1552 N Crestmont Drive. Ste B
Meridian, ID 83642
Office 208-957-5532
Fax 208-985-2261
info@doctorshousecallsofidaho.com

Doctor's House Calls of Idaho

Welcome to Doctor's House Calls

It is a privilege you have chosen Doctor's House Calls to be your Primary Care Provider. We understand how disorienting and cumbersome the process of going to the doctor can be for seniors and people with difficulty getting out of their home. That's why our providers come to you, where ever you call home. Our providers are highly trained professionals committed to treating you or your loved one with compassion, respect, and dignity.

Attached are the new patient consent forms. We will need this to be filled and returned to our office before we can schedule your first appointment-**The history & physical forms need to be complete thoroughly**. If they are not complete, we will have to delay scheduling until this information can be provided.

If you or your loved one has a Power of Attorney on file or in place, we will also require this paperwork to be returned along with a copy of patient's driver's license/ID, Insurance Cards (Front and Back).

We encourage that the Power of Attorney or family/caregiver whom is knowledge with the patient's health history to be present on initial visit with your provider.

Should you need to cancel or reschedule your visit, please provide one business day notice.

Thank you for taking the time to fully complete these forms. If you have any questions about Doctors House Call services provided or scheduling your first visit, please visit our website www.doctorshousecallsofidaho.com or contact us at **208-957-5532.**

Sincerely,

Your Doctors House Call Team

Doctor's House Calls New Patient Info

Full Name:_____
(Legal Last Name) (Legal First Name) (Middle Initial) (Preferred First Name)

Date of Birth: ____/____/_____ Age:_____ Sex/Gender: _____ SSN: (optional)_____

Address: _____ / _____/_____/ _____
(Street/PO Box) (City) (State) (Zip Code)

Phone #: ( ) _____ ( )_____ ( ) _____ **Email:** _____
(Home) (Work) (Cell/Other)

Occupation/Employer:_____ ❑ Full-Time ❑ Part-Time ❑ Student ❑ Retired ❑ Unemployed

Are you: ❑ Single ❑ Married ❑ Partnered ❑ Divorced ❑ Widowed Partner's Name: _____

Additional Information (Please fill out all fields below)

Can we leave a message regarding your medical care and test results? ❑ Yes ❑ No

Race (please select): ❑ White ❑ American Indian or Alaska Native ❑ Asian ❑ Hispanic ❑
Native Hawaiian or Pacific Islander ❑ Black or African American ❑ Other ❑ Decline

Preferred Language (please select one): ❑ English ❑ Bosnian ❑ Indian (including Hindi & Tamil) ❑ Russian ❑ Sign Language ❑Spanish ❑ Other Preferred Pharmacy Location: _____

Please provide your emergency contact information below

Name: _____ Relationship: _____ Phone:_____

Address: _____
(Street/PO Box) (City) (State) (Zip Code)

Primary Insurance

Insurance Carrier: _____Plan Name:

ID/Subscriber #: _____Group #: _____

Primary on Policy? ❑ Yes ❑ No, answer following for Primary Insured:

DOB: _____

Insured's ID #: _____Patient's Relationship to Insured: _____

Secondary Insurance

Insurance Carrier: _____Plan Name: _____

ID/Subscriber #: _____Group #: _____

Primary on Policy? ❑ Yes ❑ No, answer following for Primary Insured:

Legal Name: _____ DOB: ___/____/ ____

Insured's ID #: _____Patient's Relationship to Insured: _____

By signing below, I verify that the above information is correct and true to the best of my knowledge. I authorize Doctors House Calls to treat me. I authorize all insurance payments to be made directly to Doctors House Calls. I consent to the release of all information the insurance company may request for filing their claims. I understand Doctors House Calls will bill my insurance as a courtesy to me, but many insurance companies do not cover all charges, and that I will be responsible for and will pay for any charges not covered by my health care plan and will be billed directly. I have received and reviewed the handout called *Privacy Practices Notice.* I understand that I can ask for further information if needed. **Patient or Responsible Party Signature: _____Date:_____**

Office Policies

Please take the time to read, initial, and sign our Office Policies to acknowledge your understanding of them. We have found this policy to be most effective for both patients and providers. Outstanding balances can cause embarrassment and communication breakdowns, and potentially decrease adherence to the prescribed treatment program. If you have any questions regarding these agreements, please discuss them with Doctors House Calls staff.

