Consultative
Health and Medicine

REGISTRATION INFORMATION

5520 Ridgewood Cove
Minnetrista, MN 55364
800-873-0561 Office
866-404-2579 Fax

Patient Name:_____ DOB:____/____/____ SSN: _____

Residential Community: _____

Insurance Information (Please enclose photocopies of insurance and Medicare cards)

Medicare Number: _____

Your Current Health Plan: _____ ID: _____ Group: _____

Personal Representative (Healthcare Decision Maker) _____

Please attach Health Care Directive and/or Health Care POA documents

Name: _____ Relationship to Patient: _____

Check preferred phone number

☐ Cell: _____

☐ Home: _____

☐ Work: _____

Check appropriate descriptor and provide documentation

☐ Financial POA ☐ Conservator

☐ Health Care Agent ☐ None

☐ Guardian

Address: _____

Email: _____

Alternative Emergency Contact

Name: _____ Relationship to Patient: _____

Cell: _____ Home: _____ Work: _____

Billing Contact Information (if other than Personal Representative listed above))

Name: _____ Relationship to Patient: _____

Check preferred phone number

☐ Cell: _____

☐ Home: _____

☐ Work: _____

Check appropriate descriptor and provide documentation

☐ Financial POA ☐ Conservator

☐ Health Care Agent ☐ None

☐ Guardian

Address: _____

Email: _____

RETURN ASAP TO:
CONSULTATIVE HEALTH AND MEDICINE
5520 RIDGEWOOD COVE, MINNETRISTA MN 55364
FAX 1-866-404-2579

ENROLLMENT
CONSULTATIVE HEALTH AND MEDICINE

Patient's Name:_____ Facility:_____

I give Consultative Health and Medicine, "CH&M," permission to enroll me in CH&M's Collaborative Care Model with Medicare's Advanced Primary Care Management and Chronic Care Management Programs.

CH&M's Collaborative Model of Care involves your CH&M Primary Nurse Practitioner and Consulting Physician working together with an extended Multidisciplinary Team including facility nurses, home care and rehab providers, pharmacists and other specialty providers to coordinate and monitor your care.

- **Face-to-Face Visits**
  Each patient receives an **in-person visit** from their CH&M primary nurse practitioner every 1-2 months to manage chronic conditions and address any new or urgent medical issues. Patients also receive a periodic collaborative visit with your nurse practitioner and physician to review and revise your care plan. This consistent, hands-on care helps you maintain your best health and reduce emergency room visits and hospitalizations. Visits for additional needs or follow-up also occur between these regular visits.

Medicare's Advanced Primary Care Management and Chronic Care Management Programs

- **Ongoing Support Between Visits**
  Our care team remains actively involved in your health even between visits. We **collaborate with caregivers, community staff, specialists, and other providers** to coordinate care, refill medications, monitor test results, arrange recommended preventive care and follow up on changes in condition. A CH&M provider is available 24/7 to address urgent medical concerns.

- **A Dedicated Care Team**
  Each patient is supported by a **primary nurse practitioner and consulting physician** committed to building long-term, trusted relationships. We create personalized care plans that reflect each patient's goals, health needs, and preferences, ensuring care is aligned with what matters most to them.

- **Complex Care Management and Transitions**
  Should a patient experience an emergency room visit, hospital stay, or transition to or from rehab, our team—including your nurse practitioner and physician—will help coordinate care, advocate for appropriate treatment, and assist in returning home safely and smoothly.

CH&M's services will be billed to Medicare, Medical Assistance and/or your health insurance company with normal deductibles, coinsurance or copays. APCM or CCM services are billed as a monthly service. Face-to-Face visits are billed when they occur. I understand that depending upon my health insurance benefits, there may be co-payments or coinsurance required for some services. I may cancel services provided by CH&M at any time by providing written notice, and understand I will be responsible only for the cost of services provided to that date. Only one provider can furnish and be paid for APCM or CCM services during a calendar month. Further information on our Collaborative Model of Care with Advanced Primary Care Management and Chronic Care Management available on our website www.consultativehealth.com

Patient Signature (or legal representative): _____*Date:* _____

Print Name: _____

Relationship to patient: _____

RETURN ASAP TO:
CONSULTATIVE HEALTH AND MEDICINE
5520 RIDGEWOOD COVE, MINNETRISTA MN 55364
FAX 1-866-404-2579

CONSENT FOR SERVICES
AUTHORIZATION FOR PAYMENT
USE OF MEDICAL RECORDS

Patient's Name:_____ Facility:_____

CONSENT FOR SERVICES: I give consent for CH&M's physicians, nurse practitioners and nurses to perform or order examinations, treatments, laboratory tests or x-rays, immunizations, minor procedures and to prescribe medicine they believe to be necessary for my health. I consent to the release and disclosure by CH&M of my protected health information, including paper or electronic records, to other health care providers and facilities that are or may become involved in my care.

