Welcome to Aspire Health!

Aspire Health serves those suffering from chronic or serious disease or life-threatening health conditions as well as those that want to prepare for their future health. Our virtual and telehealth providers can care for you wherever you are - 24 hours a day. Through Aspire Health patients receive an extra layer of medical care as well as attention to their emotional and social needs. Aspire makes sure patients have everything they need to live fully every day – engaging with friends and family, and continuing the activities they enjoy.

We are an in-network provider for referring insurance companies. Aspire's support is provided by our group of specially trained health experts, including nurse practitioners, physician assistants, nurses and social workers who work in partnership with primary care and specialist providers.

Please review all information in this Aspire Registration Packet

During your first visit this information will be reviewed and your verbal consent to care will be obtained. You are not obligated to sign on to our provider services by having this first visit. You may decline care at that time as well as at any time in the future by letting your provider know or by calling the number above. The included documents are essential to enable our team to provide high quality medical care to you.

Please sign and complete the included documents and return them in the included prepaid business envelope to Aspire Health at 22 Century Blvd Suite 300; Nashville, TN 37214. If you need any support completing these documents or have questions about them please call 833-866-0925.

Included you will find the following documents:

Consent to Care
Telephonic and Video Visit Consent Form
Aspire Financial Policy
Privacy Practices
Acknowledgment of Privacy Practices
Release of Information Authorization Form

Please call 833-866-0925 for assistance, to reach your provider, or the 24/7 care line.

Please save a copy of these documents for future reference.

We look forward to caring for you.

Patient Consent for Services

Patient Name:_____ Phone #:_____
Last First MI

I. What is advanced illness care?

Advanced illness care is a patient-centered, interdisciplinary approach to care that specializes in managing serious illness and the symptoms they cause as well as advanced care planning. Our goal is to assist you with any troubling symptoms of your illness, whether physical, emotional, social or spiritual and, thus, improve the quality of your life. Through ongoing communication with you, your personal support system, and your current medical providers, we will develop a plan to help achieve your goals of care. This process may include co-management of your disease and symptoms as well as recommendations for care to other providers. It is important that you make your needs and concerns known to the Aspire Health staff so we can best meet your expectations of care. If you have any questions regarding this information or the plan of care, we will be glad to provide more information.

II. Consent for Services

- I have received a full explanation of advanced illness care.
- I choose to receive advanced illness care from Aspire Health.
- I have received a copy of the Aspire Health Notice of Privacy Practices.
- I give consent for the release of all medical information for the purposes of medical treatment, payment, and for regulatory agencies upon request.
- Aspire Health may represent me in discussions with insurance providers regarding service eligibility.
- The Aspire Health interdisciplinary team may perform necessary procedures and treatments as prescribed and included in my plan of care.
- I have had an opportunity to have my questions answered by an Aspire Health representative.
- I will notify Aspire Health of any changes in my insurance coverage.
- I give permission for Aspire Health to leave messages at my above phone number.

II. Communication Methods

Aspire Health makes use of audio/video conferencing, telephone, email and text communication to discuss your healthcare, condition, illnesses, diagnoses, plan of care, etc. (Protected Health Information or PHI). This may present a privacy risk. These methods of communication may not be secure and these communications may be intercepted, accessed, or retained by a third party. You may choose which methods you consent to use with Aspire Healthcare on the Telephonic Visit Consent Form or informing your team.

Patient/Responsible Party Signature:_____

Printed Name Patient/Responsible Party:_____

Date:_____

Aspire Health

CareMore HEALTH

Video and Telephonic Visit Consent Form

What is telehealth?
Telehealth is a way to visit with healthcare providers, such as your doctor, clinician or nurse practitioner. You can talk to your provider from any place, including your home. You do not need to go to a clinic or hospital.

How do I use telehealth?
Your provider will determine the best mode of telehealth visit, based on the purpose of the visit and your health and treatment issues presented:

- Sometimes, you may speak to your provider by phone, computer, or tablet
- Sometimes, you may use video so you and your provider can see each other

What are the benefits of visiting with my doctor, practitioner or clinician by telehealth?

- You don't have to go to a clinic or hospital to see your provider
- You won't risk getting sick from other people
- In video visits you will be able to see your provider fully for ease of communication

What are the risks of visiting with my doctor, practitioner or clinician by telehealth?

