HouseCalls-MD
Advanced Beneficiary Notice (ABN) For Facilities

Presented by HouseCalls-MD to _____

(Name of patient or POA)

WHAT DO YOU NEED TO KNOW: 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.

NOTE: Medicare does not pay for everything, even for some of the care that you or your health care provider have good reason to think you need. We do not expect Medicare to pay for services listed below:

Trip fee: 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 insurances and is due on arrival of the provider.

Scheduled visit to facility:	~~**$100**~~ **$0**
	Fee is waved in senior communities on scheduled visit days
Unscheduled Visits:	~~**$100.**~~ **$50***
After Hours Visits (after 4pm/weekends/Holidays):	~~**$150 and up.**~~ **$100 and up****

***Fee reduced at facility**
****This fee varies based on time/nature of need**

Blood draw-	**$45**
(In-home with specimen transportation to Lab)	
Routine Nail Care	**$45**
PPD skin testing and screening	**$42**
Teleservices	**$50 per 15 minutes**
(When not bundled with an encounter)	

OPTIONS (Choose only one!)

1) ____I want the services listed above when applicable to my care except those I crossed out. I will pay for them at the time of service because I understand that those services are not covered by Medicare or supplemental insurances.

2) ____I do not want the services listed above. I will not be billed and cannot appeal to see if Medicare would pay.

3) ____I want the services listed above when applicable to my care except those I crossed out. I will pay for them at the time of service, but I will also fill request to Medicare for an official decision on payment, which I can appeal if payment denied. If Medicare does pay, you will refund any payment I made, less co-pays or deductible

Please understand the services listed on the ABN form will only be performed at your request-by filling out the form you give us the option of performing these services. Without form on file Insurance Company will not allow us to charge for specific services which are not covered under their policy.

_____ _____

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)

HouseCalls-MD Authorization for Release of Protected Health Information

I hereby authorize HouseCalls-MD to disclose Protected Health Information (HPI) as deemed below.

Patient: Requestor (If other than Patient): Name: _____

Name: _____ SSN #: _____
Relationship:_____ Date of Birth: _____

Source of Legal Authority: _____ _____

Name and Address of who to receive health records/information:

HouseCalls-MD 8983 University Blvd #104-334 N. Charleston, SC 29406

Phone # 843-501-2031 Fax # 888-453-0810

___ 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 record created between: Date: _____and_____

Legal Authority Request:

___ 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 documentation, as some providers will not release records without additional documentation.

Signature: _____
Date:_____

Relationship to
Patient:_____

Name of Person Completing this
Form:_____

IMPORTANT INFORMATION REGARDING MEDICARE AND CHRONIC CARE MANAGEMENT

Dear Patient,

We enjoy and appreciate the opportunity to provide you with comprehensive primary care. Medicare has identified the care of chronic health conditions as an important goal. Chronic conditions are ongoing medical problems that must be managed effectively in a partnership between the health care team and the patient to maintain the best possible health. Examples include diabetes, high blood pressure, heart disease, depression, and others. Effective Jan. 1, 2015, federal regulations now enable Medicare to pay for chronic care management.

What is chronic care management?
Your physician and primary care team will carefully monitor and provide comprehensive care for your chronic health conditions in a systematic way to supplement regular office visit care.

How can you benefit from chronic care management?

- You will have 24/7 access to your primary care team.
- You will have preventive care services scheduled, many of which are covered by Medicare, and your medications will be closely monitored.
- You will receive a personalized, comprehensive plan of care for all of your health issues.
- Your care will be coordinated by your physician and staff, including care you may receive at other locations, such as specialists' offices, the hospital, other health care facilities, or your home.

What do you need to know before signing up?

- Understand that this care requires you to pay approximately $8 to $9 (your Medicare coinsurance amount) to your primary care practice each month that you receive chronic care management. The service is also subject to your Medicare deductible. Your secondary insurance may or may not pay for expenses.
- You must sign an agreement to receive this type of chronic care management.

Please let us know if you have questions about this new benefit or would like to receive the one-page agreement form.

Sincerely,
Dr. Stela Susac-Pavic

AGREEMENT TO RECEIVE MEDICARE CHRONIC CARE MANAGEMENT SERVICES

As of Jan. 1, 2015, Medicare covers chronic care management services provided by physician practices per calendar month. I understand that my primary care physician, named below, is willing to provide such services to me, including the following:

- Access to my care team 24-hours-a-day, 7-days-a-week, including telephone access and other non-face-to-face means of communication (e.g., email),
- 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 medication 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 professional to furnish me 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 purposes 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.

