HouseCalls-MD

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Patient Information:

Last Name_____ **First Name**_____ **MI** _____

Gender M ☐ F ☐ DOB_____ Race:_____ Soc. Sec. No. _____

Address_____ Apt/Room #_____ City_____ Zip _____

Community name (if not at home)_____ Martial Status: S ☐ M ☐ W ☐ D ☐

Home Phone_____ Cell Phone _____

E-mail _____ Preferred Pharmacy_____

Emergency Contact Person: Last Name_____ First Name_____ MI_____

Address_____ City_____ State_____ Zip _____

Home Phone_____ Cell Phone _____

Work Phone_____ ext._____ E-mail _____

Relationship to Patient_____ Responsible party Y ☐ N ☐ Power of Attorney Y ☐ N ☐

Credit Card Information (For Trip Fees or Insurance Co-Pays) Card Type: Amex ☐ MC ☐ Visa ☐ Disc ☐

Credit Card Number_____ Exp. Date:_____

Name on card_____ CVC2 (3 digit code , AmEx is 4 digits) _____

Billing Address_____ City_____ State____ Zip_____

Primary Insurance Policy Provider _____

Policy/Subscriber ID No._____ Group No._____

Claims Address (not needed for Medicare) City_____ State_____ Zip _____

Secondary Insurance Policy/Medicare Supplement _____

Policy/Subscriber ID No._____ Group No. _____

Claims Address (not needed for Medicare) City_____ State_____ Zip _____

Does Patient have Medicaid? Yes ☐ No ☐ ID#: _____

How did you find out about us?_____

Patient Name: _____ DOB:_____

1. I understand that my health care provider wishes me to engage in a telemedicine consultation.
2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.
5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.
6. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.
7. I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented.
8. I have had a direct conversation with my doctor, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____

Patient's/POA/guardian signature Date

HouseCalls-MD Authorization of Treatment

PATIENT: _____

(Please Print Patient's Name)

DOB: _____ SSN: _____

_____ 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 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.

_____ _____

Date Signature of patient or patient's Power of Attorney

(If signing as a POA, please fax a copy of your POA document as well.)

_____

(Please print name of the person signing this document)