

# The Home Doctor<sup>®</sup>

## Registration Checklist

All enrollees:

- ( ) Enrollment Form
- ( ) Copy of Insurance card(s)
- ( ) Medication List
- ( ) POA/Guardianship documents

### NOTICE

Please allow two weeks for processing this application and the resident being scheduled for treatment.

**Continue with the current medical provider for all medical needs and prescription refills until visited by The Home Doctor<sup>®</sup>.**

**THE HOME DOCTOR® Enrollment Form**



P.O. Box 98886  
Lakewood, WA 98496  
**Phone** 253-589-6484  
**Enrollments Fax** 253-588-8244

Residence Information

Name of care home: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: Washington Zip: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Patient's Room # \_\_\_\_\_

Patient Information

Name: \_\_\_\_\_ Date of Birth: Mo: \_\_\_\_\_ Day: \_\_\_\_\_ Yr: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Male Female

Medicare Number (include suffix): \_\_\_\_\_

DSHS Patient Identification Code (PIC): \_\_\_\_\_

Other Insurance or Private Pay: \_\_\_\_\_

If private pay, please fill out the Additional Contact Information, below. This will be the responsible party for billing purposes.

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 or MEDICATION LIST.***

**Additional Contact / Responsible Party / Emergency Contact Information**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work or Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Does this person have medical **Power of Attorney**? Yes No

Is this person the **financially responsible party**? Yes No

## Medical History

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

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

**This patient has a family history of:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Allergies: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Tel: \_\_\_\_\_ FAX: \_\_\_\_\_

**Personal Habits**

Alcohol Use: \_\_\_\_\_ times a week  
Coffee/Tea: \_\_\_\_\_ times a day  
Exercise: \_\_\_\_\_ times a week

Meals: \_\_\_\_\_ meals a day  
Sleep: \_\_\_\_\_ hours a night  
Tobacco: \_\_\_\_\_ packs a day

**Past Personal Habits**

Alcohol Use: \_\_\_\_\_ times a week      Tobacco: \_\_\_\_\_ packs a day for \_\_\_\_ years

**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: \_\_\_\_\_

The patient is currently (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. This information is needed for timely processing your enrollment.***

Former Primary Care Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_      Fax (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Surgical / Hospitalization History**

Include the approximate date on which the hospitalization took place, the reason for the hospitalization, and the hospital you went to.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please provide any other information you feel is important for us to know here. The more we know about you, the better we can serve you!**

\_\_\_\_\_

## Authorization to Treat Patient Statement

Be it known that I have chosen The Home Doctor® to provide my primary medical care. I live at the address 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 The Home Doctor® 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 The Home Doctor® 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 The Home Doctor® to treat me.

I certify that I am competent to make this choice and these authorizations. I also certify that all of 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:** \_\_\_\_\_  
Signature of patient or legally authorized representative

\_\_\_\_\_  
Authority or Relationship to Individual, if representative

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Date and Time

Your signature authorizes any of the Home Doctor services, which may be needed. These include: primary care, psychiatry, neurology, podiatry and dermatology.

**FINANCIAL RESPONSIBILITY  
AGREEMENT TO PAY**

**Patient Name:** \_\_\_\_\_

**I accept FULL FINANCIAL responsibility for my HOME DOCTOR home visits. 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 legally authorized Representative signature:

➤ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**I certify that I am the legal Guardian, POA or responsible party for the above named patient.**

➤ **Signature:** \_\_\_\_\_

**Acknowledgement of Receipt of Privacy Practices Statement**

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Mr. Charles Plunkett at 253-984-7247 ext. 1

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

**By my signature below I acknowledge receipt of the Notice of Privacy Practices.**

➤ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

# Authorization for The Home Doctor<sup>®</sup> to Use or Disclose My Health Care information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Previous Name: \_\_\_\_\_

## I. My Authorization:

You may use or disclose the following health care information (check all that apply):

- All health care information in my medical record
- Health care information in my medical record relating to the following treatment or condition:  
\_\_\_\_\_
- Health care information in my medical record for the date(s): \_\_\_\_\_
- Other (e.g., X-rays, bills, labs), specify date(s): \_\_\_\_\_

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

- HIV (AIDS Virus)
- Sexually Transmitted Diseases
- Psychiatric Disorders/Mental Health
- Drug and/or Alcohol Use

You may disclose this information to: **MSO Washington, Inc., d/b/a The Home Doctor**  
**P.O. Box 98886**  
**Lakewood, WA 98496-8886**

Purpose(s) for this authorization (check all that apply):

- At my request
- Other (specify): \_\_\_\_\_

**This authorization ends:** *(This document does not permit disclosure of health information created more than 90 days after the date it is signed.)*

- In 90 days from the date signed
- On (date): \_\_\_\_\_
- When the following event occurs: \_\_\_\_\_  
(No longer than 90 days from date signed)

## II. My Rights

I understand that MSO may not base treatment or payment decisions on whether or not I sign this authorization. I understand I have the right to inspect or receive a copy of my protected health information and to receive a copy of this signed form.

I acknowledge that I have the right to revoke this authorization in writing by either: (1) filling out a revocation form available from The Home Doctor or (2) sending my revocation via letter to The Home Doctor to the above address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that once health care information is disclosed, the person or organization that receives it may re-disclose it and privacy laws may no longer protect it.

\_\_\_\_\_  
Signature of patient or legally authorized representative

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Authority or relationship to individual, if representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time