



HOW DO I ENROLL A PATIENT WITH HOUSECALL MD?

The process has been designed to be user friendly and involves a few simple steps.

It is the patient's/family's/DPOA's/guardian's decision, if they want to receive services from House Call MD. The decision CANNOT be made for the patient by the caregiver or homeowner.

The enrollment package needs to be filled out in full by the responsible party (i.e. the patient or the guardian). Please complete all fields, including the secondary insurance information. If there is no secondary, we need the name of the responsible party with their address and phone number. This information goes in the "Additional Contact/Responsible Party/Emergency Contact Information" section on page 2 of your enrollment package.

A copy of the current medication list, as well as copies of any applicable insurance cards, Medicare cards, and/or medical coupons MUST be faxed with the COMPLETED election form to fax #: (888) 274-6607.

Patients are scheduled based on medical urgency. It may be possible to see them sooner if the provider's schedule permits. If the patient is otherwise stable, they may be scheduled out a bit further. If the reason for seeing the patient urgently is to refill medications, once they are on service, House Call MD providers can refill medications prior to actually seeing the patient. Please give us as much time as possible to complete our process before scheduling.

Questions about how to enroll a patient? Please call HouseCall MD at (206) 795-8420.



HouseCall MD
5414 Barnes Ave NW
Suite #1
Seattle, WA 98107

Residence Information

Adult Family Home Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: (____) _____ Fax: (____) _____

Patient Information

Name: _____
Social Security Number: _____ Gender: (circle one) M F
Date of Birth: _____
Medicare Number (include suffix): _____
DSHS Patient Identification Code (PIC): _____
Secondary Insurance or Private Pay: _____
If private pay, please fill out the Additional Contact Information, below. This will be the responsible party for billing purposes.
Preferred Pharmacy: _____
Is the patient Full Code (Resuscitate) or No Code (Do Not Resuscitate)? (Circle One)
Please include copies of the patient's Medicare card and any other insurance cards or medical coupons. We cannot process your election form without correct insurance information.

Additional Contact / Responsible Party / Emergency Contact Information

Name: _____ Relationship: _____
Address: _____
City: _____ State: _____ Zip: _____
Home phone: (____) _____ Work/cell phone: (____) _____
Does this person have medical **Power of Attorney**? (Circle One): Yes No
Is this person the **financially responsibly party**? (Circle One): Yes No

Financial Responsibility Agreement to Pay

I accept full financial responsibility for services rendered by HouseCall MD providers. Should my insurance company deny a visit or pay for a portion of a visit, I understand that I will be required to pay for these services in full.
Patient or Patient's Representative

Signature: _____ Date: _____



Medical History

Check all that apply, and fill out the lower portion if necessary.

Condition	Now	Past	Condition	Now	Past
Allergies			Hemorrhoids		
Alzheimer's Disease			High Blood Pressure		
Anemia			Kidney Problems		
Anxiety			Leg Swelling		
Arthritis			Liver Problems		
Asthma			Migraines		
Bladder Problems			Pain (_____)		
Incontinence			Prostate Problems		
Urinary Tract Infection			Skin Disease		
Blood Clots			Stomach Problems		
Blood Vessel Problems			Nausea		
Bowel Problems			Stomach Ulcer		
Constipation			Vomiting		
Cramps			Stroke		
Diarrhea			Thyroid Disease		
Irritable Bowel Synd.			Trouble Sleeping		
Rectal Bleeding			Tuberculosis		
Breast Problems			Ulcer (_____)		
Bronchitis			Reproductive Problems		
Cancer (_____)			Abnormal Pap Smear		
Dementia			Hysterectomy		
Depression			Sterility, Genetic		
Diabetes (Type 1 or 2)			Sterility, Optional		
Emphysema			Vaginal Bleeding		
Epilepsy/Seizures			Vision Problems		
Fatigue or Tiredness			Cataracts		
Fractures: _____			Glaucoma		
Gall Bladder Problems			Weight Gain		
Hearing Problems			Weight Loss		
Heart Problems			Other:		

Preferred Pharmacy name: _____ Phone #: _____

Patient has a family history of: _____

Allergies: _____



Patient Name: _____ Date of Birth: _____

Personal Habits

Alcohol Use: ____times a week Meals: ____meals a day
Coffee/Tea: ____times a day Sleep: ____hours a night
Exercise: ____times a week Tobacco: ____packs a day

Family History

Mother: Living____ Deceased (cause of death: _____)
Father: Living____ Deceased (cause of death: _____)
Sibling(s): Living____ Deceased (cause of death: _____)
Children: Living____ Deceased (cause of death: _____)

Social History

Former/Current Occupation: _____

Marital Status (circle one): Married Divorced Single Widowed

Please include a copy of the most current medication sheet available. Ensure that this medication list has drug names, dosage amounts, and dosage instructions. If you do not have a MARS (Medicine Administration Record Sheet), please create a handwritten list. Failure to provide this information may delay the processing of your enrollment package.

