



Compound Authorization Form

Patient's Name _____ DOB _____

Please strike through any of the sections below that you do NOT wish to authorize.

I authorize the release of my medical records to **PHYSICIAN HOUSECALLS** upon its request, including all examinations, diagnoses, laboratory and imaging studies, and treatments for the past two years.

Release from: _____

(Current or previous physician (including specialists) or facility releasing information)

Phone: (____)____-____ Fax: (____)____-____

Release from: _____

(Current or previous physician (including specialists) or facility releasing information)

Phone: (____)____-____ Fax: (____)____-____

I request and authorize medical care by Physician Housecalls providers as described in the General Consent for Treatment attachment.

I authorize payment of my medical benefits to **PHYSICIAN HOUSECALLS** for services rendered.

I authorize **PHYSICIAN HOUSECALLS** to exchange information necessary for payment.

I acknowledge I have been offered and/or received the Physician Housecalls Notice of Privacy Practices.

I understand and agree that I am financially responsible for all charges of services rendered to me, including balances owed after insurance payments.

I authorize **PHYSICIAN HOUSECALLS** to discuss my medical care, etc., with the following individual(s): _____

_____, _____

I give consent to the electronic download and review of medication insurance eligibility and medication history. Note: **PHYSICIAN HOUSECALLS** will check all patient's medication histories.

Signature of patient or patient's Power of Attorney

Date

Printed Name

Please note that ONLY this completed form with signatures should be returned to Physician Housecalls. The attachments following this page contain complete information on authorizations (General Consent for Treatment and Notice of Privacy Practices.) Please fax to 855-223-1999 or email to referrals@housecallsok.com.

**Physician Housecalls
Facility Patient Intake Questionnaire**

Facility Name _____ Facility Phone _____
Patient Name (Last) _____ (First) _____ (MI) _____
SSN _____ Facility Apt. # _____
Patient phone number _____ DOB _____
Patient email address (if any) _____
Patient billing address _____
Emergency contact name _____
Emergency contact relationship to patient _____
Emergency contact cell phone _____ work phone _____
Emergency contact email _____
Patient's Pharmacy _____ Phone _____
Previous primary care physician _____
Specialists involved in patient's care _____
Home Health/Hospice/Advantage Case Management Agency:

Current Medical Equipment Supplier _____

Does the patient have (circle all that apply) Advance Directive DPOA DNR
(Please send copies of all completed documents) Court-appointed Guardian

Billing and Insurance Information

DPOA or Guardian Name _____
DPOA or Guardian Address _____
Person handling patient's financials (if not DPOA) _____
Address _____

Primary Insurance Company _____

Policy Holder Name _____ DOB _____
Policy Holder SSN _____ Policy Number _____
Group Number _____ Insurance Phone Number _____
Submit claims to address _____

Secondary Insurance Company _____

Policy Holder Name _____ DOB _____
Policy Holder SSN _____ Policy Number _____
Group Number _____ Insurance Phone Number _____
Submit claims to address _____

(Important - please submit copies of front and back of insurance cards.)



Right of Choice

If your doctor determines you need home health care or hospice care, you will have the right to choose an agency to provide such care, under the Medicare home health or hospice requirements for patient choice. Your doctor will honor that choice. Even though you have the right to choose, your choice may be limited based on your insurance coverage or the availability of the agency you have selected.

X

patient signature

X

date



Patient Pain Management Educational Information

Physician Housecalls believes that controlling your pain is a very important goal in your treatment. Uncontrolled pain can affect every aspect of your life. Your ability to eat, sleep, work and even your relationships can be affected. The good news is that most pain can be controlled, and you can conduct your normal activities.

The goal of any pain treatment plan is to control pain so that you are able to conduct normal activities. It is unlikely that any treatment will totally eliminate ALL chronic pain but, for most people, treatment can help them resume their routine activities.

Of course, no treatment is without risk. This is especially true if your pain treatment plan includes the use of opioids, otherwise known as “pain killers.” These medications can be an important part of your care but carry very serious risks, particularly if they are not used exactly as prescribed.