- You and your provider won't be in the same room, so it may feel different than an office visit
- Your provider may make a mistake because they cannot examine you as closely as at an office visit
- Your provider may decide you still need an office visit
- Technical problems may interrupt or stop your visit before you are done

Will my telehealth visit be private?

- We will not record visits with your provider via video
- Telephonic visits may be recorded for quality purposes. You will be notified of this during each call and may decline recording if desired.
- If people are close to you, they may hear something you did not want them to know. You should be in a private place, so other people cannot hear you.
- Your provider will tell you if someone else from their office can hear or see you.
- We use telehealth technology that is designed to protect your privacy.
- If you use the Internet for telehealth, use a network that is private and secure.
- There is a very small chance that someone could use technology to hear or see your telehealth visit.

What if I try telehealth and don't like it?

- You can stop using telehealth any time, even during a telehealth visit. This may result in discharge from Aspire Provider Services which are provided via telehealth.
- You can decline video visits and choose to only receive your visits by telephone.

- If you decide you do not want to use telehealth again: call **833-866-0925** and say you want to stop video visits, telephone visits or both. We will cancel or change all future visits.

How much does a telehealth visit cost?

- What you pay depends on your insurance.
- A telehealth visit will not cost any more than an office visit.
- If your provider decides you need an office visit in addition to your telehealth visit, you may have to pay for both visits

What does it mean if I sign this document?

If you sign this document, you agree that:

- We talked about the information in this document
- We answered all your questions
- You want or agree to ongoing telehealth visit(s)
- You choose to receive visits by telephone or video as determined by you and your provider
- You may revoke or modify this consent at anytime by alerting your provider or calling 833-866-0925.

_____	_____	_____
Printed Patient/Responsible Party Name	Patient/Responsible Party Signature	Date

Aspire Health

CareMore HEALTH

Aspire Financial Policy

Thank you for choosing Aspire Health as one of your health care providers. The following is our Financial Policy, which will help you understand our billing and payment practices.

- Insurance is a means of reimbursement and not a substitution for payment.
- Aspire is a participating in-network provider with referring insurance companies and will file healthcare claims on your behalf for medical services rendered.
- Aspire bills as an in-network specialist provider for visits with advanced practice providers/clinicians. Social work, nursing visits and the 24/7 on-call line do NOT incur additional charges. There may be additional charges for Remote Patient Monitoring, if provided, dependent on your health plan.
- Any balance due after payment from insurance is your responsibility; payment is expected within thirty (30) days of the statement date. For billing inquires you may call: 1-800-737-1164
- **You are responsible for knowing your insurance benefits.** Patients are responsible for copayments, co-insurance, deductibles, out-of-pocket expenses and non-covered services as determined by your healthcare insurance plan at the time of service.
- You are ultimately responsible for payment of all fees for services rendered regardless of your insurance status.
- You are responsible for alerting Aspire Health to any changes in your health insurance plan.
- It may be necessary to terminate the patient/provider relationship should your insurance become ineligible for our services.

I hereby agree to be financially responsible for all charges incurred regardless of insurance coverage.

_____	_____	_____
Printed Name of Patient/Responsible Party	Signature of Patient/Responsible Party	Date

Notice of Privacy Practices

Important information about your rights and our responsibilities

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY.

State Notice of Privacy Practices

When it comes to handling your health information, we follow relevant state laws, which are sometimes stricter than the federal HIPAA privacy law. This notice explains your rights and our duties under state law.

Your state may give you additional rights to limit sharing your health information. Please call Member Services at the toll-free number (844) 232-0500 for more details.

Your Personal Information

Your nonpublic (private) personal information (PI) identifies you. You have the right to see and correct your PI. We may collect, use and share your PI as described in this notice. Our goal is to protect your PI because your information can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit.

We may receive your PI from others, such as hospitals, insurance companies, or other doctors. We may also share your PI with others outside our company — without your approval, in some cases. But we take reasonable measures to protect your information.

If an activity requires us to give you a chance to opt out, we'll let you know and we'll let you know how to tell us you don't want your PI used or shared for an activity you can opt out of.

