PHYSICIAN
HOUSECALLS

Physician Housecalls is a mobile primary care medical practice composed of highly trained and compassionate medical providers that specialize in home care.

The mission of Physician Housecalls is to increase access to healthcare when it's become difficult to transport to a traditional medical office. At Physician Housecalls we support decisions to stay at home or in a residential community, provide comprehensive healthcare anddecrease visits to the emergency department and hospital admissions.

Our philosophy surrounds our belief that patients and families deserve to be treated with dignity and respect, should be allowed control over health care decisions and have access to high quality,complex care.

Our providers offer varied levels of care, from regular exams to complex treatment plans. As Home Care Specialists, we act as your primary care provider (PCP) and work alongside your specialists. If you should need hospitalization, Mobile Medical coordinates the admission process with your hospital of choice. (Should we include that we do not provide hospital services and care would be provided by a hospitalist?) Upon discharge, our providers will coordinate a visit to ease your transition home.

Available Services:

- Physical exams
- Chronic Disease Management
- Acute Care Visits
- Prescription refills
- Functional Assessments
- Geriatric Health Assessments
- Cognitive Assessments
- Home Health & Hospice Coordination

We currently accept:

- Medicare
- Medicaid
- Private Insurance
- Private Pay

We look forward to serving you!

The Physician Housecalls Team

PHYSICIAN
HOUSECALLS

Notice of Privacy Practices

This notice tells you how we make use of your health information at Physician Housecalls, howwe might disclose your health information to others, and how you can access the same information. It is being provided to you pursuant to the regulations of the Health Insurance Portability and Accountability Act (HIPAA). Please review this notice carefully and feel free to ask for clarification about anything in this material you might not understand. The privacy of your health information is very important to us, and we want to do everything possible to protect that privacy.

We have a legal responsibility under the laws of the United States and the State of Oklahoma tokeep your health information private. Part of our responsibility is to give you this notice about our privacy practices. Another part of our responsibility is to follow the practices in this notice.This notice took effect on October 18th, 2011 and will be in effect until we replace it.

We have the right to change any of these privacy practices as long as those changes are permittedor required by law.

Any changes in our privacy practices will affect how we protect the privacy of your health information. This includes health information we will receive about you or that we create at Physician Housecalls. These changes could also affect how we protect the privacy of any of yourhealth information we had before the changes. When we make any of these changes, we will also change this notice and give you a copy of thenew notice. When you are finished reading this notice, you will be given a copy of it at no charge to you. Ifyou request a copy of this notice at any time in the future, we will give you a copy at no chargeto you.

If you have any questions or concerns about the material in this document, please ask us forassistance which we will provide at no charge to you.

Here are some examples of how we use and disclose information about your health information.

- To anyone for whom you give us written authorization to have your health information, for any reason you want. You may revoke this authorization in writing anytime you want. Whenyou revoke an authorization, it will only affect your health information from that point on.
- To anyone on our staff involved in management of your care.
- To any person required by federal, state, or local laws to have lawful access to your plan ofcare.
- To receive payment from a third-party payer for services we provide for you.
- To staff of Physician Housecalls in connection with our business operations. Examples of these include but are not limited to the following: evaluating the effectiveness of our staff, supervising our staff, improving the quality of our services, meeting incentive markers, andin connection with licensing, credentialing, or certification activities.
- To a person responsible for your care, or your personal representative in the event of an emergency. If you are present in such a case, we will give you an opportunityto object. If you object, or are not present, or are incapable of responding, we may use our professional judgment, in light of the nature of the emergency, to go ahead and use or disclose your health information in your best interest at that time. In so doing, we will only use or disclose the aspects your health information that are necessary to respond to the emergency.

