CareHere!

CareHere Blood Pressure Management Program

PATIENT INFORMATION:

Patient Last Name: _____ Patient First Name: _____

DOB (MM/DD/YY): ____/____/____ Employer: _____ Phone: (_____) _____-_____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Arm circumference in centimeters (for cuff size): _____cm

Primary Care Provider's Name: _____

Primary Care Provider's Phone (_____)_____-_____ Email: _____

For non-CareHere/Montana Health Center providers: To keep you updated on your patient's care management and status, we ask that the PCP provides their email address and phone here.

Reason for Provider Reccomendation:

Do you have specific guidelines for the patient during the program? _____
E.g. number of blood pressure readings per day, if there are specific times the patient should take readings, etc.

Is the diagnosis of Hypertension (HTN) new or pre-existing? (Circle one): New Pre-existing

SIGNATURES:

The above identified patient has hypertension or elevated BP readings without current diagnosis of hypertension and is interested in participating in the CareHere Blood Pressure Management Program.

Provider Name (printed): _____ Provider Signature: _____

The patient has been informed of and given a copy of the CareHere Blood Pressure Management Non-Compliance Policy, and agrees to its terms.

Patient Signature: _____Date: _____

Monitoring Party Signature: _____Date: _____

NOTE: The CareHere HIPAA form is attached to this document and must be completed by the patient and PCP before CareHere can transmit any data/information to the PCP. CareHere highly reccomends that the patient sign a HIPAA form specifically from their PCP before beginning this program.

Once you and your Patient have filled out this application, please return to CareHere via fax, email or mail.

Fax: To the attention of Remote Monitoring Coordinator at 406.502.1359
Email: RemoteMonitoringMT@CareHere.com.
Mail: Montana Health Center-CareHere Attn: Remote Monitoring Coordinator
405 Saddle Drive, Helena, MT 59601

The CareHere Remote Monitoring Care Team will reach out to the member with information about how the program works. Questions? Please email **RemoteMonitoringMT@CareHere.com**

CareHere abides by all federal HIPAA and confidentiality regulations.

CareHere!

CareHere Blood Pressure Management Non-Compliance Policy

1. First non-compliance notification:
   At 8 days without a synced reading, the care team will reach out via the CareHere App or phone call depending on the option initially selected by the patient to establish the reason for non-compliance and help the patient sync a reading.

2. Second non-compliance notification:
   After 3-5 additional business days have passed without a synced reading, the care team will call the patient directly to facilitate the patient's return to compliance.

3. Third non-compliance notification:
   After 3-5 additional business days have passed without a synced reading, the responsible provider or health center member designated by the provider will call the patient directly to facilitate and educate the patient on the return to compliance with the program. Additionally, the provider will let the patient know that the patient should sync a reading within 3 business days, or they will be removed from the program.

4. Fourth non-compliance notification:
   After 3 additional business days have passed without a synced reading, the patient will receive notification via email of removal from the program and the patient will be moved to the unenrolled group inside the monitoring platform.

5. If the patient reaches the 3rd non-compliance notification twice in a 6-week period, then the patient will be deemed non-compliant and removed from the program. Patient will be notified by the clinical team of the removal from the program. CareHere will educate patients on this policy during the initial enrollment period.

Provider Name (printed):_____ Date: _____

Provider Signature:_____

Patient Name (printed):_____ Date: _____

Patient Signature:_____

CareHere abides by all federal HIPAA and confidentiality regulations.

CareHere!

CareHere Blood Pressure Management and Consent

Signing below confirms you have read and understood the CareHere Blood Pressure Management and consent. Signing below indicates that you are a representative (one provider of a group) of the Patient's Primary Care practice and that you understand CareHere is solely responsible for monitoring the Patient's condition, not managing. You will be required to sign this consent form annually for all CareHere Blood Pressure Management patients in your practice and will be reminded of the policy each time a new patient joins the management program.

_____

Patient's Primary Care Practice Provider Representative Name (Printed)

_____

Patient's Primary Care Practice Provider Representative (Signature)

_____

Date

_____

Patient Name (Printed)

_____

Patient Name (SIgnature)

_____

Date

NOTICE OF PRIVACY PRACTICES

CAREHERE HEALTH CENTER SITE: _____

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.

WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI). All employees, volunteers, staff, doctors, health professionals, and other personnel are legally required to and must be abide by the policies set forth in this notice, and to protect the privacy of your health information.

This "protected health information", or PHI for short, includes information that can be used to identify you. We collect or receive this information about your past, present, or future health condition to provide healthcare to you, or to receive payment for this health care. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose (release) your PHI. With some exceptions, we may not use or release any more of your PHI than is necessary to accomplish the need for the information.

We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes to this notice will apply to the PHI already in existence. Before we make any change to our procedures, we will promptly change this notice and post a new notice in our lobby. You can also request a copy of this notice from the contact person listed at the end of this notice, and can view a copy of the notice on our web site at www.carehere.com.

I. We may use and release your protected health information for many different reasons. For some of these reasons, we will need your permission or a specific, signed authorization. Below, we describe the different categories of when we use or release your PHI and give you some examples of each category, and tell you when we need your permission.

A. WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. YOUR CONSENT IS NOT REQUIRED FOR THESE PURPOSES.

1. For Treatment. We may release your PHI to physicians, nurses, and other health care personnel and agencies who provide or are involved in your health care. For example, if you are being treated for a knee injury, we may release your PHI to an orthopedic specialist in order to coordinate your care.

2. To obtain payment for treatment. We may use and release your PHI in order to bill and collect payment for services provided to you. It is important that you provide us with correct and up-to-date PHI. For example, we may release portions of your PHI to our billing department and your health plan to get paid for health care services we provided to you. We may also release your PHI to our business associates, such as a Pharmacy Benefits Manager (PBM), to obtain eligibility and/or approval for medication.

3. To run our health care business. We may release your PHI in order to operate our facility in compliance with healthcare regulations. For example, we may use your PHI to review the quality of our services, to evaluate the performance of our staff in caring for you, or to seek outside Accreditation.

4. Organized Health Care Arrangements. We may use or disclose your PHI with members of an Organized Health Care Arrangement for health care operations. Example of an arrangement is on-site specialty care.

B. WE ALSO DO NOT REQUIRE YOUR CONSENT TO USE OR RELEASE YOUR PHI IN THE FOLLOWING:

1. When federal, state, or local law; judicial or administrative proceedings; or law enforcement agencies request your PHI. We release your PHI when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; for notification and identification purposes when a crime has occurred or in missing persons cases; when a crime has taken place on our premises; about victims of a crime with their consent or in an emergency situation; about victims of a crime with their consent or in an emergency situation; or when ordered in a judicial or administrative hearing.

2. For public health activities. We report information about births, deaths, and various mandated reportable diseases to government officials in charge of collecting that information, and we provide coroners, medical examiners, and funeral directors necessary information relating to an individual's death.

3. For purposes of organ donation. For patients that have previously agreed to organ donation, we may notify organ procurement organizations to assist them in organ, eye, or tissue donation and transplants.

4. To avoid harm. In order to avoid a serious threat to health or safety of a person or the public, we may provide your demographic PHI to law enforcement personnel or persons able to prevent or lessen such harm.

5. For workers' compensation purposes. We release your PHI in order to comply with workers' compensation laws. If you do not want workers' compensation notified, alternate insurance or payment information must be supplied.

6. For appointment reminders and health-related benefits and services. We may use your demographic PHI to contact you as a reminder that you have an appointment or to recommend possible treatment options or alternatives that may be of interest to you.

7. For health oversight activities. We may disclose PHI to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for oversight of the health care system,

government benefit programs, or entities subject to government regulations or civil rights laws.

If state law is more stringent (gives you more protection), it will be applied to the examples stated in A and B.

C. YOU HAVE THE OPPORTUNITY TO AGREE TO OR OBJECT TO THE FOLLOWING:

Information shared with family, friends, or others. We may release your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. Your choice to object may be made at any time.

D. YOUR PRIOR WRITTEN AUTHORIZATION IS REQUIRED FOR ANY USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION NOT INCLUDED ABOVE.

We will ask for your written authorization before using or releasing any of your PHI except as previously stated. If you choose to sign an authorization to release your PHI, you may later cancel that authorization in writing. This will stop any future release of your PHI for the purposes you previously authorized but will not change what was released by the valid authorization.

II. YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

A. You Have the Right to Request Limits on How We Use and Release Your PHI.

If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit PHI that we are legally required or allowed to release.

B. You Have the Right to Choose How We Communicate PHI to You.

All of our communications to you are considered confidential. You have the right to ask to ask that we send information to you to an alternative address (for example, sending information to your work address rather than your home address), or by alternative means (for example, e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested. Any additional expenses will be passed on to you for payment.

C. You Have the Right to See and Get Copies of Your PHI.

You must make the request in writing. We will respond to you within 30 days, or less if directed by state law, after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, why we denied your request. You have the right to have the denial reviewed. We will choose another licensed healthcare professional to review your request and the denial. The person conducting the review will not be the person who denied your first request. You can also request a summary or a copy of the entire medical record so long as you agree to the cost in advance. If your request to see or get a copy of the medical record is approved, we will arrange this in accordance with established policy.

D. You Have the Right to Get a List of Instances of When and to Whom We Have Disclosed Your PHI.

This list will not include uses you have already authorized, or those for treatment, payment, or operations. This list will also not include disclosures made for national security purposes, to corrections or law enforcement personnel if you were in custody, or made before April 14, 2003. We will respond within 60 days of receiving your request. The list we provide will include the dates of when your PHI was released and why, to whom your PHI was released (including their address if known) and a description of the information released for the timeframe you requested. The first list you request within a 12-month period will be free. You will be charged a reasonable fee for additional lists within that time frame.

E. You have the Right to Correct or Update Your PHI.

If you believe there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing or add the missing information. We can do this for as long as the information is retained by our facility. You must provide the request and your reason for the request in writing. We will respond within 60 days, or less if directed by state law, of receiving your request. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change or amendment to your PHI. If we deny your request, our written denial will state our reasons and explain your right to file a written statement of disagreement. If you do not file a written statement of disagreement, you have the right to request that your request that our denial be attached to all future uses or releases of your PHI.

F. You have the Right to Get This Privacy Notice by email, as well as paper.

G. Please submit all requests to view and/or obtain a copy of your medical record, to obtain a list of disclosures, or to amend your PHI to:

615-767-5568 or email medicalrecords@carehere.com

Telephone #

III. HOW TO VOICE YOUR CONCERNS ABOUT OUR PRIVACY PRACTICES: If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with:

CareHere Risk Committee

615-767-5531 or email risk@carehere.com
Telephone #

You may also send a written complaint to the Secretary of the Department of Health and Human Services at
200 Independence Avenue, SW
Washington, DC 20201
You will not penalized for filing a complaint.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003.

CareHere!

Authorization for Use and Disclosure of Protected Health Information in conjunction with CareHere's Remote Monitoring Program

_____ _____

CareHere Remote Monitoring Program(s) Date

Describe the protected health information to be disclosed and the purpose for the disclosure:

Information reasonably related to the specific CareHere Remote Monitoring Program. This includes any information collected by CareHere through the program AND any information, such as lab values and medication changes made by my primary care physician or specialist, as listed below.

Information is to be shared for my treatment under the CareHere Remote Monitoring Program(s).

1. I authorize CareHere and _____, the below listed provider, to share information related to the specific CareHere Remote Monitoring Program(s) listed above.
2. This authorization expires at the end of the CareHere Remote Monitoring Program. I may revoke the authorization at any time by providing a written statement to CareHere: **RemoteMonitoring@Carehere.com**

   The revocation will not impact protected health information already released while my permission was in effect. However, further release of that protected health information will be prohibited without my specific authorization.
3. My treatment or payment for such treatment will not be conditioned on whether I sign this authorization.
4. Once my protected health information is disclosed, it may no longer be protected by federal or state law.

Name and contact information for the healthcare professional(s) I authorize to share and discuss the aforementioned protected health information:

Non-CareHere Provider: _____

Address: _____

Phone Number: _____ Fax Number: _____

CareHere Provider: _____

Address: _____

Phone Number: _____ Fax Number: _____

_____ _____

Patient Name Print (or Personal Representative) Signature of Patient (or Personal Representative)

_____ _____

Description of Personal Representative's Authority Date

CareHere abides by all federal HIPAA and confidentiality regulations.