Patient's Name (printed) _____

Patient's Date of Birth _____

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 Facility Patients

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.

Urgent Visit Trip Fee -(after 4pm, weekends, holidays)	**$150 (Not a covered benefit)**
Urgent Nurse Visit Trip Fee -(after 4pm, weekends, holidays)	**$100 (Not a covered benefit)**
After Hours Teleservices -(after 4pm, weekends, holidays)	**$40 (Not a covered benefit)**
PPD Skin testing and screening	**$45 (Not a covered benefit)**

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 Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare 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 Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare 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 Medicare would pay.

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

Signature _____ Date_____

Printed Name of Person Completing this Form _____

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 _____

HouseCalls-MD

Authorization for Release of Protected Health Information

Patient's Name _____

Patient's Date of Birth _____ Patient's SSN _____

Name of Person Completing this Form _____

Relationship to Patient _____ Source of Legal Authority _____

☐ I hereby authorize HouseCalls-MD to disclose and receive protected health information (HPI) as deemed below.

Send health records/information to:

HouseCalls-MD PO BOX 41189 NORTH CHARLESTON SC 29423
Phone # 843-501-2031 Fax # 843-884-6146

___ I wish to have the following records copied, and I will pick them up at your facility

___ I request the facility copy the following records and fax/send them to the above address

I request the release of all medical records created between _____ and _____

Legal Authority:

___ I am the Patient noted above

___ I am the Patient's legal representative

___ I am the Patient's Power of Attorney

___ I am the Patient's legal Guardian Requestor's Initials _____

I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse) for use in medical treatment or consultation, billing or claims payment, or other purposes as I may direct. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.
If signing as a POA, please include a copy of the documentation, as some providers will not release records without the additional documentation.

Signature _____ Date _____

Relationship to Patient _____

HOUSECALLS-MD

We are excited to offer Care Management support through our new Chronic Care Management program. This support is available to Medicare patients with two or more chronic conditions.

Support

- You will be assigned a personal Care Manager who will maintain contact with you throughout the month to assist with all of your care coordination needs.
- You and your Care Manager will create a Care Plan to help manage your goals.
- Your Care Manager will assist with appointments, medication refills, referrals for treatment, referrals for resources and overall communication between you and your physicians.

DISCLOSURES:

Availability of Services and Cost Sharing: As a Medicare beneficiary you are eligible to receive Care Management support through our Chronic Care Management program. Medicare covers 80% of these services with a 20% copay. Most secondary insurances cover all or part of the 20% copay. If your secondary does not cover the copay, you may be responsible for the copayment.

Supervising Physician: Only one physician can provide Chronic Care Management support to a patient at a time. If you receive a call from another physician's office offering these services, please let them know you are already receiving them from us.

Eligible Conditions: Two or more chronic medical conditions that are expected to last at least 12-months.

Sharing Information: Your Care Plan can be shared at your request.

Canceling Services: Chronic Care Management is a voluntary program. If you consent to receive services, you can cancel services at any time by calling our office.

☐ **I consent to CCM services**

Patient Name: _____ **Date of Birth:** _____

Patient Signature: _____ **Date:** _____