HOMECARE MEDICINE *of* ATLANTA

PATIENT RESPONSIBILITIES

To ensure productive and safe home visits, HCMA expects that:

Staff is treated with respect and courtesy by patients and their families/ caregivers in all interactions.

Patients and/or family/caregivers maintain a safe, sanitary, smoke-free and alcohol/drug-free home during all home visits.

This includes securing all pets during a home visit.

Patients (and if appropriate, family and/or caregiver) will be present in their homes for all scheduled home visits unless reasonable notice has been provided.

Patients (and if appropriate, family and/or caregiver) participate in developing the care plan, including providing complete and accurate information about all matters related to your health and sharing expectations of care.

Patients (and if appropriate, family and/or caregiver) are compliant with care plan directives to the best of their ability or request assistance and/or explanation. Patients (and if appropriate, family and/or caregiver) must acknowledge and accept that there may be consequences for noncompliance.

Patients (and their guarantor, if appropriate) must meet any financial obligations agreed to with HCMA.

Patients understand that receiving medical care and related support services in the home is a privilege, not a right and accept that failure to follow these guidelines may result in discharge from the HCMA Practice.

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Ste 500
Atlanta, GA 30339
www.hcmatl.com

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1.770.740.2611 Local
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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.

Privacy Officer: Ife Oyeleye, Office Manager Effective Date: April 14, 2014

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information; and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who Will Follow This Notice

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by· this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information about You

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure is in a category listed.

For Treatment: We may use medical information about you to provide you with medical treatment or services.

Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from your insurance company or third party.

Example: we may need to send your protected health information; such as your name,

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address, office visit date and codes identifying your diagnosis and treatment to your insurance company for payment

For Health Care Operations: We may use and disclose medical information about you for health care operations to assure that you receive quality care.
Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization:

- As required during an investigation by law enforcement agencies
- To avert a serious threat to the public
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institutional or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations' activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in Domestic Violence or neglect situations
- Health oversight activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

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PATIENT CONSENT / ACKNOWLEDGEMENT

PATIENT NAME:

CONSENT TO ASSESSMENT and RIGHTS AND RESPONSIBILITIES:
I/we voluntarily consent to such care encompassing medical assessment, treatment and diagnostic procedures provided by HCMA and its associated physicians, clinicians, and other personnel as is necessary in his/her professional judgment. I/we understand the practice of medicine is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

RELEASE OF MEDICAL RECORDS:
I consent to release my hospital records and physician records to HCMA. I understand that HCMA will maintain a confidential medical record containing information about my medical condition and me. I authorize HCMA to release copies of my medical records, as necessary, to other health care providers, facilities, or regulatory or accrediting bodies for the purpose of continuing and coordinating my plan of treatment, and for quality assurance, survey and accreditation purposes.

ASSIGNMENT OF MEDICAL INSURANCE BENEFITS:
I assign to HCMA any medical insurance benefits payable to me for services provided by HCMA and permit HCMA to submit a claim for payment to Medicare or Medicaid or to other third party payers and/or any appropriate intermediary agencies as necessary, to bill for services provided by HCMA. I choose HCMA to act as my representative in claim denial appeals. Subject to applicable laws and the terms and conditions of any applicable contract between HCMA and a third-party payer, I understand that I am responsible for fees not reimbursed by my health insurance including, but not limited to, deductibles and/or co-payments.

MEDICARE/MEDICAID PAYMENT AUTHORIZATION COVERAGE:
As a Medicare or Medicaid patient, I certify that the information I have provided in applying for payment under Title XVIII and/or Title XIX of the Social Security Act is correct. If HCMA believes that I no longer qualify for benefits under Title XVIII and/or Title XIX of the Social Security Act, I will be notified verbally and in writing of any potential payment liability.

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NOTICE OF PRIVACY:

I acknowledge that I have received the HCMA Notice of Privacy Practices. I understand that the Notice of Privacy Practices explains how HCMA may use and disclose confidential health information that identifies me. I consent to let HCMA use and disclose health information about me as described in the Notice of Privacy Practices. In doing so, I am consenting to the use and disclosure of health information about substance abuse, psychiatric care, or HIV, if applicable. I consent to the release of health information about me to my insurer, other third party payers, and any agents or consultants that help HCMA get paid or assist in my treatment or its health care operations. I can revoke my consent in writing at any time except to the extent that HCMA has already relied on my consent.

I have read this form and understand its contents at this date.

