The Home Doctor
bringing healthcare home

P.O. Box 98886
Lakewood, WA 98496
Phone: 253-589-6484 ext 5
Enrollment Fax: 253-588-8244
Website: homedoctorusa.com

Name of person filling out this form: _____
Email/Contact Phone # _____
Full Name of PATIENT: _____ Male ☐ // Female ☐
Date of Birth: _____ Social Security Number: _____ Height _____
Weight _____ Patient Ethnicity _____ Race _____ Primary
Language _____ The patient is currently: ☐ Married ☐ Divorced ☐ Never Married ☐ Widowed
Care Home Residence: _____
Address: _____ City: _____
State: _____ Zip: _____ Phone: _____ Fax: _____
Residence Contact Person(s) _____ Date you moved in: _____

1. Medically home-bound? **Yes** ☐ **No** ☐ If not medically home-bound due to physical or mental conditions, we are unable to provide Primary Care. Reason for home-bound status _____
2. Are you on dialysis? **Yes** ☐ **No** ☐ If yes, we are unable to provide Primary Care for you.
3. Hospice? **Yes** ☐ **No** ☐ We are unable to accept patients currently receiving hospice services.
4. Are you presently on Coumadin or Warfarin? **Yes** ☐ **No** ☐
On Coumadin for artificial heart valve? **Yes** ☐ **No** ☐
Presently not accepting patients on coumadin. Due to COVID 19, there are no mobile phlebotomy services available.
5. Patient resides in (check 1): **Assisted Living** ☐ **Memory Care** ☐ **AFH** ☐ We cannot accept independent residents.

Please mail any financial statements (if different from above address) to:
Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work: _____ Cell: _____

Does the patient have a Financial Power of Attorney document? Yes ☐ No ☐
Does the patient have a Medical Power of Attorney document? Yes ☐ No ☐
Does the patient have a Durable Power of Attorney document? Yes ☐ No ☐
We don't have Power of Attorney document but I am their Next of Kin or Spouse and financially responsible. Yes ☐ No ☐
Does the patient have a Legal Guardianship document? Yes ☐ No ☐ or Payee? Yes ☐ No ☐

POA/Guardian Name: _____ Relationship: _____
Address: _____ City: _____
State: _____ Zip: _____ Contact Phone: _____ Email: _____

I certify that I am the Legal Guardian, POA -or- Responsible Party for the above-named patient.
Signature: _____ Relationship: _____

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Patient's Name _____

INSURANCE **Date of Birth:** _____

Medicare ID# _____

DSHS ID # _____

Upload / Capture Card Images While Uploading the **Enrollment Form**

Other Insurance: Please List Type and ID # _____

Tricare: Sponsor's Name _____ DOB _____

Sponsor's SS# _____ for verification purposes

PHARMACY: _____ Tel: _____ FAX: _____

Is this the pharmacy you will be using at the new home? Yes ☐ No ☐

** Continue with your current medical provider for all medical needs and prescription refills until visited by The Home Doctor. ** We cannot refill medications until patient has established care with our primary care provider. **

List Allergies: _____ **NO known allergies** ☐

MEDICAL HISTORY –- Check all that apply - Attach additional sheet if more room is needed.

1. Do you attend Active Day Health? Yes ☐ No ☐ Which Days? _____
2. Currently receiving home health services? Yes ☐ No ☐ Agency Name _____
3. Do you have a wound? Yes ☐ No ☐ If so, which HH agency is treating the wound? _____

Chronic Conditions:

☐ AFIB ☐ Alzheimer's Disease ☐ Arthritis ☐ Asthma ☐ Cancer: _____

☐ COPD ☐ Coumadin/Warfarin Therapy ☐ Depression ☐ Diabetes ☐ Heart Disease ☐ Heart Failure

☐ High Blood Pressure ☐ High Cholesterol ☐ Osteoporosis ☐ Kidney Disease ☐ Stroke ☐ TIA ☐

Other: _____

Other Medical Conditions:

☐ UTI ☐ Diarrhea ☐ Dementia ☐ Bladder Incontinence ☐ Thyroid Disease

☐ Wound(s) ☐ Pain, Area: _____

☐ Stomach Problems: _____

☐ Other: _____

Mental Health Conditions:

☐ Depression ☐ Schizophrenia ☐ Bi Polar Disorder

☐ Other: _____

Who is your Mental Health Provider? _____

Their Address: _____

FAMILY HISTORY: Are there any medical conditions that run in your family? Please list below:

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Patient's Name _____

Former Primary Care Provider: _____
Address and Phone Number _____
After your first visit, The Home Doctor Provider will be your Primary Care Provider. Prior to seeing the Home Doctor provider for the first time, we are unable to refill medications, sign home health orders, order durable medical equipment, etc. If you move out of the assisted living facility or adult family home you live in, The Home Doctor may not be able to follow you.

Please list any specialists you are currently under their care:

Specialist #1 Name and Specialty: _____
Address and Phone Number _____

Specialist #2 Name and Specialty: _____
Address and Phone Number _____

AUTHORIZATION TO TREAT PATIENT STATEMENT

Be it known that I have chosen The Home Doctor® to provide my primary medical care. In addition I also authorize The Home Doctor® to provide care for mental health, wound care and Foot care as needed. 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. If I am not the patient, then my signature below certifies that I am the legally appointed guardian of the patient listed below, and I make this choice and these authorizations on his or her behalf.