THIS NOTICE DESCRIBES HOW MEDICAL, VISION AND DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION WITH REGARD TO YOUR HEALTH. PLEASE READ CAREFULLY.

HIPAA Notice of Privacy Practices

We keep the health and financial information of our current and former patients private as required by law, accreditation standards and our own internal rules. We're also required by federal law to give you this notice to explain your rights and our legal duties and privacy practices.

Your Protected Health Information

There are times we may collect, use and share your Protected Health Information (PHI) as allowed or required by law, including the HIPAA Privacy rule. Here are some of those times:

Payment: We collect, use and share PHI to get payment for the medical care you receive from us or share information with the doctors, clinics, and others who bill us for your care.

Health care operations: We collect, use and share PHI for your health care operations.

Treatment activities: We collect, use and share PHI to provide the care, medicine, and services you need or to help doctors, hospitals, and others get you the care you need. Examples of ways we use your information:

- We may share PHI with other doctors or your hospital so that they may treat you.
- We may use PHI to review the quality of care and services you get.
- We may use PHI to help you with services for conditions like asthma, diabetes or traumatic injury.
- We may collect and use publicly and/or commercially available data about you to support you and help you get available health services.
- We may use your PHI to create, use or share de-identified data as allowed by HIPAA.
- We may also use and share PHI directly or indirectly with health information exchanges for payment, health care operations and treatment. If you don't want your PHI to be shared in these situations, contact Member Services at the toll-free number (844) 232-0500 for more information.

Sharing your PHI with you: We must give you access to your own PHI. We may also contact you about treatment options or other health-related benefits and services. We may also send you reminders about routine medical checkups and tests.

You may get emails that have limited PHI, such as appointment reminders. We'll ask your permission before we contact you.

Sharing your PHI with others: In most cases, if we use or share your PHI outside of treatment, payment, operations or research activities, we have to get your okay in writing first. We must also get your written permission before:

- Using your PHI for certain marketing activities.
- Selling your PHI.
- Sharing any psychotherapy notes from your doctor or therapist.

We may also need your written permission for other situations not mentioned above. You always have the right to cancel any written permission you have given at any time. You have the right and choice to tell us to:

- Share information with your family, close friends or others involved with your current treatment or payment for your care.
- Share information in an emergency or disaster relief situation.

If you can't tell us your preference, for example in an emergency or if you're unconscious, we may share your PHI if we believe it's in your best interest. We may also share your information when needed to lessen a serious and likely threat to your health or safety.

Other reasons we may use or share your information:

We are allowed, and in some cases required, to share your information in other ways — usually for the good of the public, such as public health and research. We can share your information for these specific purposes:

- Helping with public health and safety issues, such as:
  - — Preventing disease
  - — Helping with product recalls
  - — Reporting adverse reactions to medicines
  - — Reporting suspected abuse neglect, or domestic violence
  - — Preventing or reducing a serious threat to anyone's health or safety
- Doing health research.
- Obeying the law, if it requires sharing your information.
- Responding to organ donation groups for research and certain reasons.
- Addressing workers' compensation, law enforcement and other government requests, and to alert
- To work with a medical examiner or funeral director
- Responding to lawsuits and legal actions.

Authorization: We'll get your written permission before we use or share your PHI for any purpose not stated in this notice. You may cancel your permission at any time, in writing. We will then stop using your PHI for that purpose. But if we've already used or shared your PHI with your permission, we cannot undo any actions we took before you told us to stop.

Race, ethnicity and language: We may receive race, ethnicity and language information about you and protect this information as described in this notice. We may use this information to help you, including identifying your specific needs, developing programs and educational materials and offering interpretation services. We don't share this information with unauthorized persons.

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of your PHI, including a request for a copy of your PHI through email. Remember, there's a risk your PHI could be read by a third party when it's sent unencrypted, meaning regular email. So we will first confirm that you want to get your PHI by

unencrypted email before sending it to you. We will provide you a copy of your PHI usually within 30 days of your request. If we need more time, we will let you know.