Patient or responsible party signature: _____

Date: _____

Relationship to Patient: _____

Phone number: _____

Email Address: _____

Reason Patient is unable to sign (if applicable): _____

Witness signature: _____

Date: _____

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PRE-VISIT INTERVIEW

- **Please take a few moments to fill out the following medical history below before your scheduled visit**. This will provide us with helpful information about your health.
- The completed form can be **faxed to our office at (770) 800-3100.**

_____

Patient Name (**Please print**) Date of Birth

_____

Street Address City State Zip Code

Patient's Room/Apt. Number (if applicable): _____

Patient's Phone number: _____

Veteran's Status

Are you a veteran? _____Yes _____No
Did you serve war time? _____Yes _____No
If yes, when? _____
In which war did you serve? _____

Medical History

When was the last time you saw your doctor? _____
Was it a routine visit or for a specific problem? _____
When last were you last admitted to the hospital? _____
Which hospital? _____ What was the problem? _____

PLEASE CIRCLE ALL THAT APPLY:

Are you **bed bound**?	Y	N
Are you able to **walk**?	Y	N
Do you require the use of a **Walker** / **Cane**/ or **Crutch**? (Circle which one)	Y	N
Do you have a **wheelchair**?	Y	N

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Do you need someone to **assist** you in the use of the **wheelchair**?			Y	N
Do you use the wheelchair **Inside/Outside?** (Circle which one)			Y	N
Do you have control of your **bowels**?	Y	N	How often?	
Do you have control of your **bladder**?	Y	N	How often?	
Do you use the **Toilet** / **Urinal** / **Bedpan** / or **Commode**?	Y	N	Circle **each** that applies.	
Do you have a **Foley** catheter?		Y	N	
Do you have a **Colostomy**?		Y	N	
Do you have a **Urostomy**?		Y	N	

Are you able to **feed** yourself?	Y	N	Need Assistance
Do you have a **feeding tube**?	Y	N	If YES: Type?
Are you able to give yourself a **bath** / **shower**?	Y	N	Need Assistance
Are you able to **dress** yourself?	Y	N	Need Assistance
Are you able to **groom** yourself?	Y	N	Need Assistance
Are you able to **communicate** well on your own?	Y	N	Need Assistance
Do you have an **Emergency Lifeline**?	Y	N	

Do you have any **allergies** or **sensitivities** to any medications? Y N

IF YES —**what** medications, and how do you **react**?

_____

_____

_____

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PLEASE ANSWER THE FOLLOWING QUESTIONS

Who does your **grocery** shopping? _____

Who prepares your **meals**? _____

Who gives you your **medications**? _____

If your medications are pre-poured, who does that? _____

Who pays your **bills**? _____

Who **drives** you to appointments? _____

Who does your **laundry**? _____

Who does your **housework**? _____

Please tell us about your past medical history. If you are not sure whether you have a certain condition, circle no. We are looking for conditions that you are aware of.

Diabetes	Y	N	
High blood pressure	Y	N	
Coronary artery disease/Angina/Chest Pain	Y	N	
History of heart attack	Y	N	Date:
High cholesterol	Y	N	
Congestive heart failure	Y	N	
Swelling of legs / ankles	Y	N	
Heart Valve disease (heart murmur)	Y	N	
Cardiac arrhythmia (irregular heartbeat)/Pacemaker	Y	N	Circle all that apply
Ulcers – (Stomach/Duodenal)	Y	N	Circle all that apply
Pancreatitis	Y	N	
Bleeding from stomach or rectum	Y	N	Circle all that apply
Diverticulosis/Diverticulitis — of Colon	Y	N	
Acid Reflux Disease - **GERD**	Y	N	
Hard of hearing/Hearing Aid:	Y	N	
Vision problems—**can't** read even if using glasses	Y	N	
Glaucoma (increased pressure in eye)	Y	N	

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Stroke	Y	N	Date:
Parkinson's disease	Y	N	
Treated for Depression	Y	N	
Dementia (Forgetfulness)	Y	N	
Thyroid (hyper/hypo)	Y	N	
Lung disorders/Breathing problems	Y	N	
Bronchitis, pneumonia (in the last few years)	Y	N	Year:
Liver disorders/jaundice	Y	N	circle all that apply
Kidney Disorders:	Y	N	circle all that apply
Kidney Stone/Recur Bladder Infect	Y	N	
Arthritis (osteoarthritis/rheumatoid arthritis)	Y	N	circle all that apply
Cancer	Y	N	type:
Anemia	Y	N	
Blood clots (Legs or Lungs)	Y	N	
Peripheral Vascular Disease --	Y	N	
Leg pain: Walking/ at Rest	Y	N	circle all that apply
Surgeries:			
Cholecystectomy (Gall Bladder)	Y	Year: _____	N
Appendectomy	Y	Year: _____	N
Cataracts (Eye operation)	Y	Year: _____	N
Hysterectomy	Y	Year: _____	N
Please list any additional surgeries performed:			

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Any **additional** **past medical history** that you feel would be helpful for your physician to know.