- To law officers or child protection personnel, in accordance with such situations as are detailed in Oklahoma Statutes. Health care providers are required by law to report or causeto be reported the threat of homicide or suicide and threat of serious harm to self or others.
- To officers of the court, when mandated by subpoena or other court order. We will not useyour health information in any of our marketing, development, public relations, or related activities without your written authorization.
- Please note that communication with other health care providers, staff of Physician Housecalls, staff of your residential community, family members and other designated persons involved in your care may occur via secure voice message, encrypted email, andother methods not listed here to coordinate your care.

As a patient of Physician Housecalls you have these important rights:

- You have a right to a copy of this notice at no charge.
- With limited exceptions, you can make a written request to inspect your health informationthat is maintained by us for our use. This inspection will occur in the presence of your provider or designated person. Information provided for inspection will be subject to the clinical judgment of your Physician Housecalls provider or designated person, pursuant to CRS 25-1-802.
- Pursuant to CRS 25-1-802, you have the right to a written summary of your clinical records.
- You can make a written request to have us communicate with you about your health information by alternative means, at an alternative location. Your written request mustspecify the alternative means and location.
- You can make a written request that we place other restrictions on the ways we use or disclose your health information. We may deny any or all of your requested restrictions. If we agree to these restrictions, we will abide by them in all situations except those which, inour professional judgment, constitute an emergency.
- You can make a written request that we amend the information in part “B” above.
- If we approve your written amendment, we will change our records accordingly. We will alsonotify anyone else who may have received this information, and anyone else of your choosing.
- If we deny your amendment, you can place a written statement in our records disagreeingwith our denial of your request.
- You may make a written request that we provide you with a list of those occasions where weor our business associates disclosed your health information for purposes other than treatment, payment, or our operations.
- If you request the accounting in “I” above more than once in a 12-month period, we may charge you a fee based on our actual costs of tabulating these disclosures.
- If you believe we have violated any of your privacy rights, or you disagree with a decisionwe have made about any of your rights in this notice you may file a complaint with us.
- You may also submit a written complaint to the United States Department of Health and Human Services. We will provide you with that address upon written request

PHYSICIAN
HOUSECALLS

Financial Policy

Thank you for choosing Physician Housecalls. We are pleased to participate in your health care and look forward to establishing a lasting relationship as a member of your health care team. As part of this relationship, we wish to explain our expectations of your financial responsibility as outlined in our Financial Policy. Your medical insurance is a contract between you and your insurance company. We will file claims with Medicare, Medicaid and Private Insurers. You are responsible for all co-payments, deductibles, and services not covered under the Medicare and other insurer programs. Please review the following financial policy prior to your visit.

Co-Payments, Deductibles, and Fees – all co-payments, insurance deductibles, and fees for services not covered by your insurance policy are expected to be paid in full as outlined by thefinancial policy.

Insurance – in order for us to successfully bill your insurance company, we require complete information and a copy of your insurance card prior to your initial visit. If your insurance carrier is not one with which we participate, you are responsible for payment in full. Insurance plans andMedicare consider some services to be "non-covered," in which case you are responsible for payment in full. You have a responsibility to provide correct information to our office so a claim can be properly submitted. If your insurance company has not paid a claim on your behalf within90 days from the date of service, the balance will be transferred to your account, and you will be responsible for payment. If we receive payment at a later date, you will be reimbursed by Physician Housecalls, LLC.

Minors And Dependents – parents and guardians are responsible for payments for their dependents at the time the service is rendered. Minors and dependents must present a valid insurance card at each visit if a claim is to be filed. See item #2 above if an insurance card is notpresented.

Missed Appointments – we reserve the right to charge a $25 fee for missed appointments or appointments cancelled with less than 24-hour notice. We also reserve the right to terminate the provider-patient relationship after 3 missed appointments.

Prompt Payment – just as we make every effort to accommodate you when you need medical care, we expect that you will make every effort to pay your bill promptly. If you are unable to pay your bill in its entirety, please contact our billing office to discuss payment options. If your account becomes delinquent and have not established or met payment options with our billing office, your account will be turned over to acollection agency and you may be dismissed from Physician Housecalls and not eligible for services until your balance is paid in full.

