

New Patient Admission Form

Patient Name: _____
FIRST MIDDLE INITIAL LAST

Date of Birth: _____/_____/_____

Community Name _____

By signing this form, I (or my designee) acknowledge and provide consent for Twin Cities Physicians to provide primary care services, including obtaining outside medical records for continuity of care. I acknowledge that I, or my designee, will promptly follow up with the Twin Cities Physicians team regarding any questions/ concerns.

Patient or POA Signature: _____

Patient or POA Name: _____

Patient or POA Email: _____

Patient or POA Phone Number: (_____)_____-_____

Date: _____
Month Day Year

When completed please send information to:

FAX: 763-312-1800 or Email: newadmit@mytcp.org

Patient Information Sheet

Patient Name: _____

FIRST

MIDDLE INITIAL

LAST

Patient Phone Number: (_____) _____ - _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Room Number: _____

Emergency Contact/ Power of Attorney- Healthcare:

Name: _____ Phone: _____

Relationship to the patient: _____

Previous Primary Care Provider:

Provider Name/ Clinic: _____

Clinic Phone Number: (_____) _____ - _____

Clinic Fax: (_____) _____ - _____

Medical History

Patient Name: _____

FIRST

MIDDLE INITIAL

LAST

Known Allergies:

Food/ Prescription/ Other	Side Effect(s)

Past & Present medical concerns, conditions including procedures or hospitalizations:

Medical History

Patient Name: _____

FIRST

MIDDLE INITIAL

LAST

Please circle which family member(s) have/had the following:

Alzheimer's Disease or Dementia	Mother	Father	Sibling	Children
Arthritis/ Osteoporosis	Mother	Father	Sibling	Children
Asthma/ COPD/ Tuberculosis/ Other Lung Disease	Mother	Father	Sibling	Children
Blood Disorders/ Anemia/ Hemophilia	Mother	Father	Sibling	Children
Cancer-[please list type below] _____	Mother	Father	Sibling	Children
Chrones/ Other GI Disease	Mother	Father	Sibling	Children
Congenital Heart Condition, Stroke or Blood Clots	Mother	Father	Sibling	Children
Diabetes [Type 1 or 2]	Mother	Father	Sibling	Children
Heart Attack/ Heart Disease/ Vascular Disease	Mother	Father	Sibling	Children
High Blood Pressure	Mother	Father	Sibling	Children
Kidney Disease/ Kidney Stones	Mother	Father	Sibling	Children
Liver Disease	Mother	Father	Sibling	Children
Mental Health [PTSD, OCD, Schizophrenia, Addiction, Anxiety, Depression, Bipolar Disorder]	Mother	Father	Sibling	Children
Parkinson's Disease	Mother	Father	Sibling	Children
Vision Impairment/ Blindness	Mother	Father	Sibling	Children
OTHER: _____	Mother	Father	Sibling	Children

Medical History

Patient Name: _____

FIRST

MIDDLE INITIAL

LAST

Social History:

Marital Status: [Circle one] Single Married Divorced Widowed

Occupation: _____

Hours per week: _____

Tobacco:

Have you ever used tobacco products including: cigarettes, chewing tobacco or vapor products?

YES ☐ NO ☐

Approximate start date: _____ / End Date: _____

Frequency of use/ packs a day: _____

Alcohol:

Do you currently consume alcohol? YES ☐ NO ☐

How many drinks a week do you consume: _____

Drugs:

Have you ever used drugs not prescribed to you? YES ☐ NO ☐

Please list drugs and frequency of use:

General Consent

To the patient: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved.

At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/ or procedure for any identified conditions(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment.

By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended: and (2) you consent to treatment with this practice and any other satellite practice under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedures(s). I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Procedures authorizing if medically indicated: Wound care/ Wound Debridement, Telehealth.

Signature of Patient/ Legal Guardian/ POA:

Date: _____

Signature of Witness:

Date: _____

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) is a U.S. federal law that protects the privacy and security of your health information.

By signing below, you acknowledge and consent to that you have read the full HIPAA notice of privacy practices, which can be found on the QR code below. The Patient, Legal Guardian or Power of Attorney consent to Twin Cities Physicians accessing the patients personal health information through secure electronic medical records and/or secure written medical records. This information may include the patient's medical history, current and previous diagnoses, medications, treatment information, and other information necessary to support the care of the patient.

Twin Cities Physicians uses this information to create and maintain a secure patient profile that you may access through our secure patient portal. The patient's health information provides your healthcare provider with a centralized and comprehensive view of your medical history, helping them coordinate and provide appropriate care.

By signing below, you consent to Twin Cities Physicians accessing, using, and maintaining your health information as necessary to support your healthcare and treatment, in accordance with applicable HIPAA privacy and security requirements.

SCAN THE QR CODE TO ACCESS TWIN CITIES PHYSICIANS FULL HIPAA PRIVACY STATEMENT.

Signature of Patient/ Legal Guardian/ POA:

Date: _____

Signature of Witness:

Date: _____



Advanced Primary Care Management

Patient Consent Form

Patient Name: _____

Date of Birth: _____

Medicare ID or SSN: _____

Clinician: _____

Date of Consent: _____

What is Advanced Primary Care Management (APCM)?

Advanced Primary Care Management is a Medicare Part B, As well as other Commercial insurance carries, service that provides ongoing, comprehensive primary care between office visits. These services may include care coordination, medication management, care planning, communication with other providers, and support for managing chronic conditions.

What services are included?

As Part of APCM, the care team may:

- Coordinate care with specialists, hospitals, facilities, home health or hospice.
- Review and manage medications.
- Develop and maintain a personalized care plan.
- Provide care management support between visits.
- Offer access to the care team for urgent needs, including after hours.
- These services may be provided by the clinician and other members of the care team under the clinician's supervision.

Important Medicare Rules

- Only one provider or practice may bill Medicare for APCM services for you in a given calendar month.
- APCM services are billed monthly even if you do not have an office visit that month.
- APCM cannot be billed in the same month as Certain other Medicare care management services (such as Transitional Care Management).

Cost Sharing

- Medicare Part B generally applies a 20% coinsurance for APCM services.
- If you have supplemental insurance, it may cover this coinsurance.
- If you are a Qualified Medicare Beneficiary (QMB), you will not be charged coinsurance.

Your Rights

- Participation in APCM is voluntary.
- You may stop APCM services at any time by notifying the practice.
- Stopping APCM will not affect your ability to receive regular medical care from this practice.
- You may choose a different provider for APCM services in the future.

Patient Acknowledgement and Consent

By signing below, (or providing verbal consent) I acknowledge that:

- I understand what Advance Primary Care Management services are:
- I understand that APCM services are billed monthly to Medicare.
- I understand that coinsurance may apply.
- I understand that only one provider or practice may bill APCM services for me each calendar month.
- I understand that I may stop APCM services at any time.
- I agree to receive Advanced Primary Care Management services from Twin Cities Physicians.

Signature of Patient/ Legal Guardian/ POA:

Date: _____

Name of representative signing:

Signature of Witness:

Date: _____

Name of Witness:

If patient provided Verbal Consent please check box and sign above as the witness

Checking this box means that the patient verbally consents and accepts to APCM services-

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