New Patient Enrollment Form

Asante Health
MEDICAL PRACTICE

1603 N Belt St. Spokane, WA 99205

Phone: (509) 808-2835

Fax: (509) 808-2857

Email: admission@asantehealth.org

Welcome Letter

Dear Patient/Family,

Welcome to, GKM Holding Inc., doing business as Asante Health. We sincerely appreciate the opportunity to care for you and would like to share more about our commitment to the community.

At Asante Health, our mission is to advance health equity and well-being for individuals of all ages through accessible, collaborative, and patient-centered primary care services. We are dedicated to enhancing the quality of care our patients receive by prioritizing strong provider support, meaningful engagement, and ease of access.

We offer a hybrid model of primary care, delivering services both on-site and within the community to ensure care is convenient, flexible, and responsive to your needs. Our approach is grounded in collaboration, with a dedicated care team working together to provide comprehensive and coordinated support.

Whether you receive care in a clinical setting or in your community, our goal is to improve your overall health while fostering clear communication, building trust, and helping you better understand and manage your care.

We look forward to partnering with you on your journey to better health.

Sincerely,
Asante Health Team

Required Documents Checklist

- [ ] New Patient Enrollment Form - Completed/Signed
- [ ] Copy of Photo ID
- [ ] Insurance Cards
- [ ] Power of Attorney/Guardianship Documents (if applicable)
- [ ] POLST/ Advance Directive (if applicable)
- [ ] Medication List
- [ ] Recent History & Physical

Please return your completed form to us using fax, email, or mail to our address.

PATIENT DEMOGRAPHIC INFORMATION

Today's Date: _____

Patient Information:

Full Legal Name: _____ Nickname: _____

Date of Birth: _____ SSN: _____

Gender: ☐ Male ☐ Female ☐ Other Race: _____ Ethnicity: _____

Marital Status (Please choose one): ☐ Single ☐ Married ☐ Divorced ☐ Hispanic ☐ Non-Hispanic

☐ Domestic Partner ☐ Widowed ☐ Other

Address: _____
Street or PO Box City State Zip Code

Home Phone: _____ Cell Phone: _____

Which number is preferred? ☐ Home ☐ Cell Email: _____

Preferred Language: _____ Preferred Pharmacy: _____

Pharmacy Address: _____ Phone: _____ Fax: _____

Previous Primary Care Provider: _____

Emergency Contact:

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Assisted Living Facility (ALF)/Adult Family Home (AFH):

Address: _____ Room Number: _____

Phone Number: _____ Fax Number: _____ Email: _____

Insurance:

Primary Insurance: _____ Member ID: _____

Secondary Insurance: _____ Member ID: _____

POA/Guardian/Surrogate Information (person responsible for financials/bills):

Full Name: _____ Relationship: _____

Address: _____
Street or PO Box City State Zip Code

Home Phone: _____ Cell Phone: _____

Email: _____

PATIENT MEDICAL HISTORY

Patient Name: _____

Section 1: Medical Conditions (Check all that apply)

☐ Alzheimer's Disease	☐ Anxiety	☐ Asthma
☐ Atrial Fibrillation	☐ Bipolar Disorder	☐ Cancer
☐ Cerebral Palsy	☐ Congestive Heart Failure	☐ COPD
☐ Dementia	☐ Depression	☐ Diabetes
☐ Down Syndrome	☐ Emphysema	☐ Heart Attack
☐ Hypertension	☐ Hypothyroidism	☐ Liver Disease
☐ Multiple Sclerosis	☐ Obstructive Sleep Apnea	☐ Parkinson's Disease
☐ Schizophrenia	☐ Stroke	☐ Other: _____

Family & Social Medical History:

CONDITION	MOTHER	FATHER	BROTHER	SISTER	_____
Cancer	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐
Parkinson's Disease	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Other	_____	_____	_____	_____	_____

Section 2: Current Equipment / Supplies (Check all that apply)

☐ Cane	☐ Hospital Bed	☐ Walker
☐ Catheter Supplies	☐ Incontinence Supplies	☐ Wheelchair
☐ Ostomy Supplies	☐ Oxygen	☐ Other: _____

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PATIENT MEDICAL HISTORY

Patient Name: _____

Personal Habits:

Do you use the following: ☐ Alcohol ☐ Tobacco ☐ Marijuana

If Yes to alcohol, please indicate number of drinks per week: _____

If Yes to tobacco, please indicate products used: _____

Other substance history: _____

Allergies:

_____

If no known allergies, please select NKDA

Current Medications: Please provide us with complete current medication list including non-prescriptions such as vitamins. If a facility/pharmacy list is unavailable please fill in medication list below

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Prior Surgeries:

Date of Surgery	Description of Surgery
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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CONSENT TO TREAT

Please be sure to read the following information. Your signature below applies to the services rendered in conjunction with your visits while in the long term care facility including Assisted Living Facility, Group home, Adult Family Home, or Independent Living.

