PHYSICIAN HOUSECALLS

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.

Revised 06.05.19

PHYSICIAN HOUSECALLS

Patient Evaluation Questionnaire

How did you hear about Physician Housecalls? ☐ Friend Website Facility Other _____

DOB: _____

Patient Name: _____ SSN: _____

Address: _____ Facility/Apt: _____

Telephone: _____ City/State: _____

Billing Address: _____ ZIP Code: _____

Important Directions: _____

Emergency Contact: _____ Relationship to Pt: _____

Contact Telephone #1: _____ Contact Telephone #2: _____

Current Pharmacy: _____ Home Care/Hospice/Advantage CM Agency:

Previous PCP: _____ _____

Is the patient's condition related to: Employment: **Y** **N** Auto Accident: **Y** **N** Other Accident: **Y** **N**

ALLERGIES					
Food allergies:					
Drug allergies:					
Environmental allergies:					
ACTIVITIES OF DAILY LIVING HISTORY					
Are you bed bound?			Y	N	
Are you able to walk?			Y	N	Walker/Cane/Crutch/Wheelchair?
Do you have control of your bladder?			Y	N	
Do you have control of your bowel?			Y	N	
Are you able to groom/bath/dress yourself?			Y	N	
Patient's height and weight			_____Lbs.		_____'_____"
SOCIAL HISTORY					
Marital Status	Married	Single		Widowed	Divorced
Number of Children					
Smoking Status	Never	Currently		Quit	Details
Alcohol Usage	Never	Currently		Quit	Details
History of Substance or Narcotics Use			Y	N	
Oxygen Used in the Home			Y	N	If yes:_____Liters
Armed Forces Service **(if yes, THANK YOU)**			Y	N	
Previous Occupation					
Race:	Ethnicity:			Language:	
Gender: Male	Female				

FAMILY MEDICAL HISTORY			
Heart Disease	Mother	Father	Other
Cancer	Mother	Father	Other
Diabetes	Mother	Father	Other
Dementia/Alzheimer's	Mother	Father	Other
Mothers cause of death:		Fathers cause of death:	
Age at time of death:		Age at time of death:	

PAST MEDICAL HISTORY		
__Alcoholism	__Diabetes	__Hiv/Aids
__Arthritis	__Eczema/Skin Issues	__Intestinal Issues
__Anxiety/Depression	__Empysema/Asthma	__Muscle Problems
__Autoimmune Disease	__Epilepsy/Seizures	__Respiratory Issues
__Bladder/Kidney	__Eye issues	__Scarlet Fever
__Cancer	__Headaches	__Stroke
__Chronic Pain	__Heart Disease	__Swallowing Issues
__Digestive Issues	__High Blood Pressure	__Other:
__Diabetic Eye Exam	__ Diabetic Foot Exam	

PAST SURGICAL / HOSPITALIZATION HISTORY

IMMUNIZATION HISTORY		
Pneumonia Y N	**Zoster (Shingles) Y N**	**Influenza Y N**
Date:	**Date:**	**Date:**

CODE STATUS

____Do Not Resuscitate and/or ____MOST form

Does the patient have a Living Will/ Advanced Directive? _____

BILLING AND INSURANCE INFORMATION

Do you have a DPOA or Guardian? **Y** **N** If yes, who? _____

DPOA or Guardian Address: _____

Are you responsible for your financials? **Y** **N** If no, who? _____

Responsible Party Address: _____

Primary Insurance Information:

Insurance Company: _____ Number:_____

Name of Policy Holder: _____ Policy Holders DOB _____

Policy Holders SSN: _____ Group Number: _____

Insurance Phone #: _____

Submit claims to address: _____

Secondary Insurance Information:

Insurance Company: _____ Number:_____

Name of Policy Holder: _____ Policy Holders DOB _____

Policy Holders SSN: _____ Group Number: _____

Insurance Phone #: _____

Submit claims to address: _____

MEDICATION INFORMATION

□ Patient gave verbal consent to the electronic download and review of medication insurance eligibility and medication history.

Please list below all medications patient is currently taking, including injections, inhalers, eye drops, skin creams, vitamins/supplements and over the counter medications:

	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.				

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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

Revised 05.22.18

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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.

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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

Revised 06/05/19