PACWEST
HEALTHCARE

WELCOME TO PACWEST HEALTHCARE

Thank you for choosing PacWest Healthcare. We provide comprehensive, patient-centered medical care to individuals living in senior living communities, adult family homes, assisted living communities, memory care settings, and skilled nursing facilities.

Our services include on-site primary care, telehealth, medication management, chronic care management, transitional care, behavioral health, podiatry, and collaboration with specialists, home health, palliative care. Our team will collaborate with outside primary care providers as well as specialists.

Completing Your Enrollment

Please complete all applicable sections of this enrollment packet and ensure that all required signatures are included. Incomplete information may delay enrollment and scheduling.

What Happens Next?

01 Once PacWest Healthcare receives the **completed enrollment packet and all necessary supporting documents,** our team will review the information and enter the patient into our Athena electronic health record.

02 The patient can generally anticipate an initial new-patient visit within two weeks after the completed enrollment packet is received. Scheduling may depend on receipt of all required information, the patient's medical needs, provider availability, and the patient's location.

03 A PacWest team member will contact the patient, authorized representative, or facility to coordinate the initial appointment and provide information about patient portal access.

SUBMIT THE COMPLETED PACKET

PacWest Healthcare PLLC

360-880-8193

833-450-0284

officeassist1@pacwesthc.com

www.pacwesthealthcare.com

Please contact our office if you have questions, need help completing the packet, or need to confirm that your enrollment materials were received. We look forward to working with you, your family, caregivers, and healthcare team to provide responsive, coordinated, and compassionate medical care.

☐ CLINIC

1. PATIENT INFORMATION

Legal Last Name:	Legal First Name:	Preferred First Name:
Legal Sex: ☐ Female ☐ Male ☐ Other	Preferred Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them	
Date of Birth:	Last Four Digits of Social Security Number:	

Patient Residence:

Community/AFH:	Facility Contact Person: (If Applicable)
Facility Contact Telephone Number:	Date Patient Moved Into Facility: (If Applicable)

Patient Contact:

Primary Address: (including apartment number, city and zip code)		
Patient Email:	Mobile Phone:	Home Phone:

Patient Demographics:

Primary Language:	Race:
Ethnicity:	Homebound: ☐ Yes ☐ No

Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner

2. EMERGENCY CONTACT AND LEGAL REPRESENTATIVE

Emergency Contact Name:	Relationship to Patient:	
Email Address:	Primary Mobile Number:	Alternate Mobile Number:

Representative's Authority:

☐ Emergency contact only
☐ Legal guardian
☐ Financial power of attorney
☐ Healthcare power of attorney
☐ Durable power of attorney
☐ Authorized representative

Include:

May PacWest discuss the patient's care with this person?	☐ Yes	☐ No
May this person schedule appointments?	☐ Yes	☐ No

3. Guarantor or Financially Responsible Party

☐ Patient is Financially Responsible ☐ Another Person is Financially Responsible

If Another Person:

Full Legal Name:	Relationship to Patient:	Date of Birth:
Address:		
Telephone Number:	Email Address:	

4. Athena Patient Portal Access

Introductory Statement:
The PacWest Healthcare patient portal provides secure access to health information, test results, appointments, billing information and messages. Portal invitations may be sent by email or text message. The email address and mobile number must be accurate and should belong to the person who will manage the account.

Portal Selection:

☐ Patient will manage their own portal ☐ Patient declines portal access

☐ Authorized representative will manage the portal ☐ Patient does not have access to email or a phone

Portal Account Holder: (can only be one email per individual account):

Full Name:	Relationship to Patient:
Email Address:	Mobile Telephone Number:

5. Insurance Information

Primary Insurance:

Insurance Company:	Member/Subscriber ID:	Group Number:
Subscriber Name:		Subscriber Date of Birth:
Relationship to Patient:	Effective Date:	

Secondary Insurance:

Insurance Company:	Member/Subscriber ID:	Group Number:
Subscriber Name:		Subscriber Date of Birth:
Relationship to Patient:	Effective Date:	

Include: ☐ Copies of front and back of insurance cards attached

Healthcare Providers, Pharmacy and Clinical Information

6. Primary Care Provider Information

Current/Previous PCP Name:	Practice or Clinic Name:
City and State:	Approximate Date Last Seen:

7. Other Current Medical Providers

Specialty	Provider Name	Practice/Clinic	City/State
Cardiology			
Endocrinology			
Gastroenterology			
Nephrology			
Neurology			
Oncology			
Pulmonology			
Psychiatry			
Urology			
Other			

8. Preferred Pharmacy

Primary Pharmacy:		
Pharmacy Name:		
Street Address:		
City:	State:	ZIP Code:
Optional Local Pharmacy: (If using mail order)		
Pharmacy Name:		
Street Address:		
City:	State:	ZIP Code:

9. Current Prescription Medications

Current PCP:

