the Bluestone website.
- The HCH will ensure that all labs/tests ordered are completed and results are shared with the appropriate parties in a timely manner.
- One of the main focuses of the Health Care Home is to provide patient and family centered care, meaning that the participant's family is included to the fullest extent with care planning and care coordination.
- Participation in the Health Care Home is voluntary and the option is available to join at any time.