Former Primary Care Physician: _____

Address: _____

Phone: (____) _____ Fax (____) _____

Surgical/Hospitalization History

Include the approximate date on which the hospitalization took place, reason for the hospitalization, and specific hospital name

Please provide any other information you feel is important for us to know.



Patient Name: _____ Date of Birth: _____

Authorization to Treat Patient Statement

Be it known that I have chosen HouseCall MD physicians and nurse practitioners to provide my primary medical care. I live at the address given on page 2, and this is my private residence. I intend to, or have, lived at this location for longer than six months, and I have no other place that is my home. Further, I hereby authorize other medical and mental health professionals and institutions to release to HouseCall MD copies of all records deemed necessary to provide me with medical care. I give specific consent to release information relating to drug and alcohol abuse, mental health and psychiatric disorders, STDs, and HIV or AIDS Virus. Further, I authorize HouseCall MD to release copies of my medical records to other medical and mental health professionals when appropriate and related to the matter at hand. This release includes the use of an electronic medical record to other sources of medical care, such as pharmacies, etc. Patient information is regulated and protected by HIPAA standards. The signature below authorizes HouseCall MD providers to treat me.

I certify that I am competent to make this choice and these authorizations. I also certify that all the information I provided on page 2 of this document is true and correct as of the date below.

If I am not the patient, then my signature below certifies that I am the legally appointed guardian of the individual named on page 2, and I make this choice and these authorizations on his or her behalf.

Signature: _____ Date: _____

Print Name: _____ Relationship: _____



5414 Barnes Ave NW
Suite #1
Seattle, WA 98107

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Information:

Name: _____ Date of Birth _____ SSN: _____

FORMER PHYSICIAN'S INFO:

Name: _____

Address: _____

City/State/ZIP: _____

INFORMATION TO BE SENT TO:

HouseCall MD
5414 Barnes Ave NW Suite #1
Seattle, WA 98107

INFORMATION TO BE RELEASED (please check one):

- The most recent 2 years of pertinent information (chart notes, labs, X-rays)
- All medical records
- Other (please specify) _____

Purpose for which disclosure is being made: Physician or Nurse Practitioner

PATIENT AUTHORIZATION:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

MY RIGHTS:

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process of revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws.

SIGNATURE: _____ Date: _____

(Patient, guardian*, or authorized representative*)

[*Please provide documents to prove authority to sign on behalf of the patient.]



Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read carefully.

HouseCall MD is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your healthcare information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

Payment

We may disclose your health information to your insurance provider for the purpose of payment or healthcare operations.

Worker's Compensation

We may disclose your health information as necessary to comply with State Worker's Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.



Research

We may disclose your health information to researchers conducting research that has been approved by an institutional Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Appointment Reminders

As a courtesy to our patients, it is our policy to call your home the day of your appointment with an approximate appointment time. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment. Unless otherwise noted, we will call the phone number you provided at the time you scheduled your appointment.

Change of Ownership

In the event that HouseCall MD is sold or merged with another organization, your health information/record will become property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that HouseCall MD is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that House Call MD amend your protected health information. Please be advised, however, that House Call MD is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have the right to receive an accounting of disclosures of your protected health information made by HouseCall MD.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to This Notice of Privacy Practice HouseCall MD reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, HouseCall MD is required by law to comply with the Notice.



HouseCall MD is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact Shelley Soares by calling this office at (206) 795-8420. If Shelley Soares is not available, you may make an appointment for a personal conference in person or by telephone within two working days.

Complaints

Complaints about your Privacy rights, or how HouseCall MD has handled your health information, should be directed to Shelley Soares by calling (206)795-8420.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue SW
Room 509F HHH Building
Washington DC, 20201

This notice is effective as of 08/15/2014.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide HouseCall MD with my authorization and consent to use and disclose my protected healthcare information for the purposes of treatment, payment and healthcare operations as described in the Privacy Notice.

Patient's Name (print)_____

Patient's Signature_____Date_____

Authorized Facility Signature_____Date_____