- Ask that we correct your PHI that you believe is wrong or incomplete. If someone else, such as another doctor, gave us the PHI, we'll let you know so you can ask him or her to correct it. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Send us a written request not to use your PHI for treatment, payment or health care operations activities. We may say "no" to your request, but we'll tell you why in writing.
- Request confidential communications. You can ask us to send your PHI or contact you using other ways that are reasonable. Also, let us know if you want us to send your mail to a different address if sending it to your home could put you in danger.
- Send us a written request to ask us for a list of those with whom we've shared your PHI. We will provide you a list usually within 60 days of your request. If we need more time, we will let you know.
- Ask for a restriction for services you pay for out of your own pocket: If you pay the whole bill for a service, you can ask your doctor not to share the information about that service with your health plan.
- Call Member Services at the toll-free number (844) 232-0500 to use any of these rights.

How we protect information

We're dedicated to protecting your PHI, and we've set up a number of policies and practices to help keep your PHI secure and private. If we believe your PHI has been breached, we must let you know.

We keep your oral, written and electronic PHI safe using the right procedures, and through physical and electronic ways. These safety measures follow federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password-protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to do their jobs. Employees are also required to wear ID badges to help keep unauthorized people out of areas where your PHI is kept. Also, where required by law, our business partners must protect the privacy of data we share with them as they work with us. They're not allowed to give your PHI to others without your written permission, unless the law allows it and it's stated in this notice.

Potential impact of other applicable laws

HIPAA, the federal privacy law, generally doesn't cancel other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to give you more privacy protections, then we must follow that law in addition to HIPAA.

Calling or texting you

We, including our affiliates and/or vendors, may call or text you by using an automatic telephone dialing system and/or an artificial voice. But we only do this in accordance with the Telephone Consumer Protection Act (TCPA). The calls may be about treatment options or other health-related benefits and services for you. If you don't want to be contacted by phone, contact your Aspire provider to add your phone number to our Do Not Call list. We will then no longer call or text you.

Complaints

If you think we haven't protected your privacy, you can file a complaint with us by calling Member Services at the toll-free number (844) 232-0500. You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by visiting **hhs.gov/ocr/privacy/hipaa/complaints/**. We will not take action against you for filing a complaint.

Contact information

You may call us at Member Services at the toll-free number (844) 232-0500 to apply your rights, file a complaint or talk with you about privacy issues.

Copies and changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to ask for a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you, as well as any PHI we may get in the future. We're required by law to follow the privacy notice that's in effect at this time. We may tell you about any changes to our notice through a newsletter, our website or a letter.

Effective date of this notice

The original effective date of this Notice was April 14, 2003. The most recent revision is July 30, 2021.

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently based on race, color, national origin, sex, age or disability. If you have disabilities, we offer free aids and services. If your main language isn't English, we offer help for free through interpreters and other written languages. Call your clinic for help (TTY/TDD:711).

If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint through one of these ways:

- Write to Compliance Coordinator, 12900 Park Plaza Drive, Suite 150, Mailstop 6170, Cerritos, CA 90703-9329 or e-mail privacy@aspirehealthcare.com.
- File a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201.
- Call Member Services at the toll-free number (844) 232-0500.
- Go online at **ocrportal.hhs.gov/ocr/portal/lobby.jsf** and fill out a complaint form at **hhs.gov/ocr/office/file/index.html**.

Get help in your language

One more right that you have the right to get this information in your language for free. If you'd like extra help to understand this in another language, call the Member Services number on your ID card (TTY/TDD: 711).

Aside from helping you understand your privacy rights in another language, we also offer this notice in a different format for members with visual impairments. If you need a different format, please call the Member Services number on your ID card.

Aspire Health

Notice of Privacy Practices: Acknowledgement of Receipt

ACKNOWLEDGEMENT OF RECEIPT
By signing this form you acknowledge receipt of the Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our office.

If you have any questions about our Notice of Privacy Practices, please contact:

Aspire Privacy
12900 Park Plaza Drive
Mailstop: CA4600-6170
Cerritos, CA 90703

I acknowledge receipt of the Notice of Privacy Practices

Patient's/Personal Representative's Name:	
Signature:	
Date:	

INABILITY TO OBTAIN ACKNOWLEDGEMENT
Complete only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement and the reasons why the acknowledgement was not obtained.

Patient's Name:	

Reasons why the acknowledge was not obtained:

	Patient refused to sign this acknowledgement even though the patient was asked to do so and the patient was given the Notice of Privacy Practices
	Other:

Signature of Provider Representative:	
Date:	

Authorization Form

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al 833-866-0925.