Print name of Patient: _____ Date: _____

Signature: _____ _____
Signature of patient or legally authorized representative **Print Name & Relationship to Patient, if representative**

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CONSENT TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

From time to time The Home Doctor® may wish to use or disclose your protected health information to individuals involved in your care and/or treatment, including for notification purposes. As stipulated by 45 CFR 164.510, we are permitted to make such uses or disclosures after we have obtained your verbal or written permission. As an integral part of your care, The Home Doctor® is authorized to speak to your adult family home provider/caregiver or nursing staff at your residential care community regarding treatment, proposed treatment or billing. In addition, I authorize the following individuals to speak with The Home Doctor regarding treatment, proposed treatment or billing.

Authorized individuals:

Name_____ Relationship_____ Phone # _____

Name_____ Relationship_____ Phone # _____

Print name of Patient:_____ Date: _____

Signature: _____ _____

Signature of patient or legally authorized representative **Print Name & Relationship to Patient, if representative**

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. 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.

Our privacy policy can be found on our website **homedoctorusa.com**

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

Print name of Patient: _____ Date: _____

Signature: _____ _____

Signature of patient or legally authorized representative **Print Name & Relationship to Patient, if representative**

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AUTHORIZATION TO RELEASE MEDICAL HEALTH INFORMATION

I authorize the facility/clinic/hospital listed below to provide a copy of the requested health care information located in my medical record (which may include H&P, Op reports, D/C summaries, ED reports, Diagnostic reports, progress notes, etc.). This authorization, unless expressly limited by me in writing, will extend to all aspects of testing and/or treatment of sexually transmitted diseases, AIDS, HIV Infection, alcohol and/or drug abuse, mental health conditions or other sensitive information.

Name of Facility/Clinic/Hospital: _____

Address: _____ Phone number: _____ Fax number _____

Patient's Name: _____ DOB: _____ Patient's Address: _____ Phone: _____

Records being requested by the Home Doctor®:

_____

_____

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.

Unless revoked, this authorization expires in one year or on this date: _____

Print name of Patient: _____ Date: _____

Signature: _____ _____

Signature of patient or legally authorized representative **Print Name & Relationship to Patient, if representative**

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Consent to Chronic Care Management (CCM) Service

As of January 1st 2015, medicare covers chronic care management (CCM) services provided by physician practices per calendar month. I understand that my primary care physician, named below, is willing to provide such service to me, including the following.

- Access to my care team 24 hours a day, seven days a week, including telephone access and other non-face to face means of communication (e.g, email, fax)
- The ability to get successive, routine appointments with my designated primary care physician or member of my care team.
- Care management of my chronic conditions, including timely scheduling of all recommended preventive care services, medication reconciliation, and oversight of my medical management.
- Creation of a comprehensive plan of care for all my health issues that is specific to me and congruent with my choices and values.
- Management of my care as I move between and among health care providers and settings, including the following:
  - -Referrals to other health care providers
  - -Follow up after I visit an emergency department
  - -Follow up after I am discharged from the hospital or other facility (e.g, skilled nursing facility)
- Coordination with home and community-based providers of clinical services.

I understand that as part of these services, I will receive a copy of my comprehensive plan of care.

I also understand that I can revoke this agreement at any time (effective at the end of a calendar month) and can choose, instead to receive these services from another health care professional after the calendar month in which I revoke this agreement. Medicare will only pay one physician or health care provider to furnish my chronic care management services within a given calendar month.

I understand these chronic care management services are subject to the usual Medicare deductible and coinsurance applied to physician services.

I hereby indicate by signature on this agreement that _____
is designated as my primary care physician for purpose of providing Medicare chronic care management services to me and billing for them.

My signature also authorizes my primary care physician to electronically communicate my medical information with other treating providers as part of the care coordination involved in chronic care management services. This designation is effective as of the date below and remains in effect until revoked by me.

Date: _____

Patient Name (please print): _____

Patient or Guardian Signature: _____

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Remote Patient Monitoring (RPM) Consent Form

I understand that:

- I am the only person who should be using the remote monitoring equipment as instructed.
- I will not use the device for reasons other than my own personal health monitoring.
- I can only participate in this program with one Medical Provider at a time.
- The devices are only designed for the Remote Patient Monitoring program.
- I will take my readings daily or as instructed by my Healthcare Provider as part of my participation in the program.

I acknowledge that:

- It is **NOT AN EMERGENCY RESPONSE UNIT AND IS NOT MONITORED 24/7. Call 911 for immediate medical emergencies.**
- I received a _____ type of device with Device ID _____
- I am aware my BP daily readings will be transmitted from the monitor to a secure web portal for my healthcare provider.
- By opting into SMS messaging through the RPM program, my Healthcare provider can communicate with me via my mobile device my text messaging.

Financial consent:

- My insurance will be charged monthly for this service. Co-payments may apply.
- My Healthcare provider owns the equipment and I am responsible for returning the equipment when my participation in the RPM program has ended.
- I will not tamper with the equipment and understand that I may be responsible for any fees associated with misuse or loss of the equipment.
- I can withdraw my consent to participate in this program.

I, _____ have read and understood the information and consent to participate in the Remote Patient Monitoring program as stated above.

Date: _____ (month/day/year)

Patient Name _____
Signature of Patient Authorized Person _____
(Relationship of Authorized Person) _____