Patient name (please print): _____

Patient or guardian signature: _____

Date: _____

HouseCalls-MD

8983 University Blvd #104-334 N. Charleston, SC 29406
Office 843-501-2031 www.housecalls-md.com
Info@housecalls-md.com
Fax 888-453-0810

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?_____

Medical History Form Continued

Where were you born?_____

Highest level of education?_____

Occupation:_____
Are you still working or retired?_____

Are you Married ☐ Widow ☐ Divorced ☐ Single ☐ ?

Do you have Children?_____ How many?_____

Any Grandchildren?____ How Many?_____

Who resides in your home:_____

Hobbies:_____

Do you exercise regularly? Y ☐ or N ☐

Do you smoke?	Do you Drink Alcohol?	Do you use recreational or illicit drugs?
Y ☐ N ☐ Quit ☐	Occ, ☐ Socially, ☐ Often, ☐ Heavily ☐	N ☐ Y ☐ What_____

Check any symptoms that you are having

☐ Wt Loss ☐ Fevers ☐ Chills ☐ Night sweats

☐ Hair loss ☐ Skin changes ☐ Rashes ☐ New lumps/moles

☐ Headaches ☐ Blurred vision ☐ Dizziness ☐ Hearing loss ☐ vision changes

☐ Runny nose ☐ Seasonal Allergies ☐ Nose bleeds

☐ Bleeding gum ☐ Dental pain ☐ Sore Throat ☐ Swollen glands

☐ Shortness of breath ☐ Cough ☐ Breathing problems

☐ Hypertension ☐ Heart murmur ☐ Chest pains ☐ Palpitations ☐ Abnormal EKG

☐ Changes in appetite ☐ Nausea ☐ Vomiting ☐ Reflux ☐ Trouble swallowing

☐ Bowel troubles ☐ Constipation ☐ Hemorrhoids ☐ Abdominal pains ☐ Hepatitis

☐ Urinary Frequency ☐ Pain with urination ☐ Blood in your urine ☐ Incontinence

☐ Leg edema ☐ Blood Clots ☐ weakness ☐ Joint pain

☐ Numbness ☐ Nerve pain ☐ Tremors ☐ Fainting ☐ Seizures

☐ Anemia ☐ Bleeding problems ☐ Hot or Cold intolerance ☐ Thyroid problems

☐ Mood problems ☐ Anxiety ☐ Depression ☐ Memory loss ☐ Dementia

☐ Behavioral problems ☐ Substance Abuse

Medical History Form

Current Medical Problems:

_____
_____
_____
_____
_____
_____
_____
_____

Do you have or have you been treated for:
- ☐ DM
- ☐ Heart problem
- ☐ HTN
- ☐ Anxiety/Depression
- ☐ Alzheimer's/Dementia
- ☐ Arthritis/Joint Problems
- ☐ COPD/Breathing problems
- ☐ Cancer
- ☐ High Cholesterol
- ☐ Acid Reflux

Current Height: ___ft ___in Weigh: ____lbs

What other past medical problems do you have: _____
_____

In the past year have you been hospitalized? if so when and for what: _____
_____

What surgeries have you had?

☐Tonsillectomy	☐Tubal/vasectomy	Other:_____
☐Appendectomy	☐Hysterectomy	_____
☐Gall Bladder	☐Joint/Orthopedic	_____
☐C-section	☐Heart	_____

Are you Allergic to any medication?: _____

Please Provide a complete list of medications, including over the counter medications and vitamins (use a separate list if needed)_____

_____

Primary pharmacy, do you use more than one, if so please list: _____
_____

Do you have any hearing problems: ___Do you have hearing aids?___
Do you where glasses? ____ or Contacts. Reading glasses only? ____

Vaccines: do you have a current…
- ☐Flu Vaccine
- ☐Pneumonia Vaccine
- ☐Shingles Vaccine

Do you have any false teeth or dentures? _____

Age and health of your:

Mother: _____Father: _____

Do you have a Family Medical History of:
Diabetes: M☐ F☐ S☐ C☐ Heart Disease: M☐ F☐ S☐ C☐
High blood pressure: M☐ F☐ S☐ C☐ Stroke: M☐ F☐ S☐ C☐
Cancer: M☐ F☐ S☐ C☐ Asthma: M☐ F☐ S☐ C☐
Seizures: M☐ F☐ S☐ C☐ Bleeding problems: M☐ F☐ S☐ C☐
Mental Disease: M☐ F☐ S☐ C☐

M- Mother, F-Father, S-Sibling, C-Child

Screenings:
Last Mammogram Year:_____
Last Pap smear Year:_____
Last PSA tested Year:_____
Last colonoscopy Year:_____