☐ Medication list attached

☐ Patient does not currently take medications

☐ Medication information entered below

Medication Name	Instructions	Reason

10. Allergies and Adverse Reactions

Does the patient have any known drug allergies?	If yes, please list the drug allergies:
☐ Yes ☐ No	

Past Medical and Surgical History

11. Past Medical History (Check all conditions the patient currently has or has previously been treated for.)

Cardiovascular		
☐ Atrial Fibrillation	☐ Heart Attack	☐ High Cholesterol
☐ Blood Clot/DVT	☐ Heart Failure	☐ Hypertension
☐ Coronary Artery Disease	☐ Heart Valve Disease	☐ Other Abnormal Heart Rhythm
☐ Peripheral Vascular Disease	☐ Pacemaker Or Implanted Defibrillator	
Neurologic and Cognitive		
☐ Alzheimer's Disease	☐ Gait Or Balance Impairment	☐ Neuropathy
☐ Dementia	☐ Migraine/Headaches	☐ Parkinson's Disease
☐ Frequent Falls	☐ Multiple Sclerosis	☐ Seizure Disorder
☐ Stroke/TIA	☐ Traumatic Brain Injury	

Check all conditions the patient currently has or has previously been treated for.		
Respiratory		
☐ Asthma	☐ Copd/Emphysema	☐ Recurrent Pneumonia
☐ Chronic Respiratory Failure	☐ Home Oxygen Use	☐ Sleep Apnea
Endocrine and Metabolic		
☐ Adrenal Disorder	☐ Obesity	☐ Thyroid Disorder
☐ Electrolyte Disorder	☐ Osteoporosis	☐ Type 1 Diabetes
☐ Type 2 Diabetes		
Kidney and Genitourinary		
☐ Chronic Kidney Disease	☐ Enlarged Prostate	☐ Kidney Stones
☐ Dialysis	☐ Indwelling Urinary Catheter	☐ Recurrent UTI
☐ Urinary Incontinence	☐ Urinary Retention	
Gastrointestinal and Liver		
☐ Chronic Constipation	☐ GI Bleeding	☐ Liver Disease/Cirrhosis
☐ Chronic Diarrhea	☐ Hepatitis	☐ Pancreatitis
☐ Feeding Tube	☐ Inflammatory Bowel Disease	☐ Peptic Ulcer Disease
☐ GERD	☐ Irritable Bowel Syndrome	
Musculoskeletal and Pain		
☐ Amputation	☐ Chronic Pain Syndrome	☐ Joint Replacement
☐ Arthritis	☐ Contracture	☐ Limited Mobility
☐ Chronic Back or Neck Pain	☐ History of Fracture	☐ Wheelchair Dependence
Hematologic and Immune		
☐ Anemia	☐ Bleeding Disorder	☐ Immunodeficiency
☐ Autoimmune Disease	☐ Clotting Disorder	☐ Long-Term Anticoagulant Use
Cancer and Infectious Disease		
☐ C. Difficile	☐ HIV	☐ MRSA
☐ Cancer—Type:	☐ History of Cancer	☐ Other Communicable Disease
☐ Recurrent Infections		
Mental Health		
☐ Anxiety	☐ Psychiatric Hospitalization	☐ Schizophrenia/Schizoaffective
☐ Bipolar Disorder	☐ Insomnia	☐ Substance-Use Disorder
☐ Depression	☐ PTSD	
Other		
☐ Chronic Wound	☐ Hospice/Palliative-Care History	☐ Pressure Injury
☐ Hearing Impairment	☐ No Major Past Medical History	☐ Vision Impairment
☐ Other Significant Condition:		

12. Surgical and Procedural History

Surgery or Procedure:	Approximate Date/Year:

Social History, Family History and Required Signatures

13. Social and Functional History

Tobacco		Alcohol	
What is the patient's tobacco use status? ☐ Never ☐ Former ☐ Current		What is the patient's alcohol use status? ☐ None ☐ Former Use ☐ Current Use	
Product/Type:	Amount Used:	Type:	
Years Used:	Year Quit:	Amount Used:	Frequency:
Other Substances (THC, illicit drug use)			
What is the patient's other substance use status? ☐ None ☐ Former Use ☐ Current Use		Substance:	Frequency:

14. Advance-Care Planning

Advance Directive: ☐ Yes ☐ No ☐ Unknown	Current Code Status, If Documented: ☐ Full Code ☐ DNR ☐ Limited Interventions ☐ Not Established/Unknown
Healthcare Power of Attorney: ☐ Yes ☐ No	
POLST: ☐ Yes ☐ No	

15. Family Medical History

CONSENT AND ACKNOWLEDGMENT

Please Read Each Statement and Initial Where Indicated.

_____ **Consent for Medical Evaluation and Treatment (Required)**
I voluntarily consent to medical evaluation and treatment by PacWest Healthcare PLLC and its physicians, nurse practitioners, physician assistants, podiatrists, and other authorized clinical personnel. Services may include in-person or telehealth visits, assessments, diagnosis, medication management, laboratory testing, imaging, referrals, care coordination, and other medically appropriate services. I understand that no specific result or outcome can be guaranteed.

