HOMEMD
HOUSECALL SERVICES

Phone (855) 466-3631
Fax (810) 244-0226
intake@homemdhealth.com

Referred by_____

Patient Information:

First Name: _____ Last Name: _____ MI: ____

Birthdate: ____ / ____ / _____ Social Security #: _____ Gender: ☐ M ☐ F

Address: _____City/State: _____

Phone Number: _____Building Name/Room #: _____

☐ Memory Care ☐ Assisted Living ☐ Group Home ☐ Independent Living

Patient personal cell or direct phone only (if applicable): _____

Marital Status (choose one): ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered ☐ Single

Primary Language: _____ Country of Origin: _____

Insurance: Please submit a copy of your insurance cards:

Medicare ID #:_____

Primary Plan: _____ Policy ID #: _____ Group #: _____

Secondary Plan: _____ Policy ID #: _____ Group #: _____

Pharmacy Name/Phone #: _____ Mail Order Pharmacy Name:_____

I acknowledge and agree that by signing this form as Legal Representative, I swear and attest that I am legally authorized to act and make decisions on the patient's behalf. I am required to provide a copy of valid and effective documentation outlining my role as a Legal Representative in order to receive related communications. Upon signing this form or any other required documentation as a Legal Representative for the patient, I hereby release and hold harmless HomeMD Housecall Services and its representatives from any claims or damages arising from HomeMD's reliance on my attestation that I am the patient's Legal Representative.

Legal Representative:

Name: _____ Relationship:_____

Mobile Phone #: _____ Email: _____

Address: _____ City: _____ State: ____ Zip: _____

Billing Contact:

☐ Self or Other Name: _____ Relationship: _____

Mobile Phone #: _____ Email: _____

Address: _____ City: _____ State: ____ Zip: _____

HIPAA Consent for Use and Release of Information:

I give permission to HomeMD Housecall Services to release and/or transfer any information about me, my health, the health services provided to me, or payment for my health services that may be necessary. This includes, but is not limited to, inpatient hospital and rehab reports and discharge paperwork, skilled care and hospice paperwork/records, labs, diagnostic reports, and documents pertaining to all outpatient medical services:

- For my treatment - to any physician or other health care providers or facilities which need the information for my continued care.
- For payment purposes - to determine whether I am eligible for insurance coverage and if this treatment is authorized for payment by my insurance.

My signature on this authorization indicates that I am giving permission for the use and disclosure of my protected health information (PHI). I hereby release HomeMD Housecall Services, its associated providers, and its employees from all liability that may arise from the release of information as I have directed. My signature confirms that I am informed of my rights to privacy regarding my protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). If requested a detailed description of the Notice of Privacy Practices will be provided.

By law, you must specifically request the following information for it to be released and to whom:
Chemical dependency program: ☐ **Yes** ☐ **No** **Behavioral health notes:** ☐ **Yes** ☐ **No**

Name(s):_____

Assignment of Benefits:

I hereby authorize and instruct my insurance carrier to make payment directly to HomeMD Housecall Services. I agree to personally pay for any charges that are not covered by or collected from any insurance program, including any deductibles and coinsurance amounts.

Please be advised that HomeMD Housecall Services not only includes a visiting practitioner to care for your medical needs, diagnoses, and treatments, but we also provide a variety of medical professionals to support additional needs. services may vary each month depending on your needs. These services are billed by HomeMD Housecalls under the supervision of Dr. Steven Katzman.
HomeMD Housecall Services patient portal and other means of information transmission are HIPAA-compliant communications. This consent applies to health information HomeMD Housecall Services already has about me, information about future care I may receive from HomeMD Housecall Services, and will continue unless I cancel by giving written notice to HomeMD Housecall Services. **I HAVE READ OR HAVE HAD READ TO ME AND FULLY UNDERSTAND THIS CONSENT; I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAVE HAD THESE QUESTIONS ADDRESSED.**

Who can we discuss your medical care with?

Name_____ **Phone** _____

Name_____ **Phone** _____

Is there anyone you DO NOT want your medical care discussed with?

Name_____**Name**_____

Patient or Authorized Signature_____ **Date**_____

Patient Consent for Treatment

This consent provides HomeMD Housecall Services appointed physician, and/or mid-level provider (Nurse Practitioner or Physician Assistant), and other health care providers of the designees as deemed necessary to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that you intend that this consent will remain fully effective until it is revoked in writing.

