Housecall Providers Primary Care
Patient Registration Form

Housecall Providers
Part of the CareOregon Family

*****PLEASE CONTACT INTAKE DEPARTMENT BEFORE COMPLETING THIS FORM*****

To be seen by a Housecall Providers Primary Care Provider:

1) Call the Intake office at **(971) 202-5500** so we can confirm we can help you
   Please have ready: Current insurance card
   Patient address
2) Complete all information on this form. Missing information may delay the admission process
3) Return form:
   Mail: Intake Office
   Housecall Providers
   5100 S Macadam Ave, Suite 200
   Portland, OR, 97239

   Fax: (971) 202-5555
   Email: intake@housecallproviders.org *Please note that email transmissions may not be secure. Contact us if you would like to encrypt your email* ***before*** *sending.*
4) We will contact you when we have your application. Please keep seeing your current provider until we have completed an intake visit with you. The time this will take varies.

Patient Information

Patient Name: Last_____ First_____ M. I. _____

Patient DOB: _____/_____/_____

Email:_____ SSN: _____-_____-_____

Current Gender: _____ Pronouns:_____

Sex at Birth: ☐ Male ☐ Female ☐ Intersex

How did you hear of us? _____

Race: _____ Ethnicity: _____

Primary Language: _____ Interpreter Needed: ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Veteran of U.S. Armed Forces: ☐ Yes ☐ No

Receiving Veterans Affairs Services (Medical, Pharmacy)? ☐ Yes ☐ No

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Patient Name: _____ Patient DOB: _____

Address where patient will be seen: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Describe potential safety concerns, if any, for persons visiting the home (e.g. aggressive behaviors, aggressive pets, suspicious activity in neighborhood): _____
_____

Residence Type:

☐ Private Home ☐ Group Home ☐ Assisted Living Facility
☐ Foster Home ☐ Residential Care Facility ☐ Other

Facility Information (Skip if patient resides in private home)

Name of Facility: _____

Name of Caregiver/Owner: _____

Facility Phone_____ Facility Fax _____

Name of Pharmacy _____ Pharmacy Phone _____

Insurance Information

Are you covered by insurance? ☐ Yes ☐ No
Do you have a spouse that is currently employed? ☐ Yes ☐ No
If yes, do you have group health plan (GHP) coverage based on your own, or a spouse's current employment? ☐Yes ☐No
Are you receiving Black Lung Benefits: ☐Yes ☐ No
Is this illness/injury due to a work-related accident/condition? ☐Yes ☐ No

Medicare Number: _____ **Medicaid Number**: _____

The Medicare number and Medicare Advantage ID number are not the same. If you have a Medicare advantage plan, we need both ID numbers.

Primary Insurance:	Secondary Insurance:
Subscriber Name:	Subscriber Name:
Policy Number:	Policy Number:
Group Number:	Group Number:

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Patient Name: _____ Patient DOB: _____

Patient Health Information

Are you currently receiving Home Health services? ☐Yes ☐No
Have you received Home Health services in the past 12 months? ☐Yes ☐No
If yes, name of Home Health agency: _____

Are you currently receiving Hospice Services? ☐Yes ☐No
If yes, name of Hospice agency: _____

Have you been admitted to hospital overnight in past 12 months? ☐ Yes ☐ No
If yes, Hospital: _____ Date(s): _____

Have you been admitted to the Emergency Room in past 12 months? ☐ Yes ☐ No
If yes, Hospital: _____ Date(s): _____

Have you been in a skilled nursing facility in past 12 months? ☐ Yes ☐ No
If yes, Facility: _____ Date(s): _____

Are you on a ventilator? ☐Yes ☐No

Current Medications* (please list name, dose and frequency or attach medication list)

_____
_____
_____
_____
_____
_____
_____

* For patients living in a care home or facility - medication list will be requested from caregivers prior to admission visit to ensure the most up-to-date list

Other Providers

Name of Current Primary Care Provider (PCP): _____
Phone: _____ Fax: _____

Name of Specialist Provider: _____
Phone: _____ Fax: _____

Name of Specialist Provider: _____
Phone: _____ Fax: _____

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Patient Name: _____ Patient DOB: _____

Contacts

Emergency Contact: _____
Relationship to Patient: _____
Address: _____
Phone: _____ Fax: _____
Email Address: _____

Guardian or Healthcare Proxy (if applicable): _____
Relationship to Patient: _____
Address: _____
Phone: _____ Fax: _____
Email Address: _____

******Please attach copies of guardianship or Healthcare Proxy (Advance Directive) documents******

Name for Billing Statements: _____
Relationship to Patient: _____
Address: _____
Phone: _____ Fax: _____
Email Address: _____

Case Manager (if applicable): _____
Organization: _____
Address: _____
Phone: _____ Fax: _____
Email Address: _____

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Patient Name: _____ Patient DOB: _____

Current Medical Information (Please fill out as much as possible)