Patient Name:_____ DOB: _____

Asante Health Agreements

By signing below, you acknowledge and accept the following agreements included in this packet, pertaining to the professional services provided by licensed health care providers of GKM Holding Inc., doing business as Asante Health:

- Patient Services Agreement
- Patient Financial Agreement

You confirm that you have comprehensively understood both the services offered by Asante Health and your financial responsibilities for those services.

Patient/POA/Guardian Signature _____ Date_____

Informed Consent Forms:

Your signature below certifies that you comprehend the descriptions of primary care and telehealth services outlined in the following Informed Consent Forms:

- Informed Consent for Primary Care Services
- Informed Consent for Telemedicine Services

You confirm your understanding of the potential benefits, risks, and alternatives related to these services. You assert your competence to consent to treatment, confirm that you have had the opportunity to ask questions and have received satisfactory answers, and provide consent to receive primary care and telehealth services from Asante Health and its providers.

Patient/POA/Guardian Signature _____ Date_____

Consent to Treat:

I, the undersigned, consent to the outpatient and/or telehealth care provided by Asante Health encompassing routine diagnostic procedures, examination, and medical treatment including but not limited to: routine laboratory work (such as blood, urine, and other studies), and administration of medications prescribed by the provider. I further consent to the performance of those diagnostic procedures, examinations and referring of medical treatment by the medical staff including physicians, nurse practitioners, physician's assistants, medical assistants or their designees as is necessary in the medical staff's judgment. I authorize Asante Health to release any information necessary to file and settle insurance claims, including any third-party insurances. I understand I am personally financially responsible to Asante Health for all charges not covered by assignment including co-pays, co-insurance and ineligibility.

Patient/POA/Guardian Signature _____ Date_____

CONSENT TO TREAT CONT.

Payments:

Co-pays, nominal fees, or other patient responsibility is due within 60 days of service. If you are unable to provide payment, arrangements will need to be made with the office and/or billing department.

Prescription Refill Policy:

If you need a refill on a previously prescribed medication, please contact your pharmacy. The pharmacist will fax us your request along with current dosages and medications for your healthcare providers approval. Please allow 3-5 business days from the time we receive the fax from the pharmacist for your refill request to be processed.

Communication Consent:

Outside of agreed-upon visits, Asante Health can be accessed by fax, phone or email. Emails may only be used to clarify issues discussed in prior visits. They may not be used to address new concerns. By your signature to this agreement, you understand and agree that: (1) there is some level of risk that the information in unencrypted electronic communications, including email and text messaging, could be read by a third party, and (2) you consent to Asante Health use of unencrypted electronic communications, including email and text messaging, to communicate with you.

Patient/POA/Guardian Signature _____ Date_____

Patient Rights & Responsibilities:

I, the undersigned, have received the Patient Rights and Responsibility Form. I understand and agree to abide by the conditions for treatment with GKM Holding Inc DBA Asante Health.

Patient/POA/Guardian Signature _____ Date_____

Relationship to Patient _____

HIPAA AND RELEASE OF INFORMATION

Acknowledgement of Privacy Practices:

I, the undersigned, have received a copy of the Notice of Privacy Practices, containing a more complete description of the uses and disclosures of my health information.

Disclosure of Protected Health Information (PHI):

This is to certify that I, the undersigned, authorize Asante Health to disclose Protected Health Information (PHI) to family members and friends. Please note that the below list will replace any previous authorization, list all parties you wish to grant access. Please identify individual(s) and relationship(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

PATIENT NAME: _____ DOB: _____

PATIENT/POA/GUARDIAN SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____ DATE: _____

NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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.

What is "Protected Health Information" or "PHI"?

"Protected Health Information" or "PHI" for short, is information that identifies who you are and relates to your past, present, and future physical or mental health or condition, the provision of health care to you, or past, present, or future payment for the provision of health care to you. PHI does not include information about you that is publicly available or that is in a summary form that does not identify who you are. If you are an employee of our participating physician's office, PHI does not include your health information in your personal life.

Purpose of This Notice

In the course of doing business, we gather and maintain PHI about our patients. We respect the privacy of your PHI and understand the importance of keeping this information confidential and secure. This notice describes our privacy practices and how we protect the confidentiality of our PHI. We are obligated to maintain the privacy of your PHI implementing reasonable and appropriate safeguards. We are also obligated to explain to you by this notice about our legal obligations to maintain the privacy of your PHI. We must follow our notice that is currently in effect.

