HouseCalls-MD

Patient Information

Last Name _____ First Name _____ MI _____

Gender M ☐ F ☐ DOB _____ SSN _____

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

Address _____

Community Name_____ Apt/Room # _____ City _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____ Preferred Pharmacy _____

Pharmacy Phone # _____ Pharmacy Address _____

Responsible Party (If not the patient, must have copies of legal documents on file)

Last Name _____ First Name _____ MI _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ ext. _____ **Email** _____

Relationship to Patient? _____ Medical POA? Y ☐ N ☐ Financial POA? Y ☐ N ☐

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

Where were you born? _____ Height? _____ft _____in Weight? _____lbs

Highest level of education? _____

Occupation? _____ Are you employed or retired? _____

Do you have children? _____ How many? _____

Any grandchildren? _____ How many? _____

Who resides in your home? _____

Hobbies _____

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? _____

Use smokeless tobacco? Y ☐ N ☐ Vape? Y ☐ N ☐

Have hearing aids? Y ☐ N ☐ Have false teeth or dentures? Y ☐ N ☐ Wear glasses? Y ☐ N ☐

Wear only reading glasses? Y ☐ N ☐ Wear contacts? Y ☐ N ☐

Date of your last vaccinations:

Flu _____ Pneumonia _____ Shingles _____

Covid-19 Dose 1_____ Covid-19 Dose 2_____ Covid-19 Booster_____

Date of your last screenings:

Mammogram _____ PAP Smear _____ Colonoscopy _____

Family Medical History

Please check the initial for each relative type that has the below issues. M=Mother F=Father B=Brother S=Sister C=Child

Diabetes M ☐ F ☐ B ☐ S ☐ C ☐

High Blood Pressure M ☐ F ☐ B ☐ S ☐ C ☐

Cancer M ☐ F ☐ B ☐ S ☐ C ☐

Seizures M ☐ F ☐ B ☐ S ☐ C ☐

Mental Illness M ☐ F ☐ B ☐ S ☐ C ☐

Heart Disease M ☐ F ☐ B ☐ S ☐ C ☐

Stroke M ☐ F ☐ B ☐ S ☐ C ☐

Asthma M ☐ F ☐ B ☐ S ☐ C ☐

Bleeding Problems M ☐ F ☐ B ☐ S ☐ C ☐

Medical History Form

Advanced Directive

- ☐ DNR (Do not resuscitate)
- ☐ Full Code

Current Medical Problems

_____

_____

_____

_____

_____

Past Medical Problems

_____

_____

_____

_____

In the past year, have you been hospitalized? If so, when, where and why?

_____

_____

_____

Please list any surgeries and dates.

_____

_____

_____

Please list allergies including medications.

_____

_____

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. _____

_____

_____

_____

_____

_____

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 _____

___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 29323
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 _____

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 _____