Your pain treatment plan should include one or more of a variety of ways to control pain other than medications. These could include, among others:

- Heat/Ice
- Exercise
- Deep breathing
- Total body relaxation
- Massage

For more information on these options, please call the Physician Housecalls office or talk with your physician or other provider.

When your treatment plan also includes opioid pain medications, you should be aware of the risks. The most dangerous side effect of opioids is that they may cause your breathing to slow down. This slowing of your breathing increases the risk that your breathing and heart may stop.

*While you are using opioid pain medication it is very dangerous to drink alcohol or use sleeping pills, illegal drugs (such as cocaine, heroin, methamphetamines), that your provider did not prescribe while you are taking your prescribed pain medication. If you do, your breathing and heart could stop. Be sure to talk with your provider about any anxiety medication you are taking as the combination could also be very dangerous. **If you experience any difficulty breathing, are difficult to arouse or have any other serious side effect, you or a caregiver should call 911 immediately.***

There are also very serious or even life-threatening possible side effects when using opioids. If you experience any of these, contact our office right away. These could include:

- Sleepiness and slowed reflexes, making it unsafe to drive or use machinery
- Nausea and vomiting
- Constipation (you will likely need to take laxatives or stool softeners, drink plenty of water and eat a high fiber diet while taking opioids)
- Worsened depression
- Weight gain
- Reduced sexual desire
- Trouble thinking and impaired judgment
- Allergic reaction, such as difficulty breathing, swelling, rash, itchiness, etc. that potentially may be life-threatening. **If you are experiencing a serious side effect, call 911 immediately**
- Addiction is also possible. The risk of addiction increases the longer you take the medication. If you become addicted, it may be hard to control how often you take it or how much you take.
- Your body may become dependent on the medication. This means that you may have symptoms of withdrawal if you suddenly stop taking it. Some symptoms of withdrawal are nausea, vomiting and sweating. These are not life-threatening. If you have been taking opioids for an extended time, it is usually best to gradually reduce the amount you are taking rather than stopping it suddenly, so that you do not experience withdrawal. Talk with your physician or other provider for if you have questions regarding stopping your pain medication.

When taking pain medication, it is extremely important to:

- Take these medicines with food and plenty of water
- Tell your doctor or other provider about all medications you are taking
- Take all your medications ONLY as prescribed
- Do not share your medications with any other person
- Safeguard your medications so that they are not accessible to others
- Destroy your medications in a responsible manner if you do not need them anymore. For safe disposal methods, call your pharmacy or our office.

If you will be taking opioid pain medication, you should consider having naloxone (Narcan) available in case you accidentally take too much. This medication can reverse some of the most dangerous side effects of opioid overdose, such as difficulty breathing. It is available at any pharmacy and does not require a physician's prescription.

We hope you find this information helpful. If you should have questions at any time, please contact our office at (844) 765-3339. After hours and weekends, please leave a message and a nurse will call you back.



Patient Drug Contract

This drug contract stipulates the conditions under which Physician Housecalls will provide controlled medications to patients. The stipulations are as follows:

- If any medications are lost, stolen or otherwise unavailable, no more medications will be prescribed until the next available refill date.
- Patient will submit to routine drug screens, and if the tests are positive for any controlled substances other than those that are prescribed by the attending physician, no other medications will be provided and services may be terminated.
- Patient agrees to reserve the medications only for personal use to control pain and will be truthful in reports of pain ratings.
- Any positive drug test for any illegal substance may result in immediate termination of services.
- Any negative drug tests for prescribed controlled substances may result in immediate termination of services.
- Patient agrees to receive controlled medication prescriptions only from Physician Housecalls providers. If the Prescription Monitoring Program reveals prescriptions from other providers, the patient may be terminated from Physician Housecalls practice.

I hereby agree to the conditions listed above and understand that Physician Housecalls will not provide medications to me if the conditions are not met. With my signature, I acknowledge that the opioid patient information sheet has been made available.

Patient Signature

Date

Physician Housecalls Representative Signature

Date