How do we protect your PHI?

We restrict access to your PHI to those employees who need access in order to provider service to our patients. We have established and maintain appropriate physical, electronic, and procedural safeguard to protect you PHI against unauthorized use or disclosure. We have established a training program that our employees must complete and update annually. We have also established a privacy officer, which has overall responsibility for developing, training, and overseeing the implementation and enforcement of policies and procedures to safeguard your PHI against inappropriate access, use, and disclosure.

Types of use and disclosure of PHI we may make without your authorization

Federal and state law allows us to use and disclose your PHI in order to provide health care services to you as well as to bill and collect payments for the health care services provided to you by our physicians. For example, we may use your PHI to authorize referrals to specialists and to review the quality of care provided by your participating physician. We may disclose your PHI to health plans or other responsible parties to receive payment for the services provided to you by our physician. We may also use or disclose your PHI, for example, to recommend to you treatment alternatives, to inform you about health-related benefits and services that we offer or to contact you to remind you of our appointments. We conduct these activities to provide health care to you and not as marketing. Federal and state law also allow us to use and disclose your PHI as necessary in connection with our health care operations. For example, we may use your PHI for resolution of any grievance or appeal that you file if you are unhappy with the care you have received. We may also use our PHI in connection with population-based disease management programs. We may use or disclose your PHI to perform certain business functions to our business associates, who must also agree to safeguard your PHI as required by law.

We are also allowed by law to use and disclose your PHI without your authorization for the following purposes:

1. When required by law- In some circumstances, we are required by federal or state law to disclose certain PHI to others, such as public agencies for various reasons.
2. For public health activities- Such as report about communicable diseases, defective medical devices to the FDA or work-related issues.
3. Reports about any types of abuse, neglect, or domestic violence against any persons.
4. For health oversight activities- Such as reports to governmental agencies that are responsible for licensing physicians or other health care providers.
5. For lawsuits and other legal disputes - In connection with court proceedings before administrative agencies or to defend us or our participating physicians in a legal dispute.
6. For law enforcement purposes- such as responding to a warrant or reporting a crime.
7. Reports to coroners, medical examiners, or funeral directors- To assist them in performance of their legal duties.
8. For tissue or organ donations- To organ procurement or transplant organizations to assist them.
9. For research- To Medical researchers with an approval of an institution review board (IRB) or privacy board that oversees studies on human subjects. Researchers are also required to safeguard out PHI.
10. To avert a serious threat to the health or safety of you or other members of the public.
11. For national security and intelligence/ military activities- Such as protection of the President or foreign dignitaries.
12. In connection with services provided under workers' compensation law.

Acknowledgment of Receipt of Notice of Privacy Practices:

By signing below, you acknowledge that you have received a copy of the Notice of Privacy Practices for Asante Health included in this packet.

Patient/POA/Guardian Signature _____ Date_____

Patient Name: _____

Care Management Programs (CCM, RPM, APCM):

If your provider determines that care management services are appropriate for you, your signature below indicates your agreement to the following programs as applicable:

- Chronic Care Management Consent Agreement
- Remote Patient Monitoring Consent Agreement
- Advanced Primary Care Management Consent Agreement

Chronic care management patients receive comprehensive care plans for multiple conditions, and Asante Health may suggest remote monitoring for managing these conditions.

Should you desire to receive CCM services through Asante Health, we will only bill Medicare for CCM services once per 30-day billing cycle. Furthermore, your provider agrees only to bill Medicare for CCM Services if you have more than one chronic condition.

By signing this agreement, you agree to the following: You consent to Asante Health providing CCM Services to you. You certify that your Asante Health provider has fully explained the scope of CCM services to you. You acknowledge that only one practitioner can furnish and be paid for CCM Services during a calendar month. You authorize electronic communication of your medical information between treating providers as part of your care. You understand that CCM Services are subject to Medicare cost-sharing requirements, and so you may be billed for a portion of the CCM Services. You have the right to discontinue CCM Services at any time by revoking this Agreement, effective at the end of the current thirty (30)-day service period. Revocation can be done verbally by calling 509 808 2835 or in writing to Asante Health 1603 N Belt St, Spokane WA 99205.

Signature _____ Date_____

Patient/POA/Guardian

This sample form does not constitute legal advice. Please consult with your legal counsel to ensure compliance with current applicable regulations.