_____

_____

_____

Date of last **Colonoscopy** _____ Never

Date of last **Mammogram** _____ Never not applicable.

Date of last **Flu shot** _____ Never

Date of last **Pneumovax** shot (Bacterial pneumonia): _____ Never

Date of last **Shingles Vaccine** _____ Never

FAMILY HISTORY

Please answer the following questions about your family history. Please **list which family member** applies on each line.This **includes** your parents, brothers, sisters, aunts, uncles, grandparents, etc.

Diabetes _____

High Blood Pressure _____

Heart Attacks at age 40's or 50's _____

Cancer (type) _____

Rheumatoid Arthritis _____

Mother Living/Dead Age at death _____ Cause of death _____

Father Living/Dead Age at death _____ Cause of death _____

SOCIAL HISTORY

Current **marital** status: _____ Do you have any children? **Y N** #____

Current **religious** status: _____ Is religion important to you now? **Y N**

Do you have a **Do Not Resuscitate** (**DNR**) Order in place? _____

If No—are you interested in talking with the doctor about this? _____

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Do you have a **Health Care Proxy**? _____

If No—are you interested in talking with the doctor about this? _____

What **work** are you retired from: _____ Age at retirement: ____

Are you presently smoking **cigarettes**? **Y** **N** Other tobacco products: _____

If Yes, how many **packs per day**? _____ For how many **years:** _____

If No, have you smoked in the past? **Y** **N**

If Yes in the past, how many **packs per day?** ____ For how many **years**? _____

When did you quit? _____

Do you drink more than **one alcoholic beverage** a week? **Y** **N**

If Yes, how often _____ what do you drink? _____

If No— Have you had a period where you drank daily or drank more than 5 drinks on the weekend? **Y** **N**

Do you use oxygen at home? **Y** **N**

Does anyone else in the home use oxygen? **Y** **N**

Please list *all* your Medicines on the next page, including:

- **Injections** — Insulin, Vitamin $B_{12,}$ etc.
- **MDIs** — Meter Dose Inhalers & Nebulized medications.
- **Eye Drops**
- **Pain and Sleep** medications — Tylenol, Anacin and other OTC's.
- **Bowel** medications, **Vitamins**, **Calcium**, **Herbal** Products, **Supplements**.
- **Skin creams** and any other over the counter medicines you are using.

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	Medicine	Dosage	Currently Use (Y/N)?	How many times a day *and* When taken during the day?
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				

Preferred Pharmacy

Name: _____
Number: _____
Address: _____

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CONSENT AGREEMENT
FOR PROVISION OF CHRONIC CARE MANAGEMENT

By signing this Agreement, you consent to HomeCare Medicine of Atlanta (HCMA), providing chronic care management (CCM) services to you as more fully described below.

CCM Services are available to you because you have been diagnosed with two (2) or more chronic conditions which are expected to last at least twelve (12) months and which place you at significant risk of further decline.

CCM Services include 24-hours-a-day, 7-days-a-week access to a physician at HCMA to address acute chronic care needs; systematic assessment of your health care needs; processes to assure that you receive timely preventative care services; medication reviews and oversight; a plan of care covering your health issues; and management of care transitions among health care providers and settings. The Provider will discuss with you the specific services that will be available to you and how to access those services.

HCMA's Obligations.
When providing CCM Services, the HCMA must:

- Explain to you (and your caregiver, if applicable), and offer to you, all the CCM Services that are applicable to your conditions.
- Provide to you a written or electronic copy of your care plan.
- If you revoke this Agreement, provide you with a written confirmation of the revocation, stating the effective date of the revocation.

Beneficiary Acknowledgment and Authorization.
By signing this Agreement, you agree to the following:

- You consent to HCMA providing CCM Services to you.
- You authorize electronic communication of your medical information with other treating providers as part of the coordination of your care.

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• You acknowledge that only one practitioner can furnish CCM Services to you during a calendar month.
• You understand that cost-sharing will apply to CCM Services, so you may be billed for a portion of CCM Services even though CCM Services will not involve a face-to-face meeting with the Provider.

Beneficiary Rights.
You have the following rights with respect to CCM Services:

• The Provider will provide you with a written or electronic copy of your care plan.
• You have the right to stop CCM Services at any time by revoking this Agreement effective at the end of the then-current month. You may revoke this agreement verbally (*by calling 770-740-2611*) or in writing (to *HCMA, 3330 Cumberland Blvd, Atlanta, GA 30339).* Upon receipt of your revocation, the Provider will give you written confirmation (including the effective date) of revocation.

Beneficiary	**Beneficiary's Representative and/or Caregiver (if applicable)**
Signature: _____	Signature: _____
Print Name: _____	Print Name: _____
Date: _____	Date: _____

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