

CONDITIONS OF REGISTRATION

Telehealth / Palliative Medicine Consultation Agreement

This form pertains to telehealth consultation. No ongoing care relationship is implied or established unless both parties agree in writing. Terms related to home visits, membership, or chronic care management do not apply unless otherwise specified. This Agreement outlines the terms under which you ("Patient") receive care from Gurpreet K. Padam MD PC, doing business as Home Based Medicine ("HBM" or "the Practice").

CONSENT TO CARE, TELEHEALTH & PALLIATIVE CONSULTATION: I voluntarily consent to telehealth consultation, including review of history, symptom assessment, education, recommendations, and care coordination. I understand this may include discussions related to serious illness, goals of care, or advance planning, including advance directives or POLST forms. I may decline any part of the visit, and no outcomes are guaranteed. I consent to receive care via telehealth. I understand its limitations (e.g., no physical exam, need for in-person follow-up, and standard billing). Telehealth is only available in California. Controlled substances will not be prescribed or refilled via telehealth. I may revoke consent at any time.

I authorize communication via HIPAA-compliant tools (e.g., Spruce, EMR, fax). If I use unsecured email or text, I accept the associated risks and release HBM from liability. I understand digital communication is not for emergencies. I authorize limited photography or video for care, documentation, education, or quality assurance. I understand AI tools may assist my provider under supervision.

FINANCIAL TERMS & BILLING AUTHORIZATION: I authorize HBM to bill my insurance and assign benefits directly to the Practice. I understand I am financially responsible for all charges not covered by insurance, including copays, deductibles, coinsurance, non-covered or out-of-network services, and self-pay fees. Copays are due at the time of service. If my deductible is unmet, I will be billed for any balance. Payment is due within 14 days. A \$20 late fee applies to overdue balances. Accounts unpaid after three notices may be referred to collections; I agree to pay related costs, including fees, legal expenses, and interest. I authorize HBM to charge my card for patient-responsibility balances, including missed appointment fees, returned check fees, or form fees. I will provide card information securely and not dispute valid charges. I understand insurance disputes must be resolved directly with my insurer.

MEDICAL RECORDS, PRIVACY & INFORMATION SHARING: HBM uses Athenahealth for its patient portal and electronic medical record. Use of the portal indicates acceptance of Athenahealth's Terms and Privacy Policy. The Practice is not responsible for third-party outages or data breaches beyond its control.

A brief consultation summary will be provided on request at no charge. Additional records may incur a fee. Records are released in compliance with HIPAA. I authorize the Practice to use and disclose my protected health information (PHI), including sensitive health details (e.g., mental health, substance use, HIV status), for treatment, payment, and operations.

I authorize sharing of medical information with other providers, caregivers, or family as necessary for care. I authorize prior providers to release my records to HBM. I may revoke this authorization in writing at any time, except where HBM has already acted.

APPOINTMENTS, CONDUCT & CONTINUITY OF CARE: Appointments are scheduled with adequate time for patient care. Cancellations require one full business day's notice; otherwise, a \$100 no-show/late fee may

apply. I understand physicians may be unavailable due to vacation, illness, or emergencies. The Practice will make reasonable efforts to notify me and may offer rescheduling, telehealth alternatives, or covering provider contact.

HBM may terminate the patient relationship for cause, including repeated no-shows, non-compliance with care, abusive behavior, or failure to pay balances. I agree to raise any concerns directly with the Practice before posting public comments and not to make knowingly false or misleading statements.

SCOPE OF SERVICES, REFERRALS & EMERGENCY CARE: This is a telehealth consultation. Any future continuity, concierge or home visit care requires a separate agreement. The Practice may refer me to specialists, imaging, or labs. I am responsible for confirming insurance coverage and network status for referrals. HBM may share relevant records to support coordination of care.

I understand HBM is not a substitute for emergency or urgent care. In an emergency, I will call 911 or go to the nearest emergency department. For urgent matters, I will use urgent care services. If a home visit is arranged, I agree to ensure a safe environment: no weapons, no smoking or drugs, pets secured, and accessible space. Unsafe conditions may result in cancellation or refusal of the visit.

CONTROLLED SUBSTANCE POLICY: Controlled substances will not be prescribed during one-time consultations. For ongoing care, controlled substances are prescribed only at the provider's discretion, after an in-person evaluation and under a signed Controlled Substance Agreement. Prescriptions require: Full compliance with laws and policies, Disclosure of all current medications, Use of one designated pharmacy, Scheduled visits for prescription issuance. I consent to random drug testing and monitoring through California CURES. Early refill requests, lost/stolen reports, unauthorized dose changes, misuse, or suspected diversion will be considered a material breach and may result in tapering, discontinuation, reporting, or discharge.

ELECTRONIC PRESCRIPTIONS: I authorize the Practice to transmit prescriptions, access my pharmacy benefits, and retrieve my medication history as permitted by law. This remains in effect until revoked in writing or the physician-patient relationship ends.

This Agreement is governed by California law. The Practice will comply with applicable laws. If legal changes affect any provision, that provision will be updated automatically. This Agreement replaces any prior agreements. Modifications must be in writing and signed by both parties.

Arbitration: Any claim of medical malpractice (e.g., negligence, failure to obtain informed consent, breach of contract) will be resolved by binding arbitration under the California Arbitration Act. This waives the right to a court or jury trial. This applies to all services by HBM, its staff, and representatives, and binds anyone acting on the patient's behalf. You may cancel this agreement within 30 days by written notice. Emergency care is excluded. If any part is unenforceable, the remainder stays in effect.

PATIENT ACKNOWLEDGMENT & AGREEMENT: By signing below, I confirm that I have read, understood, and voluntarily agree to the terms of this Agreement. I consent to receive care, authorize communication and record sharing, and accept all responsibilities as outlined. I understand that my electronic signature is legally binding.