Last Occupation: _____

Number of children: _____ Height: _____ft _____in Weight: _____lbs

Major Illnesses/Health Problems: _____

_____

Drug Allergies (name and type of reaction): _____

_____

Operations: _____

Family Health History (provide family member and disease): _____

_____

Smoking History: ☐ Never ☐ Current ☐ Former Packs per day:_____ Total years: _____

Would you like to quit? ☐Yes ☐ No Alcohol History: ☐ Never ☐ Current ☐ Former

Alcohol type: _____ Drinks per week: _____

Drug Use (describe past and present): _____

Check if you have any of the following:

General
- □ Appetite loss
- □ Fatigue
- □ Weight loss
- □ Weight gain

Skin
- □ Bruises
- □ Dryness/Itching
- □ Rashes
- □ Wounds

Head
- □ Headache
- □ Head injury

Eyes
- □ Double vision
- □ Eye pain
- □ Eye redness
- □ Glasses or contacts
- □ Glaucoma
- □ Vision Loss/Changes

Ears
- □ Ear pain
- □ Hearing loss
- □ Ringing in ears

Nose
- □ Nosebleeds
- □ Runny nose
- □ Sinus pain

Throat
- □ Decreased sense of taste
- □ Difficulty chewing
- □ Sore throat

Neck
- □ Neck mass
- □ Neck Pain
- □ Neck Stiffness
- □ Swollen glands

Lungs/Breathing
- □ Spitting up blood
- □ Cough
- □ Decreased exercise tolerance
- □ Difficulty breathing
- □ Wheezing

Heart/Circulation
- □ Chest pain or discomfort
- □ Difficult to breathe lying flat
- □ Foot/Ankle/Leg swelling
- □ Noticeable heartbeat

GI/Digestion
- □ Constipation
- □ Diarrhea
- □ Difficulty swallowing
- □ Heartburn
- □ Nausea/Vomiting
- □ Rectal bleeding

Blood Conditions
- □ Bleeding from gums
- □ Easy bruising

Urinary
- □ Burning or pain
- □ Frequent need to urinate
- □ Incontinence
- □ Urgent need to urinate

Bones/Joints/Muscles
- □ Back pain
- □ Joint redness
- □ Joint stiffness
- □ Joint swelling
- □ Muscle or joint pain
- □ Weakness

Nervous System
- □ Dizziness
- □ Fainting
- □ Numbness
- □ Seizures
- □ Tingling
- □ Tremor/shaking

Mental Health
- □ Anxiety/nervousness
- □ Depression
- □ Trouble sleeping
- □ Memory loss

Hormone Conditions
- □ Excessive sweating
- □ Excessive thirst
- □ Excessive urination
- □ Thyroid problem

Patient Name: _____ Patient DOB: _____

Admissions Consent Form - *Please Initial Below if Accepted*

Consent to Treat:
I authorize Housecall Providers to deliver home-based medical care to the person identified above. I understand that all health care interventions I receive from Housecall Providers are in the opinion of the treating provider deemed medically necessary or advisable. I understand that all health care interventions recommended are voluntary and that I have the right to refuse treatment or terminate services at any time by notifying Housecall Providers of my intention to do so. I understand that Housecall Providers may at any time terminate services provided by notifying me of the termination. _____**Initial here**

Notice of Privacy Practices:
I certify that I have received a copy of the Housecall Providers Notice of Privacy Practices. I understand that this document is also available to me online at www.housecallproviders.org. _____**Initial here**

Financial Agreement and Assignment of Benefits:
At the time of your admission, we will verify your insurance coverage and we will bill your insurance on your behalf. If at any time your insurance coverage should change, please contact us immediately to ensure that you will not be billed unnecessarily for our services. Deductibles, co-pays and co-insurances will be billed to you monthly at the address you provide. We are required to keep your signature on file authorizing us to bill your insurance carrier for proper consideration of our claim.

I have read and understand the Financial Agreement described above. I assign all health benefits to which I am entitled directly to Housecall Providers for services rendered on my behalf. I understand that I am financially responsible for all charges, regardless of my insurance coverage. _____**Initial here**

Patient Consent To The Use of Telemedicine and Telephone visits:
I hereby give my informed consent for the use of telemedicine in my medical care. I hereby authorize Housecall Providers to use telemedicine in the course of my diagnosis and treatment. I understand my insurance may be billed for this service and that I am responsible for any balance due. _____ **Initial here**

Agreement to Receive Chronic Care Management Services:
Chronic Care Management services include:

- 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.
- The ability to get routine appointments with my designated PCP or another member of my Care Team.
- Care Management of my chronic conditions, including timely scheduling of all recommended preventative 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 fits with my choices and values.
- Management of my care as I move between and among health care providers and settings, including:
    - 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
    - Coordination with home and community-based providers of clinical services

Patient Name: _____ Patient DOB: _____

I understand that as part of these services I will receive a copy of my Comprehensive Plan of Care.