- I am aware that the practice of medicine and surgery is not an exact science and no guarantees have been made to me with respect to the results of such diagnostics or treatment.
- I understand that samples of body fluids and/or tissues may be withdrawn from me during routine diagnostic procedures. I authorize HomeMD Housecall Services to dispose of the bodily fluids.
- A drug screen (blood or urine) sample may be obtained with verbal consent for purposes of compliance with medication regimens or when misuse is suspected, or signs or symptoms of toxicity exist.
- I have been informed that registered nurses will be utilized to provide care coordination and monthly telephone case management services to educate, inform and develop yearly care planning to maintain, improve and/or assist with transitional, behavioral health, and chronic care management.

You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your provider about the purpose, potential risks, and benefits of any test ordered for you. If you have concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature _____**Date** _____

Please select in-home services needed:

☐ **Behavioral Health Care (BHI): *BHI consent referenced above**
Need for continued therapy or for a current crisis?

_____

☐ **Wound Care:**
Specify the location and time the wound has been there.

_____

☐ **Dietician:**
Is this for a disease-specific diet or is tube-feeding assistance needed?

_____

☐ **Care Coordinator:**
Do you have current needs for resource management or disease-specific education?

_____

☐ **Primary Care:**
We can take care of your primary care needs or work with your current medical providers.

_____

☐ **Palliative Care:**
We are here to assist with chronic care matters that come with aging.

_____

☐ **Remote Monitoring Care:**
We can manage many conditions remotely like diabetes, congestive heart failure, COPD

_____

☐ **Podiatry Care:**
Every 9 weeks we can take care of your foot care

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INFORMED CONSENT FOR WOUND CARE TREATMENT

Patient Name:_____Date of Birth:_____

Patient hereby voluntarily consents to Wound Care Treatment by HomeMD Housecall Services and their respective staff. Patient understands that this consent form will be valid and remain in effect as long as the patient remains active and receives services and treatments. A new consent form will be obtained when a patient is discharged and returns for services and treatments. Patient has the right to give or refuse consent to any proposed service or treatment.

1. General Description of Wound Care Treatment: Patient acknowledges that their treatment for wound care has been explained to them and can include, but not be limited to: debridement's, dressing changes, biopsies, skin grafts, off-loading devices, physical examinations and treatment, diagnostic procedures, laboratory work (such as wound care cultures), request x-rays, recommend hyperbaric oxygen therapy, other imaging studies and administration of medications prescribed by a physician. Patient acknowledges that the physician has given them the opportunity to ask any questions related to the services or treatments being provided and that all questions have been answered.
2. Benefits of Wound Care Treatment: Patient acknowledges that they have been explained the benefits of wound care treatment, which include: enhanced wound healing and reduced risks of amputation and infection.
3. Risks and Side Effects of Wound Care Treatment: Patient acknowledges that they have been explained that wound care treatment may cause side effects and risks including, but not limited to: infection, pain and inflammation, bleeding, allergic reaction to topical and injected local anesthetics or skin prep solutions, removal of healthy tissue, delayed healing or failure to heal, possible scarring and possible damage to: blood vessels, surrounding tissues, organs and nerves.
4. Likelihood of achieving goals: Patient acknowledges that they have been explained by following the proposed treatment plan they are more than likely to have optimized treatment outcomes; however, any service or treatment carry the risk of unsuccessful results, complications and injuries, from both known and unforeseen causes.
5. General Description of Wound Debridement: Patient acknowledges that they have been explained that wound debridement means the removal of unhealthy tissue from a wound to promote healing. During the course of treatment, multiple wound debridement's may be necessary.
6. Risks/Side Effects of Wound Debridement: Patient acknowledges that they have been explained the risks and/or complications of wound debridement include, but are not limited to: potential scarring, possible damage to blood vessels or surrounding areas such as organs and nerves, allergic reactions to topical and injected local anesthetics or skin prep solutions, excessive bleeding, removal of healthy tissue, infection, ongoing pain and inflammation, and failure to heal. Patient specifically acknowledges that they have been explained that bleeding after debridement may cause rapid deterioration of an already compromised patient. Patient specifically acknowledges that they have been explained that drainage of an abscess or debridement of necrotic tissue may result in dissemination of bacteria and bacterial toxins into the bloodstream and thereby cause severe sepsis. Patient specifically acknowledges that they have been explained that debridement will make the wound larger due to removal of necrotic (dead) tissue from the margins of the wound.
7. Patient Identification and Wound Images: Patient understands and consents that those images (digital, film, etc.) may be taken by HomeMD Housecall Services of the patient and all patient's wounds with their surrounding anatomic features. The purpose of these images is to monitor the progress of wound treatment and ensure continuity of care. Patient further agrees that their referring physician or other treating physicians may receive communications, including these images, regarding patient's treatment plan and results. The images are considered protected health information and will be handled in accordance with federal laws regarding the privacy, security and confidentiality of such information. Patient understands that HomeMD Housecall Services will retain ownership rights to these images, but the patient will be allowed access to view then or obtain copies according to state and Federal law. Patient understands that these images will be stored in a secure manner that will protect privacy and that they will be kept for the time period required by law. Patient waives any and all rights to