_____ **Medication and Treatment History (Required)**
I authorize PacWest Healthcare to obtain and review information reasonably necessary for my care, including medication history, prescription records, treatment history, laboratory results, imaging, hospital and rehabilitation records, and records from other healthcare providers, as permitted by law.

_____ **Coordination of Care (Required)**
I authorize PacWest Healthcare to communicate and exchange information necessary for my treatment, payment, and healthcare operations with involved facilities, pharmacies, hospitals, skilled nursing or rehabilitation facilities, home health and hospice agencies, laboratories, imaging providers, specialists, caregivers, and other healthcare professionals participating in my care, as permitted by law.

_____ **Consent for Use of Artificial Intelligence (AI) (Required)**
PacWest Healthcare may use secure, healthcare-appropriate artificial intelligence (AI) tools to assist with clinical documentation, care coordination, administrative tasks, and clinical support. AI does not replace the professional judgment of your healthcare provider. Patient information used with AI tools will be handled in accordance with applicable privacy and security requirements, including HIPAA when applicable. By signing, I acknowledge and consent to PacWest Healthcare's use of AI-assisted technology in my care and related healthcare operations.

_____ **Assignment of Insurance Benefits (Required)**
I authorize PacWest Healthcare to submit claims to Medicare, Medicaid, and other applicable insurance plans. I assign directly to PacWest Healthcare any insurance benefits payable for covered services and authorize the release of information reasonably necessary to process and obtain payment for those claims.

_____ **Telephone, Voicemail, Text and Email Communications (Required)**
I authorize PacWest Healthcare to contact me or my authorized representative using the telephone numbers and email addresses provided in this packet, consistent with my selected communication preferences. Communications may include appointment information, portal invitations, care-coordination messages, billing notices, and other healthcare-related information. I understand that standard voicemail, text messaging, and email may involve privacy risks. I may update my communication preferences or withdraw this permission by notifying PacWest Healthcare; withdrawal will apply to future communications.

_____ **Financial Responsibility (Required)**
I understand that I am responsible for providing accurate and current demographic and insurance information. I accept financial responsibility for applicable copayments, deductibles, coinsurance, noncovered services, and charges not paid by my insurance plan, except where prohibited by law or contract. I understand that insurance authorization or claim submission does not guarantee payment.

_____ **Notice of Privacy Practices (Required)**
I acknowledge that I have received, reviewed, or been offered access to PacWest Healthcare's Notice of Privacy Practices. I understand that the notice explains how my health information may be used or disclosed and describes my privacy rights.

PODIATRY SERVICES

Please Select One: ☐ I consent to podiatry evaluation and treatment. ☐ I decline podiatry services at this time.

_____ **Chronic Care Management Consent (Optional service)**
I understand that Chronic Care Management is an optional service for patients with two or more chronic medical conditions. Services may include development and maintenance of a comprehensive care plan, medication review, coordination with other healthcare providers, assistance with transitions of care, and communication with me or my caregivers between regular office visits. I know that it I want further into a CCM I can reach out to request @ 360 858 8693.

_____ **Podiatry Consent (Required if consenting to podiatry)**
I voluntarily consent to evaluation and treatment by a PacWest Healthcare podiatry provider. Services may include assessment of the feet, ankles, skin, circulation, sensation, gait, toenails, calluses, wounds, infections, pain, deformities, and other podiatric concerns. When medically appropriate, treatment may include routine or medically necessary foot care, trimming or debridement of toenails, reduction of calluses or corns, wound care, medication recommendations, diagnostic testing, referrals, and patient or caregiver education. Any procedure requiring separate informed consent will be explained before it is performed. I understand that Podiatry services are subject to the coverage rules of my insurance plan. Medicare and other insurers may not cover routine foot care unless specific medical-necessity requirements are met. I may be responsible for deductibles, copayments, coinsurance, or noncovered services. Insurance verification or claim submission does not guarantee payment. I may decline or discontinue podiatry services at any time.

_____ **Accuracy of Information (Required)**
I confirm that the information provided in this enrollment packet is accurate and complete to the best of my knowledge. I agree to notify PacWest Healthcare of changes to my contact information, insurance, medications, allergies, healthcare representatives, or other information relevant to my care. By signing below, I confirm that I have reviewed this section, had an opportunity to ask questions, and consent to the services selected above.

I authorize PacWest Healthcare to obtain, use, and exchange health information with healthcare providers, hospitals, skilled nursing facilities, assisted living facilities, adult family homes, pharmacies, laboratories, imaging centers, home health agencies, hospice agencies, insurance plans, and other individuals or organizations involved in my care. Information may include medical history, diagnoses, medication records, treatment notes, laboratory and imaging results, hospital and discharge records, and other information necessary for treatment, payment, care coordination, and continuity of care.

Patient Signature:	Printed Name:	Date:
Authorized Representative Signature:	Printed Name:	Date:

Required: Patient OR authorized representative signature, printed name, and date.