I understand that these services are subject to the Medicare deductible and the standard twenty percent (20%) copay requirement. **_____Initial here**

I understand that I can revoke this agreement at any time (effective at the end of a calendar month) and choose, instead, to receive these services from another health care professional after the calendar month in which I revoke this agreement. Medicare will pay only one physician or other qualified health care professional to furnish me chronic care management services within a given calendar month.

I hereby indicate by signature on this agreement that Housecall Providers is designated as my Primary Care Provider (PCP) for purposes of providing Medicare Chronic Care Management Services to me and that I will be responsible for payment for those services as outlined by Medicare (CMS).

My signature also authorizes my PCP to electronically communicate my medical information with other treating providers as part of the care coordination involved in chronic care management.

This designation is effective as of the date below and remains in effect until revoked by me.
_____Initial here

I certify that I have read and understand the contents of this Admission Consent form and voluntarily agree to the conditions outlined within this document. If the patient is unable to sign this form, I certify that I have assumed responsibility for the patient and consent to Housecall Providers providing services to the patient on the patient's behalf.

_____

Patient or Authorized Representative Signature **Date**

_____

Printed Name // Relationship to Patient

Effective:
8/28/2010
Revised:
12/24/2018

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PATIENT COPY

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 REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how Housecall Providers Services, LLC and Housecall Providers P.C. may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. PHI is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required by law to maintain the privacy of your protected health information and to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

USES AND DISCLOSURES OF PHI

We may use and disclose health information for the following purposes:

Treatment: We will use and disclose your PHI in order to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third-party. Different personnel in our organization may share information about you and disclose information to people who do not work for Housecall Providers Services, LLC. and Housecall Providers P.C. in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. Another example is that your PHI may be provided to a physician, to whom you have been referred, to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for the healthcare services you receive from Housecall Providers. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will pay for the treatment.

Healthcare Operations: We may use and disclose health information about you in order to run Housecall Providers Services, LLC. and Housecall Providers P.C. and make sure that you and our other patients receive quality care.
These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For

example, we may disclose you PHI to medical students that see patients at our practice. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

- ***Fundraising*:** We may use limited information about you, including your name, address, telephone number, email, dates of service, treating physician, and contact information for others involved in your care, to provide organizational news, updates and fundraising communications. If you do not wish to receive fundraising communications, or would like to change what communications you receive, please notify us at ~~info@housecallproviders.org~~ or by advising us of your preference **in writing** at the address listed at the bottom of this Notice.

We may use or disclose your PHI in the following situations without your authorization. These situations include:

To avert serious threat to health and safety, as required by Law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners, funeral directors and organ donation, research, criminal activity, military activity and national security, worker's compensations, inmates, required uses and disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance of section 164.500.

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific written *Authorization*. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, **in writing**, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

PATIENT RIGHTS

You have the following rights regarding health information we maintain about you:

You have the right to inspect and copy your protected health information. You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to our Compliance Officer in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. A modified request may include requesting a summary of your medical record.

Effective:
8/28/2010
Revised:
12/24/2018

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PATIENT COPY

If you request to view a copy of your health information, we will not charge you for inspecting your health information. If you wish to inspect your health information, please submit your request **in writing** to our Compliance Officer. You have the right to request a copy of your health information in electronic form if we store your health information electronically.

We may deny your request to inspect and/or copy your record or parts of your record in certain limited circumstances. If you are denied copies of or access to health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend. If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by Housecall Providers Services, LLC. and Housecall Providers P.C. To request an amendment, contact our Compliance Officer.

We may deny your request for an amendment if your request is not **in writing** or does not include a reason to support the request. In addition, we may deny or partially deny your request if you ask us to amend information that:

- We did not create
- Is not part of the health information that we keep
- Is already accurate and complete
- The law restricts your access to inspect and copy

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures". This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, health care operations, when specifically authorized by you and a limited number of special circumstances involving national security, correctional institutions and law enforcement.

To obtain this list, you must submit your request **in writing** to our Compliance Officer. It must state a time period that may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member, or friend. For example, you could ask that we not use or disclose information about a surgery you had.

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- We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or we are required by law to use or disclose the information.

- We are required to agree to your request if you pay for treatment, services, supplies and prescriptions "out of pocket" and you request the information not be communicated to your health plan for payment or health care operations purposes. There may be instances where we are required to release this information if required by law.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy.

CHANGES TO THIS NOTICE

We will abide by the terms of the notice of privacy practices currently in effect. We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. You are entitled to a copy of the notice currently in effect. We will inform you of any significant changes to this Notice.

BREACH OF HEALTH INFORMATION

We will inform you if there is a breach of your unsecured health information.

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services at:

Office for Civil Rights Region X - Seattle
U.S. Department of Health & Human Services - Regional Manager
2201 Sixth Avenue - M/S: RX-11
Seattle, WA 98121-1831
Phone 800-368-1019, Fax 206-615-2297, TDD 800-537-7697

To file a complaint with Housecall Providers Services, LLC and Housecall Providers P.C contact our Compliance Office at **971-202-5500 or compliance@housecallproviders.org**.

You will not be penalized for filing a complaint.