



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? _____

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 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 North 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: _____

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

Advanced Beneficiary Notice (ABN) For Home Patients

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.

Trip charge: **\$100** (Not a covered benefit)

After Hours Visits (after 4pm/weekends/Holidays): **\$150 and up** (Not a covered benefit)
****This varies based on time of need, provider location and availability.**

Blood draw **\$45** (Not a covered benefit)
(with specimen transportation to Lab)

Routine Nail Care **\$45** (Not a covered benefit)

PPD skin testing and screening **\$42** (Not a covered benefit)

Teleservices **\$50 per 15 minutes** (Not a covered benefit)
(when not bundled with 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

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?

<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> Tubal/vasectomy	Other: _____
<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Hysterectomy	_____
<input type="checkbox"/> Gall Bladder	<input type="checkbox"/> Joint/Orthopedic	_____
<input type="checkbox"/> C-section	<input type="checkbox"/> 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 wear 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

Screenings:

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

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

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 <input type="checkbox"/> N <input type="checkbox"/> Quit <input type="checkbox"/>	Occ, Socially, Often, Heavily <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	N <input type="checkbox"/> Y <input type="checkbox"/> 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