Your insurance policy is a contract between you and your insurance company. Doctors House Calls is not a party to that contract. As a service to you and upon your request we can bill your insurance provider. It is your responsibility to provide our office with your insurance details and present your insurance card to our staff, so we can bill your insurance carrier completely and accurately. When possible, our staff will call to verify your insurance coverage prior to your appointment. Please be aware that an estimate of benefits is not a guarantee of payment. If an insurance company provides you or our staff with inaccurate information they may not honor the benefits that were quoted.

Please initial here_____

It is your responsibility to be aware of your coverage and co-pay, as well as any deductible and maximums, per your insurance contract. All co-payments, co-insurance payments, deductibles, supplements/products, supplies, therapeutic equipment, and costs of services not covered by your insurance company are due and payable at the time of each visit.

Please initial here_____

Once we receive payment from your insurance company, we will apply this to your bill. If we find you have a credit, this will remain on your account for use toward future services and/or purchases. If instead you would like to be issued a refund, please let us know and we will be happy to issue you a check.

Please initial here_____

Patients must be responsible for following the referral, prescription, or treatment plan prescribed by their physician, practitioner, and/or insurance provider. Insurance companies may not pay for services when the treatment plan is not followed, thus patients are responsible for scheduling and attending appointments accordingly.

Please initial here_____

Patients are responsible for notifying Doctors House Calls if their insurance coverage or details change.

Please initial here_____

As a patient of Doctors House Calls, I acknowledge and agree to the above statements and understand that a part or all of my care may not be a covered benefit of my health plan. I acknowledge and agree to be financially responsible for my treatment.

Release of Patient Records

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ SSN #: _____

I request and authorize:

Name/Provider: _____

to release healthcare information of the patient named above to:

Name: DOCTORS HOUSE CALLS
Address: 1552 N CRESTMONT DRIVE, STE B
City: MERIDIAN State: ID Zip Code: 83642
Phone: 208.957.5532 Fax: 208.985.2261

This request and authorization applies to:

❑ Healthcare information relating to the following treatment, condition, or dates:

❑ All healthcare information

_____ _____
Patient Name (Please Print) Relationship to Patient (if not self)

_____ _____
Patient Signature (or Responsible Party) Date

✓ THIS AUTHORIZATION IS IN EFFECT FOR THE DURATION OF YOUR TREATMENT.

General Consent to Treatment

I hereby voluntarily consent to the performance of such diagnostic procedures and/or medical treatment as my physician, non-physician practitioner (PA-C/CNP), their assistants or designees at Doctors House Calls may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, specialty referrals, and routine medical care. I authorize my physician(s) or provider(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my care is directed by my physician/ provider and that other personnel render care and services to me according to the physician's instructions.

- I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees or promises have been made to me with regard to results of such diagnostic procedures or medical treatment.

I acknowledge that I have read or have had read to me this consent, and fully understand its details. I have had the opportunity to ask questions and have had these questions addressed.

Patient Signature: _____ Date:_____

Patient Name:_____ Date of Birth: _____

Residence and Living

Primary Caregiver or Facility
(Person responsible for providing day-to-day care for the patient. Appropriate documentation must be provided.)

❑ N/A - I do not have a primary caregiver ❑ Same as emergency contact

Name: _____ Relationship:_____ Phone: _____

Legal Guardian or Healthcare Proxy
(Court appointed person to make healthcare decisions in place of patient. Appropriate documentation must be provided.)

❑ N/A - I do not have a Legal Guardian or Healthcare Proxy ❑ Same as emergency contact

Name: _____ Relationship:_____ Phone: _____

Emergency Contact

Please provide your emergency contact information below.

