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:**_________________

Legal Representative:

I am the legal guardian for this persons healthcare matters and will provide a copy for the medical record. Upon signing this form or any other required documentation as a Legal Representative for the patient, I hereby release 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.

Name: ____ **Relationship:**____________________________
Mobile Phone #: ______________________________ **Email:** ____________________________________
Address: ______________________________ **City:** ______________________ **State:** ___ **Zip:** ________

Billing Contact:

☐ Self or Other Name: _______________________________ **Relationship:** ______________________
Mobile Phone #: _____________________________ **Email:** ____________________________________
Address: _______________________________ **City:** ____________________ **State:** ____ **Zip:** _______

Who can we discuss your medical care with?
Name_______________________________________**Phone** _______________________________________
Name_______________________________________**Phone** _______________________________________
Is there anyone you DO NOT want your medical are discussed with?
Name____**Name**_______________________________________

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.

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, this includes:

- 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

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 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.

Patient or Authorized Signature________________________________ Date_______________

Would you be agreeable to a virtual visit if necessary? YES ☐ NO ☐

Do you have a cell phone/tablet/computer? YES ☐ NO ☐

Would you need assistance from one of our Clinical Liaisons to conduct this visit? YES ☐ NO ☐

Please select in-home services needed:

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

☐ **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 (Facility Patients ONLY):**
Every 9 weeks we can take care of your foot care

List or attach copy of all medications, include dosage, OTC, and vitamins. Do you need refills at this time:

____

____

____

____

____

____

(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