TELEHEALTH SERVICES: I consent to the use of telehealth services in the course of my diagnosis and treatment with my CH&M Providers. (Telehealth involves the use of audio, video or other electronic communications to interact with you, and consult with your healthcare providers.)

AUTHORIZATION OF PAYMENT:I authorize payment from Medicare, Medical Assistance and/or my health insurance company, to be paid directly to CH&M for my care and treatment. I understand that I am responsible for normal deductibles, coinsurance or copayments.

INSURANCE CONSENT: I give permission to CH&M to release my protected health information, including paper or electronic records of my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment, to Medicare, Medical Assistance and/or my health insurance company for the purposes of payment, treatment or health care operations. I understand that this information serves as a source of information for applying my diagnosis and treatment information to my medical bill; a verification to third party payers that I did in fact receive these health care services; and a tool for routine health care operations.

USE OF HEALTH CARE RECORDS IN PROGRAM EVALUATION AND TRAINING: I give CH&M permission to use information gathered during the course of my treatment from CH&M, including information from my treatment records, for the purposes of program evaluation, training and quality review.

NOTICE OF PRIVACY PRACTICES: I acknowledge I have received a copy of CH&M's Notice of Privacy Practices (included with this enrollment packet) and I understand that I have a right to review these privacy practices before signing this consent form. I understand that CH&M Privacy Practices including future changes are posted on CH&M's web site (www.consultativehealth.com), and that I may request a copy of the new privacy practices at any time. I also understand that I can contact CH&M's Privacy Officer with any questions I may have about the Notice of Privacy Practices.

This consent applies to health records that my CH&M health care providers already have about me, and information about future care I may receive from them. This consent will continue unless I cancel by giving written notice to CH&M or it expires as required by law. If I cancel the consent, it will apply to information generated after the date when the notice to cancel is received. It will not affect information that has already been shared among my providers.

Patient Signature (or legal representative): _____ *Date:* _____

Print Name: _____

Relationship to patient: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT

Name (Last, First, MI): _____ DOB: _____ SSN: _____

Address: _____ City, State, Zip: _____ Phone: _____

INFORMATION TO BE RELEASED FROM

Name of health care provider, clinic, or facility _____
Address: _____
Date Requested: _____ Date Needed By: _____

INFORMATION TO BE SENT TO

By Fax, TO: _____ at Consultative Health and Medicine FAX: **855-356-4042**

By Mail TO: **Consultative Heath and Medicine, P.A.**
5520 Ridgewood Cove
Minnetrista, MN 55364

INFORMATION TO BE RELEASED

PLEASE RUSH: Our clinic is assuming primary care for the patient and need the following information for continuity of care.

X Most recent H&P and 6 months of MD/NP clinic visits
X Problem List
X Medication List
X Lab and Xray reports from last 6 months
X Immunization Record

Other _____

PATIENT AUTHORIZATION

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 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.

_____ _____ _____/_____/_____
Signature Printed Name Date

(Patient, legal guardian or legal representative)

If you are the legal representative, please include with this form a copy of **Medical or Health Care Power of Attorney/Guardian** so that medical records can be sent without additional delay. This can be found on a Health Care Directive naming a Health Care Agent or a separate Medical or Health Care POA/Guardian document. MN Statutory Short Form Power of Attorney documents are not accepted for release of medical records.

Effective Date*: *03-04-2026

Notice of our Privacy Practices

Consultative Health and Medicine, PA

Chris J Johnson, M.D.
Chief Compliance and Privacy Officer
Consultative Health and Medicine, PA,
5520 Ridgewood Cove Minnetrista, MN 55364
https://consultativehealthandmedicine.com/

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Our Uses and Disclosures

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the preventive care and the care you receive for certain chronic illnesses is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence or to prevent or reduce a serious threat to anyone's health or safety. We will only make this disclosure if you agree or when required or authorized by law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
To the extent that we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Your Choices

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In These Cases, You Have the Right and Choice to Tell Us To:

Share Information with Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Share Information in A Disaster Relief Situation. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

Include Your Information In A Hospital Directory. We may disclose your information in a hospital directory. We will provide you with an opportunity to agree or object to such a disclosure.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In These Cases, We *Never* Share Your Information Unless You Give Us Written Permission:

Marketing Purposes. In this case we never share your information unless you give us written permission.