Name (Print):_____ Relationship to Patient: _____

Telephone:_____ Address: _____

Consent to Contact

Consent for communication with delegated individual

By initialing, I authorize Doctors House Calls to communicate with the following individual about my health care which may include information about my medical diagnosis, eligibility status and appointments.

First Name	Last Name	Relationship	Initials

Terms of Consent

By signing below, I agree to the terms and information above. I am giving this consent of my own free will. I fully release Doctors House Calls as well as their Officers, Directors, Board Members, employees, and agents (i.e.: volunteers, students) harmless from any and all damages, losses, liabilities (joint or several) payments, obligations, penalties, claims, litigation, demands, defenses, judgements, suits, proceedings, costs, disbursements or expenses(including without limitation, fees, disbursements and expenses of attorney, and other professional advisors and of expert witnesses and costs of investigation and preparation) of any kind or nature whatsoever resulting from, relating to or arising out of my receipt of services.

I have had the opportunity to ask any questions and have had them answered in a language that I understand. I further agree to abide by the terms of this consent. I understand that this document remains in effect until I revoke my consent in writing. I also understand that I am free to revoke my consent at any time.

Client Name Printed Initials

Signature of Client or Parent/Guardian or Power of Attorney Date

Witness Signature Date

Advance Directives/DNR/DNI

Living Wills and Idaho's Natural Death Act

We plan for many important events in life. We plan for retirement, a wedding, vacations, and for a child's education. Sadly, the health choices that are made at the end of life are seldom planned and many times they are made for us. Decisions are put off and desires are not expressed because it is difficult to contemplate or discuss death.

There are many things to plan for at the end of life. Transfer of property and the wellbeing of a spouse or child are all issues to be considered and planned for. However, the topic discussed here involves end of life health care issues, the importance of living wills, and advance directives. The principle way to ensure that your desires are fulfilled if you are no longer able to communicate your wishes is through a Living Will.

(Idaho law provides for individuals to ensure that their wishes about their healthcare are carried out in the event they become incapacitated and are not able to speak for themselves. Generally, there are two kinds of Advance Directives. The first is called a Living Will, and the second is called a Durable Power of Attorney for Health Care. During the 2005 Idaho Legislative session, a modification was made to the Natural Death and Medical Consent Act. Consequently, in Idaho, it is now possible to complete one (1) form for both a Living Will and a Durable Power of Attorney for Healthcare.

A Living Will sets forth your instructions for dealing with life-sustaining medical procedures in the event you are unable to decide for yourself. A Living Will directs your family and medical staff on whether to continue, withhold, or withdraw life-sustaining medical procedures, such as tube feeding for hydration (water) and nutrition (food), if you are incapable of expressing this yourself due to an incurable and terminal condition or persistent vegetative state.

A Durable Power of Attorney for Health Care allows you to appoint a person to make all decisions regarding your health care, including choices regarding health care providers and medical treatment, if you are not able to make them yourself for any reason.

You should not execute and Advanced Directive without having first thought about end of life issues, considered your personal values, and discussed your end of life wishes with your family, physicians, attorney, and clergy.

Advance Directives

I am informed of my rights to formulate an Advance Directive. I am aware that I am not required to have an Advance Directive in order to receive medical treatment by any healthcare provider. The terms of any Advance Directive that I execute will be followed by any healthcare provider and my caregiver to the extent permitted by the law.

DO YOU HAVE ANY ADVANCE DIRECTIVES?

❑No ❑Yes ❑Do Not Resuscitate ❑Medical Power of Attorney ❑Living Will If the answer is No, would you like information on Advance Directives, POST/DNR and the Idaho Registry? ❑ Yes ❑ No

By signing below, I verify that the above information is correct and true to the best of my knowledge. I authorize Doctors House Calls to treat me. I authorize all insurance payments to be made directly to Doctors House Calls. I consent to the release of all information the insurance company may request for filing their claims. I understand Doctors House Calls will bill my insurance as a courtesy to me, but many insurance companies do not cover all charges, and that I will be responsible for and will pay for any charges not covered by my health care plan. I have received and reviewed the handout called *Privacy Practices Notice.* I understand that I can ask for further information if needed.