Aspire Health

This form is to be filled out if there is a request to release or receive health information to or from another person or company. Please include as much information as you can.

PART A: YOUR INFORMATION

Last name	First name	Middle initial	Date of birth

Street address	City	State	Zip code

Daytime telephone number (with area code)	Cell/mobile telephone number (with area code)

PART B: PERSON OR COMPANY WHO WILL RECEIVE THIS INFORMATION

The following people or organizations have the right to receive or share my information.

Name (a person, a class of persons like "Doctors who treated me in August 2014," or an organization)		Phone Number (if known)	
Street address (if known)	City	State	Zip code

The information may be disclosed to:

Name		Phone Number (if known)	
Aspire Health		833-866-0952	
Street address (if known)	City	State	Zip code
22 Century Blvd Suite 300	Nashville	TN	37214

Name (a person, a class of persons like "family members residing with me," or an organization)		Phone Number (if known)	
Street address (if known)	City	State	Zip code

PART C: INFORMATION THAT CAN BE RELEASED

I allow the following information to be used or released by or to Aspire on my behalf: (check only one box).

☐ All my information. This can include health, a diagnosis (name of illness or condition), claims, doctors and other health care providers and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below. OR

☐ Only limited information may be released (check all boxes below that apply to you).

- ☐ Billing
- ☐ Diagnosis (name of illness or condition) and procedure (treatment)
- ☐ Doctor and hospital
- ☐ Financial
- ☐ Medical records
- ☐ Pre-certification and pre-authorization (for treatment approvals)
- ☐ Referral
- ☐ Treatment
- ☐ Dental
- ☐ Vision
- ☐ Pharmacy
- ☐ Other: _____

I also approve the release of the following types of sensitive information by Aspire (check all boxes that apply to you):

☐ All sensitive information[2] OR ☐ Just information about topics checked below

- ☐ Abortion
- ☐ Abuse (sexual/physical/mental)
- ☐ Substance use disorder[1,2]
- ☐ Genetic testing
- ☐ HIV or AIDS
- ☐ Maternity
- ☐ Mental health
- ☐ Sexually transmitted illness
- ☐ Other: _____

1. Specify time period of records to be disclosed: _____
   Description of records that may be disclosed: _____
2. Unless I specify otherwise on this form, I intend this disclosure to include all substance use disorder records maintained by Aspire about me. I understand that my substance use disorder records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time, or as described in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

PART D: PURPOSE OF THIS APPROVAL (CHECK ONLY ONE BOX).

☐ To give out the information as shown on this form

OR

☐ For this reason(s): _____

PART E: DATE YOUR APPROVAL EXPIRES (CHECK ONLY ONE BOX).

If this document was not already withdrawn, this approval will end on the earliest of the following dates:

☐ One year from the signature date in Part F

OR

☐ Earlier than one year and upon the date, event or condition described below:

_____

PART F: REVIEW AND APPROVAL

I have read the contents of this form. I understand, agree, and allow the use and release of my information as I have stated above or as required by applicable law. I also understand that signing this form is of my own free will. I understand that I am not required to sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits. I have the right to withdraw this approval at any time by giving written notice of my withdrawal to the organization releasing my information. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Signature or Designated Legal Representative/Guardian signature **X**	Date (MM/DD/YYYY)

DESIGNATED LEGAL REPRESENTATIVE/GUARDIAN

Complete this section only if you have documentation supporting Legal Representation.

If this form is signed by someone other than the patient or parent, such as a personal representative, legal representative or guardian, please submit the following:

- A copy of a health care, general or Durable Power of Attorney.

OR

- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the patient's behalf. **Please complete the following:**

Legal representative (print full name)	Legal relationship to patient

Legal representative street address	City	State	Zip code

Signature **X**	Date (MM/DD/YYYY)

Please return the completed form to:

Aspire Health
22 Century Blvd Suite 300
Nashville, TN 37214

Be sure to keep a copy of this form for your records.

FOR RECIPIENT OF SUBSTANCE USE DISORDER INFORMATION

This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any patient with a diagnosis of substance use disorder.

For internal use only:	Inquiry tracking number