Method of Payment - we accept cash, checks, credit and debit cards. Our providers reserve theright to not collect cash at the time of service for safety reasons. To arrange payment, please contact our office at (405) 896-8058. We also offer payment plans upon request.

Returned Checks – the fee for all checks returned for insufficient funds is $30.00. This fee willbe automatically charged to your account when your check is returned from the bank.

Patient Name:_____ DOB _____

PHYSICIAN HOUSECALLS

CONSENT FOR TREATMENT

I hereby voluntarily consent to the rendering of healthcare services by providers of Physician Housecalls I acknowledge and understand that this consent authorizes providers of Physician Housecalls to manage and treat medical conditions, including but not limited to, physical examinations, diagnostic procedures, performance of tests, and administration of medications and therapies. I understand that I have the right to discuss proposed procedures or treatments with my provider and to consent to or refuse such procedures or treatments. I understand that there are limitations to my care in the setting that I reside, and there are no guarantees to the effect of such examination or treatment of my condition. I understand that this consent will be valid and remain in effect if I am in the care of Physician Housecalls.

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

I hereby authorize Physician Housecalls to release information from my medical record for treatment, payment and healthcare operations as described in the Physician Housecalls Notice of Privacy Practices to insurance companies, third party payers, authorized agents or claims review organizations to process a claim for payment on my behalf. This information may be available to any and all employer's insurance companies or their designees who may provide coverage for medical charges and to comply with the requirements of any Professional Review Organization. This authorization may be revoked at any time except to the extent that action has already been taken in reliance on it.

MEDICARE AND MEDICAID

I hereby certify that the information given by me in applying for payment under the Medicare and/or Medicaid programs is correct. I authorize release of information needed to act on this request. I request that payment of physician/provider Medicare and Medicaid benefits, if applicable, be made on my behalf.

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.

ACKNOWLEDGEMENT OF RECEIPT OF FINANCIAL POLICY

I hereby acknowledge that I have been presented with the opportunity to receive the Physician Housecalls Financial Policy. I understand and agree to the policy. I understand that if there is no guarantee of reimbursement or payment from any insurance company or other payer and that I am financially responsible for all charges not paid for any reason, including but not limited to charges that are non-covered, no billed, not collected, or otherwise not paid by insurance companies or third-party payers. I understand that all deductibles and co-payments will be due by me.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability and Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that Physician Housecalls has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

AUTHORIZATION FOR COMMUNICATION

I hereby authorize Physician Housecalls providers, employees, and representatives to communicate with myself, designated person(s) below, other health care providers, and persons involved in my healthcare/business operations, using secure methods of communication.

I hereby consent to the following person (s) to be personal representatives to receive or know personal information regarding my medical status and plan of care. I understand that this information will be effective at the date of signature and will remain in effect until Physician Housecalls is notified in writing of requested change.

_____ _____

Name Relationship Name Relationship

I understand and agree to the above statements in this document

_____

Date Name Relationship

PHYSICIAN
HOUSECALLS

PHI USE AND DISCLOSURE AUTHORIZATION

I authorize _____ to use and disclose the following protected health information:
(*specialist or previous practitioner*)

☐ All records for the past _____ years.
To include lab results, radiology, EKG, nuclear test results, emergency room records, hospital records, operative reports, pathology reports, diagnostic test results and medical notes.