Sale of your information. In this case we never share your information unless you give us written permission.

Psychotherapy notes. In this case we never share your information unless you give us written permission.
*CH&M does not create or maintain psychotherapy notes.

In The Case of Fundraising:

Fundraising. We may contact you for fundraising efforts, but you can tell us not to contact you again.

Uses and disclosures of certain PHI deemed "Highly Confidential."

For certain kinds of PHI, federal and state law may require enhanced privacy protection. These would include PHI that is:

- Maintained in psychotherapy notes.
- About alcohol and drug abuse prevention, treatment, and referral.
- About HIV/AIDS testing, diagnosis or treatment.
- About venereal and/or communicable disease(s).
- About genetic testing.

We will obtain your authorization unless specifically permitted or required by law. Use or disclosure of SUD records in legal proceedings requires your written consent or a Part 2–compliant court order. Any other uses and disclosures not described in this Notice will only be made with your prior written authorization.

Special Protections for Substance Use Disorder (SUD) Records (42 CFR Part 2). Consultative Health & Medicine is not itself a Part 2 program; however, we may receive Part 2 protected information from providers or programs during activities such as utilization management, case management, appeals, or care coordination. Certain records identifying you as receiving SUD diagnosis, treatment, or referral for treatment from a federally assisted "Part 2 program" are protected by 42 CFR Part 2 and are subject to heightened confidentiality rules. We will use or disclose Part 2 records only as permitted by your written consent that complies with Part 2 or as otherwise allowed by law. Your single consent may authorize future uses and disclosures for treatment, payment, and health care operations. Once lawfully received with appropriate consent, HIPAA-regulated entities (like Consultative Health & Medicine) may redisclose SUD information in accordance with HIPAA, except where Part 2 provides additional protections (for example, certain counseling session notes).
SUD records may not be used or disclosed in legal proceedings without your written consent or a court order that complies with Part 2. In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

Cancellation of Authorization. You may cancel ("revoke") a written authorization you previously gave us. The cancellation, submitted to us in writing, will apply to future uses and disclosures of your PHI. It will not impact disclosures made previously, while your authorization was in effect.

Your Rights

Right to an Electronic or Paper Copy of Your Medical Records. You have the right to inspect, receive or copy an electronic or paper copy of your medical record and other health information we have about you or transmitted to another individual or entity. This includes medical and billing records, other than psychotherapy notes. We will make every effort to provide access to your Protected Health Information in the form or format you request if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. To receive the electronic or paper copy of your medical records or health information, you must make your request, in writing, to Chris J. Johnson, M.D., Chief Compliance and Privacy Officer. We have up to 30 days to make your Protected Health Information available to you and may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to Amend. If you feel that the Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to Chris J. Johnson, M.D., Chief Compliance and Privacy Officer. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to Chris J. Johnson, M.D., Chief Compliance and Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Chris J. Johnson, M.D., Chief Compliance and Privacy Officer. We are not required to agree to your request and may say "no" if it would affect your care. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment. If you paid out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer (or in other words, if you have requested that we not bill your health plan for a specific item or service which you have paid out-of-pocket in full, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations). We will say "yes" unless a law requires us to share that information.

Right to an Accounting of Disclosures. You have the right to request a list of the times we've shared your health information for six years prior to the date you asked, who we shared it with, and why for certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Chris J. Johnson, M.D., Chief Compliance and Privacy Officer. We'll provide

one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.consultativehealth.com or by reaching out to Chris J. Johnson, M.D., Chief Compliance and Privacy Officer.

Right to Choose Someone to Act For You. If you have given someone health care power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

Right To File A Complaint If You Feel Your Rights Are Violated. If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Chris J. Johnson, M.D., Chief Compliance and Privacy Officer. To file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights, send a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, call 1-877-696-6775, or visit www.hhs.gov/ocr/ privacy/hipaa/complaints/. All complaints must be made in writing. **You will not be penalized for filing a complaint**.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us, will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.
Effective Date: 03-04-2026

If You Have Any Questions About This Notice, Please Contact:

Chris J. Johnson, M.D.
Chief Compliance and Privacy Officer
Consultative Health and Medicine, PA,
5520 Ridgewood Cove Minnestrista, MN 55364
Chris@consultativehealth.com
612-868-0136

This Notice of Privacy Practices applies to the following organizations:

Consultative Health and Medicine, PA