Patient Information

Last Name ______________________ First Name ______________________ MI ________

Gender M ☐ F ☐ DOB ________/________/____________ SSN __________-__________-____________

Marital Status S ☐ M ☐ W ☐ D ☐ Race ______________________________

Address ____

Hotel Name______________________ Apt/Room # _______ City ________________ Zip __________

Room Phone ______________________ Cell Phone ______________________

Email ______________________

Emergency Contact

Last Name ______________________ First Name ______________________ MI ________

Home Phone ______________________ Cell Phone ______________________

Work Phone ________________ ext. _________ Email ______________________

Relationship to Patient? ______________________

Primary Insurance Policy

Provider ________________ Policy/Subscriber ID________________ Group No. __________

Secondary Insurance Policy

Provider ________________ Policy/Subscriber ID________________ Group No. __________

Does Patient have Medicaid? Y ☐ N ☐ ID# ______________________

How did you find out about us? ______________________

Medical History Form

Height? ______ft ______in   Weight? ______lbs

Do you:

Exercise regularly? Y ☐ N ☐   Drink alcohol? Occasionally ☐ Socially ☐ Often ☐ Heavily ☐

Use recreational or illicit drugs? Y ☐ N ☐ If yes, what? ____

Smoke? Y ☐ N ☐ Quit ☐ If yes, how many years have you smoked? ________ How many packs per day? ________

Current Medical Problems

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____

Past Medical Problems

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____

Please list allergies including medications.

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____

Please provide a complete list of medications, including over the counter medications and vitamins (use a separate list if needed). Please include dosage amounts and frequency. ____

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Authorization of Treatment

_______ I authorize the release of my medical records to HouseCalls-MD upon its request, including all examinations, diagnoses, laboratory and imaging studies, and treatments from the past two years.

_______ I authorize payment of my medical benefits to HouseCalls-MD for services rendered.

_______ I authorize disclosure of my medical record to HouseCalls-MD's business associates.

_______ I authorize HouseCalls-MD to give my insurance company any information about services rendered to me necessary to process claims.

_______ I acknowledge that I received or was offered the practice's Notice of Privacy Practices describing the use and disclosure of confidential healthcare information, also available at www.housecalls-md.com/forms/.

_______ I understand and agree that I am financially responsible for all charges for services rendered to me, including balances owed after insurance payments.

Signature ____ Date_________/_________/_____________

Printed Name of Person Completing this Form ____

Relationship to Patient ____

***If signing as a POA, please include a copy of the power of attorney.**

Advanced Beneficiary Notice (ABN) for Hotel Guest

NOTE: If Medicare doesn't pay for the services below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for services below.

WHAT YOU NEED TO DO NOW: Read this notice, so you can make an informed decision about your care. Ask us any questions that you may have after you finish reading this document. Choose an option below about whether to receive the items listed below.

Trip Charge: This fee compensates for our travel time, the lost income or "opportunity cost" associated with seeing patients at their home instead of the physician's office. This fee is not covered by any insurance and is due upon the arrival of the provider.

Trip Charge	**$100**
Nurse visits	**$50**
Field Testing	**$40 (separate from lab testing)**
Teleservices	**$40 (uninsured guest)**

Please choose only one:

1) ____I want the services listed above when applicable to my care except those I crossed out. You may ask to be paid now, but I also want my insurance billed for an official decision on payment. I understand that if my insurance doesn't pay, I am responsible for payment, but I can appeal to Insurance. If insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.
2) ____I want the services listed above, but do not bill insurance. You may ask to be paid now as I am responsible for payment. I cannot appeal if insurance is not billed.
3) ____I don't want the services listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if insurance would pay.

Signature ____ Date _________/_________/_____________

Relationship to Patient ____

Release of Information Authorization

I authorize the following person(s) to obtain my medical information, pick up prescriptions, and speak to HCMD regarding my care.

Name ____ Relationship ____

Name ____ Relationship ____

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other ______________________________
Cardholder Name (as shown on card): ______________________________
Card Number: ______________________________
Expiration Date (mm/yy): ____________________ CVC (code on back) __________
Cardholder ZIP Code (from credit card billing address): ______________________________

I agree HouseCalls-MD may charge my credit card on file for the balance due when they receive a copy of the EOB. This authorization relates to all balances not covered by my insurance company for services provided by HouseCalls-MD. This could be amounts resulting from balances related to copayment, deductible, co-insurance, non-covered services, or denials for no coverage/eligibility but is not limited to these scenarios.

______________________________ ______________________________

Cardholder Signature Date

Patient Name:______________________________