quality assessment and improvement activities and development of proprietary clinical processes and healing algorithms. Patient's PHI may be disclosed by HomeMD Housecall Services to its affiliated companies, and third parties who have executed a Business Associate Agreement. Disclosure of patient's PHI shall be in compliance with the privacy regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Patient specifically authorizes use and disclosure of patient's PHI by HomeMD Housecall Services its affiliates, and business associates for purposes related to treatment, payment and health care operations. If patient wishes to request a restriction to how his/her PHI may be used or disclosed, patient may send a written request for restriction to HomeMD Housecall Services, 5758 Cooley Lake Road, Waterford, MI 48327.

3. Financial Responsibility: Patient understands that regardless of his or her assigned insurance benefits, patient is responsible for any amount not covered by insurance. Patient authorizes medical information about patient to be released to any payor and their respective agent to determine benefits or the benefits payable for related services.

The patient hereby acknowledges that he or she has read and agrees to the contents of sections 1 through 9 of this document. Patient agrees that his or her medical condition has been explained to him or her. Patient agrees that the risks, benefits and alternatives of all care, treatment and services that patient will undergo while a patient at HomeMD Housecall Services have been discussed with patient. Patient understands the nature of his or her medical condition, the risks, alternatives and benefits of treatment, and the consequences of failure to seek or delay treatment for any conditions. Patient has read this document, or had it read to him/her and understands the contents herein. The patient has had the opportunity to ask questions and has received answers to all of his or her questions.

By signing below, patient consents to the care, treatment and services described in this document and orally, consents to the creation of images to record his or her wounds and consents to the transfer of health information protected by HIPAA. Explanation to the patient (or his or her legal representative), the nature of the treatment, reasonable alternatives, benefits, risks, side effects, likelihood of achieving patient's goals, complications and consequences which are/or may be associated with the treatment or procedure(s) has been provided.

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Patient Signature or Authorized Representative Date

(Optional) Hardship Program Agreement:

Medicare law requires Health Care Providers to bill for co-payment of services billed to any of the Medicare programs. Health Care providers may elect to waive all of a portion of the Medicare Co-ins if the beneficiary cannot pay the Medicare Co-insurance. By signing this form, you are indicating that you are unable to pay the Co-Insurance required by Medicare due to hardship of fixed or low income. Income will need to be verified for this program.

Signature_____ **Date**_____

- Individual monthly income limit $1,060
- Married couple monthly income limit $1,430
- Individual resource limit $7,730
- Married couple resource limit $11,600

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Medical History:
Check if you have or had any symptoms in the following areas & briefly explain.