Patient Name: _____

Date _____

Patient Representative Name: _____

Signature: _____

Home Based Medicine

101 S San Mateo Dr #106

San Mateo, CA 94401

Phone & Text: (650) 360-9309 | Fax: (650) 360-0781

info@homebased.sprucecare.com | www.HomeBasedMedicine.com

ACKNOWLEDGEMENT OF RECEIPT: NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

RECEIPT OF HEALTH INFORMATION PRIVACY PRACTICES

By signing this form, . I acknowledge receipt of the Notice of Health Information Privacy Practices of our office. The notice provides information about how we may and may not use or disclose your protected health information. As such, you should read it in full.

Our Notice of Health Information Privacy Practices is subject to change. If we change it, you may obtain a revised copy at your next visit or by calling (650) 360-9309.

I acknowledge receipt of the Notice of Health Information Privacy Practices of the office of Gurpreet K Padam MD PC

Patient Name: _____

Date _____

Patient Representative Name: _____

Signature: _____

CHRONIC CARE MANAGEMENT (CCM) OPT-IN

INFORMED CONSENT

You are eligible for a new Medicare program that enables us to provide you with care coordination of your care and improve your overall wellness. Chronic conditions are ongoing medical problems like diabetes, high blood pressure, dementia, heart disease, depression, osteoporosis, and many others. These conditions must be managed effectively in partnership between the healthcare team and patient to maintain the best possible overall health and wellness. CCM Services are available to you because you have been diagnosed with two (2) or more chronic conditions which are expected to last at least twelve (12) months and which place you at significant risk of further decline.

THE BENEFITS OF SIGNING UP FOR CHRONIC CARE MANAGEMENT SERVICES?

- Coordinate visits with your doctors, facilities, labs, radiology, or others
- Provide access to around-the-clock (24/7) services from your care team.
- Assist with management of medications
- Provide a personalized and comprehensive care plan management
- Assist with scheduling preventive care services, many of which are covered by insurance

WHAT YOU NEED TO KNOW BEFORE SIGNING UP

You will have 24/7 access to your electronic medical record if you ever have questions. Our practice is compliant with HIPAA and all laws related to the privacy and security of Protected Health Information (PHI). As a part of this program, your PHI may be shared between caregivers directly involved with your health.

YOU HAVE THE RIGHT TO:

Discontinue this service at any time for any reason. Because your signature is required to end your chronic care management services, please ask any of our staff members for the CCM termination form. The provider will continue providing CCM services until the end of the month and may bill Medicare for those services.

NOTE: Only one physician can bill for this service for you. Please let your physician or our staff know if you have entered into a similar agreement with another physician/practice.

BENEFICIARY ACKNOWLEDGMENT AND AUTHORIZATION

By signing this Agreement, I agree to the following:

- I consent to the Provider providing CCM Services to you.
- I authorize electronic communication of your medical information with other treating providers as part of coordination of your care.
- I acknowledge that only one practitioner can furnish CCM Services to you during a calendar month.
- I understand that cost-sharing will apply to CCM Services, so you may be billed for a portion of CCM Services even though CCM services will not involve a face-to-face meeting with the Provider.

I agree to participate in the Chronic Care Management program. You have had the opportunity to ask questions about the program, and your queries have been answered to your satisfaction. I hereby consent to participate in this program and authorize the use of your health information for the purposes outlined above.

Patient Name: _____

Date _____

Patient Representative Name: _____

Signature: _____

TELEHEALTH CONSULT-NEW CLIENT INTAKE

(Put N/A or leave blank if not applicable, send intake forms via HIPAA compliant text, email or fax)

Telehealth **Self-Pay**

Full Legal Name _____ **Gender:** _____

Date of Birth: _____ Marital Status: _____ Spouse/Partner Name: _____

Patient's Residence/Facility Name: _____

Residence phone: _____ Residence Fax: _____

Firearms, pets, smoking, parking or other issues we need to be aware of? _____

Parking for home visiting staff Parking lot or Driveway/Street/Other _____

Health Care Decision Maker Name: _____ **Relationship** _____

Email: _____ Phone _____ Okay to leave message?: _____

Do you have an Advance Directive (Y / N) _____ POLST _____

Race/Ethnicity: _____ (Prefer Not to Answer) Language: _____

Interpreter Needed? (Y / N) _____ Who may we thank for referring you? _____

Billing Information: _____
If different than above (Name) (Relationship)

Billing/Guarantor Address: _____

Email: _____ Phone _____

NEW CLIENT HISTORY

Current PCP: _____ Phone: _____ City/State: _____

Current Known Medical Conditions
<input type="checkbox"/> Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Cholesterol <input type="checkbox"/> Heart Disease <input type="checkbox"/> COPD <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Insomnia <input type="checkbox"/> Arthritis <input type="checkbox"/> Chronic Pain <input type="checkbox"/> Cancer <input type="checkbox"/> Thyroid <input type="checkbox"/> Dementia or Memory <input type="checkbox"/> Incontinence
Date of last Medicare Annual Wellness Visit (AWV): _____
Recent Hospitalization (date and place): _____
Family History: _____
Surgeries: _____
Do you smoke? _____ Daily Alcohol: _____
Recreational substances: _____

Education	Highest level of education: _____
Current	Height: _____ feet & _____ inches , Weight: _____ lbs
Allergies:	_____
Current Medications (list or attach)	_____
Your preferred	Pharmacy: _____ Lab: _____ Imaging: _____
RPM	Are you interested in Remote Patient Monitoring? (Yes/No): _____
Vaccines	Are you interested in routine RSV, Flu, etc vaccines? (Yes/No): _____