

The Home Doctor[®]

Registration Checklist

All enrollees:

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

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[®].



THE HOME DOCTOR® Enrollment Form

4903-A 108th Street SW

P.O. Box 98886

Lakewood, WA 98496

Phone 253-589-6484

Fax 253-984-1079

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			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:		

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

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:** _____ **Date:** _____

Print your name here: _____ Relationship: _____

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**

This form must be completed in full before providing services to any patient without proof of insurance coverage or who is private 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 Patient's Representative

➤ **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 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 (Aid Virus)
- Sexually Transmitted Diseases
- Psychiatric Disorders/Mental Health
- Drug and/or Alcohol Use

You may disclose this information to:

The Home Doctor
P.O. Box 98886
Lakewood, WA 98496-8886

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

- At my request
- Check only if (practice/facility) requests the authorization for marketing
- Check only if (practice/facility) will be paid or get something of value for providing health information for marketing
- 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 I do not have to sign this authorization in order to get health care benefits. However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party. I may revoke this authorization in writing. If I did, it would not affect any actions already taken by The Home Doctor based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:
 - Fill out a revocation form. A form is available from The Home Doctor. Or
 - Write a letter to The Home Doctor.
- Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature

Date Time

Print Patient's Name

For individuals on Medicare and Medicaid only

Some individuals are insured by both Medicare and Medicaid. These are known as “duals”. The Home Doctor providers welcome these patients who are contracted through any of the following Medicare Advantage plans:

Cigna
Molina
Evercare
All Medigap plans

If you are not covered by one of these plans, sign and date the form following this page titled:

Sales Appointment Confirmation Form

and fax to: 253-984-1079. A licensed agent employed by Washington Practice Management, LLC* will contact you. If you have any other questions contact one of the agents listed below.

Lauren Dudley
253-230-4116
lauren@anova-nw.com

or

Charles Plunkett
253-318-0215
cp1@mso-wa.com

**** Washington Practice Management, LLC is a separate legal entity from the management company (MSO Washington, Inc. d/b/a The Home Doctor). By signing the appointment confirmation form, you are giving permission for the employed agent to contact you. You retain the option of using any other agent licensed and appointed for any of the plans listed above.***

Initial here: _____

Sales Appointment Confirmation Form

To be completed by person with Medicare.

Please initial below in the box beside the plan type that you want the agent to discuss with you. If you do not want the agent to discuss a plan type with you, please leave the box empty. (Please note that an agent may also discuss a Medicare Supplement policy with you.)

<input type="checkbox"/>	Stand-alone Medicare Prescription Drug Plans (Part D)
Medicare Prescription Drug Plan (PDP) — A stand-alone drug plan that adds prescription drug coverage to the Original Medicare Plan, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.	
<input type="checkbox"/>	Medicare Advantage (Part C), Medicare Advantage Prescription Drug Plans, and other Medicare Plans
Medicare Private Fee-For-Service (PFFS) Plan — A type of Medicare Advantage Plan in which you may go to any Medicare-approved doctor or hospital that accepts the plan's payment and terms and conditions.	

By signing this form you are agreeing to a sales meeting with a sales agent to discuss the specific types of products you initialed above. The person that will be discussing plan options with you is either employed or contracted by a Medicare health plan or prescription drug plan that is not the Federal government, and they may be compensated based on your enrollment in a plan.

Signing this form does NOT affect your current enrollment, nor will it enroll you in a Medicare Advantage Plan, Prescription Drug Plan, or other Medicare plan.

Beneficiary Signature: _____

Date: _____ **Time:** _____

To be completed by Agent:

Agent Name:	Agent Phone:	
Beneficiary Name:	Beneficiary Phone:	
Beneficiary Address:		
Initial Method of Contact:		
Agent's Signature:	Date:	Time:
[Plan Use Only:]		