☐ Skin/Wound	☐ Chest/Heart	☐ Memory changes
☐ Head/Neck	☐ Back	☐ Weight changes
☐ Ears	☐ Intestinal	☐ Energy level changes
☐ Nose	☐ Bladder/Kidney	☐ Ability to sleep changes
☐ Throat	☐ Bowel	☐ Pain Location
☐ Lungs	☐ Circulation	☐ Pacemaker/Defibrillator
☐ Cancer	☐ Joints	☐ Falls/Dizziness
☐ Diabetes No Insulin	☐ Dementia/Alzheimer's	☐ HIV/Hepatitis
☐ Diabetes Yes Insulin	☐ Autoimmune Disorder	☐ Other

Do you currently smoke or use tobacco products? ☐ yes ☐ no

How much daily? _____

Do you have advanced care directives? ☐ yes ☐ no

Please list all medications, include dosage, over the counter meds, vitamins and if there is a need for refills at this time:

Annual Wellness Visit Questionnaire Question Response			
1. How often do you have trouble handling stressful things such as your health, finances, or work relationships?			
☐ Always	☐ Sometimes	☐ Never	
2. How often do you get the social and emotional support you need?			
☐ Always	☐ Sometimes	☐ Never	
3. In general, how satisfied are you with your life?			
☐ Very Satisfied/Very Happy	☐ Satisfied/Happy		
☐ Unsatisfied/Unhappy	☐ Unsatisfied/Very Unhappy		
4. Do you struggle to hear the TV or radio, or struggle to understand conversations?			
☐ Always	☐ Sometimes	☐ Never	
5. Do you need help with preparing meals, transportation, shopping, taking your medicine, or managing your finances?			
☐ Always	☐ Sometimes	☐ Never	
6. Do you need help eating, getting dressed, grooming, bathing, and/or using the toilet?			
☐ Always	☐ Sometimes	☐ Never	
7. Do you have a working smoke alarm in your home?			
☐ Yes	☐ No		
8. Does your home have loose rugs in the hallway?			
☐ Yes	☐ No		
9. Does your home have poor lighting?			
☐ Yes	☐ No		
10. Does your home have grab bars in the bathroom?			
☐ Yes	☐ No		
11. Does your home have handrails on the stairs?			
☐ Yes	☐ No		
12. Do you live alone?			
☐ Yes	☐ No		
13. Do you always fasten your seat belt when you are in the car?			
☐ Always	☐ Sometimes	☐ Rarely	☐ Never
14. In the past 7 days, on how many days did you drink alcohol?			
☐ None	☐ 1-2 days	☐ 3-4 days	☐ Daily

15. How many of those days did you have four or more drinks?

☐ Never ☐ 1-2 days ☐ 3-4 days. ☐ Daily

16. Do you ever drive after drinking or ride with a driver who has been drinking?

☐ Never ☐ Sometimes ☐ Always

17. How many days a week do you usually exercise?

☐ Never ☐ 1-2 times ☐ 3-4 times ☐ Daily

18. How intense is your typical exercise?

☐ None ☐ Light (slow walking) ☐ Moderate (brisk walking, using light weights, swimming) ☐ Heavy (running, using heavy weights)

19. On a typical day, how many servings of high fiber or whole grain foods do you eat? (1 serving = 1 slice of 100% whole wheat bread, 1 cup of whole grain or high fiber ready-to-eat cereal, ½ cup of cooked cereal such as oatmeal, ½ cup of cooked brown rice or whole wheat pasta)

☐ None ☐ 1-2 servings ☐ 3-4 servings

20. On a typical day, how many servings of fruits and/or vegetables do you eat? (1 serving=1 cup of fresh vegetables, 1/2 cup of cooked vegetables, or 1 medium piece of fruit.)

☐ None ☐ 1-2 servings ☐ 3-4 servings

21. On a typical day, how many servings of fried or high-fat foods do you eat? (ex: fried chicken, fried fish, bacon, French Fries, potato chips, corn chips, doughnuts, creamy salad dressings, and foods made with whole milk, cream, cheese, or mayonnaise)

☐ None ☐ 1-2 servings ☐ 3-4 servings

22. In the past 7 days, on a scale of 1 – 10, how much pain have you felt?

☐ None ☐ 1-3 minimal pain ☐ 4-6 moderate pain ☐ 7-8 severe pain ☐ 9-10 uncontrollable pain Location:_____

23. How many hours of sleep do you usually get each night?

☐ 0-1 hours ☐ 2-4 hours ☐ 5-6 hours ☐ 8 hours+ ☐ Nap daily ☐ have difficult time falling asleep

24. Who are your current medical suppliers? (Example: durable medical equipment, oxygen supplier, etc.) Name and Phone Number:

25. Who are the doctors you see? (Example: heart specialists, lung specialists, etc) Name and Phone Number: