The Home Doctor®

Registration Checklist

All enrollees:

(   ) Enrollment Form

(   ) Copy of Insurance card(s)

(   ) Medication List

(   ) POA/Guardianship documents

NOTICE

Please allow two weeks for processing this application and the resident being scheduled for treatment.

Continue with the current medical provider for all medical needs and prescription refills until visited by The Home Doctor®.
Residence Information

Name of care home: _____________________________________________________________
Address: _____________________________________________________________________
City: _____________________________ State: Washington  Zip: _______________________
Phone: (____) _____-_______  Fax: (____) _____-_______  Patient’s Room #________

Patient Information

Name: ________________________________ Date of Birth:  Mo: _____ Day:_____ Yr: _____
Social Security Number: _______-_______-_______  Male  Female
Medicare Number (include suffix): __________________________________________________
DSHS Patient Identification Code (PIC): _____________________________________________
Other Insurance or Private Pay: _____________________________________________________

If private pay, please fill out the Additional Contact Information, below. This will be the responsible
party for billing purposes.

Is the patient Full Code (Resuscitate) or No Code (Do Not Resuscitate)? (Circle One)

Please include copies of the patient’s Medicare card and any other insurance cards or medical
coupons. We cannot process your election form without correct insurance information or
MEDICATION LIST.

Additional Contact / Responsible Party / Emergency Contact Information

Name: ________________________________ Relationship: _____________________________
Address: _____________________________________________________________________
City: ____________________________ State: ______ Zip: __________
Home Phone: (____) _____-_______  Work or Cell Phone: (____) _____-_______

Does this person have medical Power of Attorney?  Yes  No

Is this person the financially responsible party?  Yes  No
## Medical History
Check all that apply, and fill out the lower portion if necessary.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Now</th>
<th>Past</th>
<th>Condition</th>
<th>Now</th>
<th>Past</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
<td></td>
<td></td>
<td>High Blood Pressure</td>
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<tr>
<td>Alzheimer's Disease</td>
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<td>High Cholesterol</td>
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<td>Anemia</td>
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<td>Kidney Problems</td>
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<tr>
<td>Anxiety</td>
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<td>Leg Swelling</td>
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<td>Arthritis</td>
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<td>Liver Problems</td>
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<td>Asthma</td>
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<td>Mental Health Problems</td>
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<td>Bladder Problems</td>
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<td>Migraines</td>
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<tr>
<td>Incontinence</td>
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<td>Pain (__________)</td>
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<tr>
<td>Urinary Tract Infection</td>
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<td></td>
<td>Prostate Problems</td>
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<td>Blood Clots</td>
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<td>Skin Disease</td>
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<td>Blood Vessel Problems</td>
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<td>Stomach Problems</td>
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<tr>
<td>Bowel Problems</td>
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<td></td>
<td>Nausea</td>
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<tr>
<td>Constipation</td>
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<td>Stomach Ulcer</td>
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<td>Cramps</td>
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<td>Vomiting</td>
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<td>Diarrhea</td>
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<td>Stroke</td>
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<tr>
<td>Irritable Bowel Synd.</td>
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<td>Thyroid Disease</td>
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<tr>
<td>Rectal Bleeding</td>
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<td>Trouble Sleeping</td>
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<tr>
<td>Breast Problems</td>
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<td>Tuberculosis</td>
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<td>Bronchitis</td>
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<td>Ulcer (__________)</td>
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<td>Cancer (__________)</td>
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<td>Reproductive Problems</td>
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<tr>
<td>Dementia</td>
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<td>Abnormal Pap Smear</td>
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<tr>
<td>Depression</td>
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<td>Hysterectomy</td>
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<tr>
<td>Diabetes (Type 1 or 2)</td>
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<td>Sterility, Genetic</td>
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<tr>
<td>Emphysema</td>
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<td>Sterility, Optional</td>
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<tr>
<td>Epilepsy/Seizures</td>
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<td>Vaginal Bleeding</td>
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<tr>
<td>Fatigue or Tiredness</td>
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<td>Vision Problems</td>
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<tr>
<td>Fractures (__________)</td>
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<td>Cataracts</td>
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<td>Gall Bladder Problems</td>
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<td>Glaucoma</td>
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<tr>
<td>Hearing Problems</td>
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<td>Weight Gain</td>
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<tr>
<td>Heart Problems</td>
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<td>Weight Loss</td>
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<tr>
<td>Hemorrhoids</td>
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<td>Other:</td>
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</tbody>
</table>