*please note that this serves as an agreement to the above, however your provider will assess your current medical history for appropriateness for potential benefit prior to initiating service

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Address: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Information to be released from:

Primary Care Provider: _____

Address: _____

Office Phone Number: _____ Fax Number: _____

Specialist: _____

Address: _____

Office Phone Number: _____ Fax Number: _____

Information to be released to:

Asante Health

1603 N Belt St, Spokane WA 99205

Fax Number: (509) 808-2857 Office Phone Number: (509) 808-2835

Email: admission@asantehealth.org

What kind of information do you want released?

☐ Information from the most recent 1 year

☐ Specific Information (please specify):_____

☐ I authorize verbal communication about my medical history to the party listed above

This record is requested for the following reason (REQUIRED):

☐ Transfer of Care to Asante Health as primary care provider

☐ Other (please specify): _____

Federal regulations require a description of how much and what kind of the following information is to be disclosed. The following items must be individually initialed to be included in the use or disclosure of other health information: Federal law prohibits the re-disclosure of such information. Agreement must be terminated in writing or documented oral agreement to restrict disclosure.

____*HIV/AIDS related health information and/or records
____*Birth Control/Pregnancy information and/or records
____*Mental Health information and/or records
____ Other:_____
____*Sexually Transmitted Disease information and/or records
____*Drug/Alcohol diagnosis, treatment and/or referral information
____*Genetic testing information and/or records
____*Restricted protected health information

*I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirement.
*I understand I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used disclosed under this authorization.
*This authorization will automatically expire six months from the date signed. I understand that I may revoke this authorization at any time to the extent that action has been taking in reliance thereon. To revoke this authorization, I must submit my request in writing to the practice's office.

_____ _____

Signature of Patient of Legal Guardian Date (Month/Day/Year)

Asante Health - AI Ambient Scribe Consent (Athena)

As part of your care at Asante Health, we may use Ambient Scribe through our electronic health record system (Athena) to assist with clinical documentation during your visit.

This technology involves audio recording of the clinical conversation between you and your provider. The purpose is to help ensure that all relevant information discussed is accurately documented in your medical record for current care, future visits, and appropriate follow-up.

All recordings and generated documentation are stored securely in compliance with applicable privacy and security standards, through the Athena EHR.

Participation is voluntary. You have the right to decline or withdraw consent at any time. Your decision will not affect your access to care or the quality of services provided.

By consenting, you acknowledge and agree that:

- The visit may be audio recorded for documentation purposes
- The recording will be used solely to support your medical care
- Asante Health is not responsible for technical errors, omissions, or limitations related to AI-assisted documentation, and all final clinical decisions remain with your provider

If you have any questions or concerns, please let us know before proceeding.

Consent Decision

Yes - I consent to the use of AI ambient scribe (including audio recording) during today's visit.

No - I do not consent to the use of AI ambient scribe.

_____ _____

Guardian/POA Signature Date (Month/Day/Year)

Photo Consent and Release

Patient Name: _____ Date of Birth: _____ I consent for photographs and/or video to be taken of me by Asante Health or a representative. I understand the images or videos will be a part of my medical record and may be used for purposes of medical teaching or training or for marketing purposes (website, print, digital or social media).

By consenting to photographs and/or video images I understand I will not be compensated from any party. Although photographs and/or video images will be used without identifying information such as name, I understand it is possible someone may recognize me.

I further acknowledge that my participation is voluntary and agree that use of any photographs and/or video confers no rights of ownership or royalties whatsoever.

I authorize the use of photographs and/or video images:

_____ For educational purposes (medical teaching or training)

_____ For marketing and advertising purposes (website, print, digital, or social media)

_____ For medical records

By initialing here, I ONLY authorize the usage of photographs and/or video images for medical records, ____

By initialing here, I DO NOT authorize the usage of photographs and/or video images for any reason,____

I hereby release Asante Health, its employees, and any third parties involved in the creation of or publication of educational or marketing materials, from liability for any claims by me or any third party in connection with my participation.

By signing this form, I confirm understanding of this consent and unless initialed above, authorize the use of photographs and/or video images for the reasons listed above. If I wish to withdraw my consent in the future, I may do so via written request submitted to Asante Health or by completion of a new form.

Signature: _____ Date: _____

Patient/POA/Guardian

Patient's legal representative signing on behalf of patient: I, the individual named below, attest that I am the legal representative of the patient named above. I certify that the patient named above is not competent to sign contracts and provide informed consent to treatment. I certify that I am authorized by applicable law to sign contracts and consent to treatment on behalf of the patient. POA/Guardian

Signature: _____ Date: _____

Print Name: _____ Relationship to Patient:_____

Note: POA Documents must be provided if patient is not able to consent for their own care.