Patient or Responsible Party Signature Date

Health History

Name: _____ Today's Date: DOB: Age:

Please line through any questions that do not apply to you

Current Medications (include prescription and non-prescription drugs, birth control pills, herbs, supplements)

Allergies and Reactions (medication and foods)

Are you currently under the care of a doctor? (list name and type of doctor)

Any recent rehabilitations stay? _____If so name and month you were in that facility? _____

Preventive Care (Write the name of your most recent)

_____ Tetanus booster vaccine Flu Vaccine

_____ Hepatitis A vaccine TB skin test

_____ Hepatitis B vaccine HIV test

_____ Eye Exam

_____ Dental Exam

Family History (Include Mother [M], Father [F], Brother [B], Sister [S], Grandmother [GM], Grandfather [GF])

- ❑ Cancer Heart attack before age 50
- ❑ Diabetes (insulin/diet control) High blood pressure
- ❑ Genetic problem/birth defect High cholesterol
- ❑ Osteoporosis
- ❑ Mental Illness
- ❑ Other:

Personal Medical History (Check all that apply)

- ❑ Chest pain, difficulty breathing
  Birth Defects
- ❑ Redness, pain in legs
- ❑ Uterine fibroid or tumor
- ❑ Sickle cell trait disease
- ❑ Hepatitis A, B, C
- ❑High cholesterol
- ❑ Herpes, warts syphilis, chlamydia, and/or gonorrhea
- ❑ Cancer
- ❑ Numbness of arms or legs
- ❑ Unusual vaginal bleeding or discharge
- ❑ Kidney or bladder disease
- ❑ Discharge from penis
- ❑ Anemia
- ❑ HIV

❑ Do you think you are currently pregnant? ❑ Yes ❑ No

# of pregnancies: _____ # of live births: _____ Date of last menstrual period: _____❑ N/A-Menopausal

- ❑Frequent or severe headaches
- ❑ Abdominal/pelvic pain or infection
- ❑ Stomach/bowel problems
- ❑ Breast discharge/lump
- ❑ Blood transfusions
- ❑ Liver problems
- ❑ High blood pressure
  Stroke
- ❑ Heart murmur/problem
- ❑ Blurred or double vision

Personal Medical History continued (Check all that apply)

❑ Swollen legs/ankles

Increase in thirst or urination

❑ Stomach/bowel problems

❑ Skin allergies/irritation

❑ Seizure disorder

Surgical history: _____

_____

_____

Emotional problems/depression: (list) _____

_____

Patient Mental Health Assessment

In the last 14 days have you experienced any of the following:

Depressed/anxious mood, sadness/crying most of the day, nearly every day?

Less interest or pleasure in all, or almost all activities, most of the day, nearly every day?

A change in sleep patterns?

Thoughts/attempts of hurting or killing myself or others?

Have you heard or seen things that other people don't hear or see?

Drug and Alcohol Use and History

Do you currently use tobacco?

How many per day? _____ For how long? _____ Have you previously used tobacco? _____
How many per day? _____ For how long? _____ When did you quit? _____

Do you currently drink alcohol?

How many per week? _____

Do you currently use drugs?

Types and how often: _____

Have you used drugs in the past?

Types, dates and how often: _____

Other

Are you currently on Home Health? _____ If so, name of agency?_____

How did you hear about us? _____ Name of person or entity that referred you? _____

Did you include copies of your Identification and Insurance cards? _____

What is the need for service? Circle all that apply

Medication management Unable to get to Doctor Unhappy with current provider and why?

I have answered all of the questions about my medical history and my present physical condition fully and truthfully. I have told the doctors or other designated health center personnel about any conditions I may have, which may affect my overall health care. It is my responsibility to inform my provider should this information change in the future. By signing below, I confirm that I have reviewed and answered the entire four-page document. Any spaces left blank are not applicable to me.

Reviewing Provider's Signature*_____ Date_____

* By signing above, I confirm that I have reviewed the entire two-page document and obtained clarification from the patient as necessary. Any blank spaces in this history form should be lined through by the patient and initialed by the reviewing provider to identify that it is not applicable to the patient.