I hereby authorize the release of the following information as well as previously indicated above:
☐ Mental Health Records
☐ Communicable diseases (including HIV and AIDS)
☐ Alcohol/drug abuse treatment
☐ Genetic markers
☐ Other (please specify) _____

Purpose of Disclosure: ☐ At request of patient ☐ Continuing Care ☐ Personal Records ☐ Legal ☐ Insurance

Other Name of Entity or Person(s) to Receive Info:

Physician Housecalls
101 W Hefner
Oklahoma City, OK 73114
Phone: (405) 896-8058
Fax: (855) 223-1999

I understand that I have the right to terminate or revoke this authorization at any time. To do so, my request must be providedto your office in writing. Written requests can be sent to addresses above. I understand that revocation is not effective if my authorization was obtained as a condition of obtaining insurance coverage. I understand that this authorization is effective 12 months from signature date unless a different expiration date is provided. I understand that information that is disclosed under this authorization may be disclosed by the recipient, as such the privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to. Iunderstand that my authorization is not required as a condition to receive treatment, payment, or enrollment or eligibility forbenefits.

_____
Name of Patient or Personal Representative (Print)

_____ _____
Signature of Patient or Personal Representative Date

_____
Description of Personal Representative's Authority

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 beprescribed until the next available refill date.
- Patient will submit to routine drug screens upon request, and if the tests are positive for any controlled substances other than those that are prescribed by the attending provider, no othermedications will be provided, and services may be terminated.
- Patient agrees to reserve the medications only for personal use to control pain and will betruthful in reports of pain ratings.
- Any positive drug test for any illegal substance may result in immediate termination ofservices.
- Any negative drug tests for prescribed controlled substances may result in immediatetermination of services.
- Patient agrees to receive controlled medication prescriptions only from Physician Housecallsproviders. If the Prescription Monitoring Program reveals prescriptions from other providers,the patient may be terminated from Physician Housecalls practice.
- Physician Housecalls reserves the right to not prescribe or stop prescribing controlled substances if use is deemed inappropriate, outside of our scope, or should a violation of thiscontract occur.
- We may continue to manage medical conditions without the management of chronic pain,alongside the care of an outside chronic pain manager.

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 thatthe opioid patient information sheet has been made available.

_____

Patient Signature Date

_____

Physician Housecalls Representative Signature Date

PHYSICIAN
HOUSECALLS

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: _____

PHYSICIAN
HOUSECALLS

Patient Evaluation Questionnaire

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

Patient Name:_____ DOB:_____

Gender: Male Female SSN:_____ Telephone:_____

Address:_____ Facility/Apt:_____

City/State:_____ ZIP Code: _____

Billing Address: _____

Important Directions: _____

Email Address: _____

Emergency Contact:_____ Relationship to Pt:_____

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

Home Care/Hospice/Advantage CM Agency: _____

Current Pharmacy:_____

Previous PCP: _____

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

Activities of Daily Living

Are you bed bound? ☐ Y ☐ N
Are you able to walk? ☐ Y ☐ N Walker/Cane/Crutch/Wheelchair? ☐ Y ☐ N
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 _____

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 (it yes, THANK vou) ☐ Y ☐ N
Previous Occupation _____
Race:_____Ethnicity:_____Language:_____

PHYSICIAN
HOUSECALLS

Medications and Allergies

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

	Medication	Dosage	Number of Times & When Taken
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

Allergies

Food allergies: _____

Drug allergies: _____

Environmental allergies: _____

PHYSICIAN
HOUSECALLS

Family Medical History			
☐ Heart Disease	☐ Mother	☐ Father	☐ Other
☐ Cancer	☐ Mother	☐ Father	☐ Other
☐ Diabetes	☐ Mother	☐ Father	☐ Other
☐ Dementia/Alzheimer's	☐ Mother	☐ Father	☐ Other
Mother's cause of death:		Age at death:	
Father's cause of death:		Age at death:	

Past Medical History		
☐ Alcoholism	☐ Diabetes	☐ HIV/Aids
☐ Arthritis	☐ Eczema/Skin Issues	☐ Intestinal Issues
☐ Anxiety/Depression	☐ Emphysema/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 ☐ Y ☐ N	Influenza ☐ Y ☐ N
Date:	Date:	Date:

Code Status
Do Not Resuscitate and/or MOST form: ☐ Y ☐ N
Living Will or Advanced Directive: ☐ Y ☐ N