This patient has a family history of: _________________________________

_____________________________________________________________________

_____________________________________________________________________

Allergies: ___________________________________________________________

Pharmacy: ____________________  Tel: _______________  FAX: ______________
Personal Habits

Alcohol Use: _____ times a week  
Meals: _____ meals a day  
Coffee/Tea: _____ times a day  
Sleep: _____ hours a night  
Exercise: _____ times a week  
Tobacco: _____ packs a day

Past Personal Habits

Alcohol Use: _____ times a week  
Tobacco: _____ packs a day for ___ years

Family History

Mother: Living Deceased (cause of death:________________________)  
Father: Living Deceased (cause of death:________________________)  
Sibling(s) Living: _____ Deceased: _____ (cause of death:________________________)  
Children Living: _____ Deceased: _____ (cause of death:________________________)

Social History

Former/Current Occupation: ____________________________

The patient is currently (circle one): Married  Divorced  Single  Widowed

Please include a copy of the most current medication sheet available. Ensure that this medication list has drug names, dosage amounts, and dosage instructions. If you do not have a MARS (Medicine Administration Record Sheet), please create a handwritten list. This information is needed for timely processing your enrollment.

Former Primary Care Physician: ____________________________

Address: __________________________________________________

Phone: (______) _______-_______  Fax (______) _______-_______

Surgical / Hospitalization History

Include the approximate date on which the hospitalization took place, the reason for the hospitalization, and the hospital you went to.

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Please provide any other information you feel is important for us to know here. The more we know about you, the better we can serve you!

____________________________________________________________________

____________________________________________________________________
Authorization to Treat Patient Statement

Be it known that I have chosen The Home Doctor® to provide my primary medical care. I live at the address on page 2, and this is my private residence. I intend to, or have, lived at this location for longer than six months, and I have no other place that is my home. Further, I hereby authorize other medical and mental health professionals and institutions to release to The Home Doctor® copies of all records deemed necessary to provide me with medical care. I give specific consent to release information relating to drug and alcohol abuse, mental health and psychiatric disorders, STDs, and HIV or AIDS Virus. Further, I authorize The Home Doctor® to release copies of my medical records to other medical and mental health professionals when appropriate and related to the matter at hand. This release includes the use of an electronic medical record to other sources of medical care, such as pharmacies, etc. Patient information is regulated and protected by HIPAA standards. The signature below authorizes The Home Doctor® to treat me.

I certify that I am competent to make this choice and these authorizations. I also certify that all of the information I provided on page 2 of this document is true and correct as of the date below.

If I am not the patient, then my signature below certifies that I am the legally appointed guardian of the individual named on page 2, and I make this choice and these authorizations on his or her behalf.

➤ Signature: ____________________________________________

Signature of patient or legally authorized representative

___________________________________________

Authority or Relationship to Individual, if representative

___________________________________________

Print Patient’s Name

___________________________________________

Date and Time

Your signature authorizes any of the Home Doctor services, which may be needed. These include: primary care, psychiatry, neurology, podiatry and dermatology.
Patient Name: _______________________________________________

I accept FULL FINANCIAL responsibility for my HOME DOCTOR home visits. Should my insurance company deny a visit or pay for a portion of a visit, I understand that I will be required to pay for these services IN FULL.

Patient or legally authorized Representative signature:

➢ Signature: _______________________________ Date: ________________

I certify that I am the legal Guardian, POA or responsible party for the above named patient.

➢ Signature: _______________________________

Acknowledgement of Receipt of Privacy Practices Statement

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Mr. Charles Plunkett at 253-984-7247 ext. 1

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

➢ Signature: _______________________________ Date: ________________

Printed Name: __________________________________________ Relationship: ________________
Authorization for The Home Doctor® to Use or Disclose My Health Care information

Patient Name: _____________________________________ Date of Birth: ____________________________

Social Security Number: ___________________________ Previous Name: __________________________________

I. My Authorization:

You may use or disclose the following health care information (check all that apply):

- □ All health care information in my medical record
- □ Health care information in my medical record relating to the following treatment or condition:
  ____________________________________________________ __________________________________
- □ Health care information in my medical record for the date(s): _____________________________________
- □ Other (e.g., X-rays, bills, labs), specify date(s): ________________________________________________

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

- □ HIV (AIDS Virus)
- □ Sexually Transmitted Diseases
- □ Psychiatric Disorders/Mental Health
- □ Drug and/or Alcohol Use

You may disclose this information to: MSO Washington, Inc., d/b/a The Home Doctor
P.O. Box 98886
Lakewood, WA 98496-8886

Purpose(s) for this authorization (check all that apply):

- □ At my request
- □ Other (specify): __________________________________ __________________________________

This authorization ends: (This document does not permit disclosure of health information created more than 90 days after the date it is signed.)

- □ In 90 days from the date signed
- □ On (date): ______________________________________
- □ When the following event occurs: ____________________________________________
  (No longer than 90 days from date signed)

II. My Rights

I understand that MSO may not base treatment or payment decisions on whether or not I sign this authorization. I understand I have the right to inspect or receive a copy of my protected health information and to receive a copy of this signed form.

I acknowledge that I have the right to revoke this authorization in writing by either: (1) filling out a revocation form available from The Home Doctor or (2) sending my revocation via letter to The Home Doctor to the above address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that once health care information is disclosed, the person or organization that receives it may re-disclose it and privacy laws may no longer protect it.

_____________________________________________ __________________________________
Signature of patient or legally authorized representative Print name

_____________________________________________ ___________________________________
Authority or relationship to individual, if representative Date Time
For Individuals on BOTH MEDICARE AND MEDICAID ONLY

Individuals on both Medicare and Medicaid need additional insurance to use The Home Doctor service. This can be a traditional Medicare Supplemental plan or a Medicare Advantage plan.

All Medicare Supplemental plans are accepted by The Home Doctor.

The Home Doctor is contracted with the following Medicare Advantage Plans:

- AARP
- Cigna
- Evercare
- Humana
- Regence
- Secure Horizons
- United Healthcare

If you are on Medicare AND Medicaid and not covered by one of these plans, sign and date the form following this page titled:

Sales Appointment Confirmation Form

Fax to: 253-588-8244.

A licensed agent will contract you to discuss your options. If you have any questions you may contact:

Jason Schreib
253-365-6466 or toll-free 1-855-332-9483
jason@schreibinsurance.com
Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss.

☐ Stand-alone Medicare Prescription Drug Plans (Part D)
☐ Medicare Advantage Plans (Part C) and Cost Plans

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan.

Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

| Beneficiary or Authorized Representative Signature and Signature Date: |
| Signature | Signature Date |
| If you are the authorized representative, please sign above and print clearly and legibly below: |
| Name (First_Last) | Relationship to Beneficiary |

| To be completed by Agent (please print clearly and legibly) |
| Agent Name (First_Last) | Agent Phone | Agent ID |
| Beneficiary Name (First_Last) | Beneficiary Phone (Optional) | Date Appointment Completed |
| Beneficiary Address (Optional) |
| Initial Method of Contact | Plan(s) the agent represented during the meeting |
| Agent’s Signature |

Scope of appointment (SOA) is subject to CMS Record Retention Requirements
Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting: Please check all that apply
☐ Unplanned Attendee  ☐ New SOA required (consumer requested other Health Product information)
☐ Walk in  ☐ Other (please explain): ________________________________

Fax to: 1-866-994-9659

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