HOUSE CALLS
OF NEW MEXICO
— AN ADDUS HOMECARE COMPANY —

New Patient Intake Packet

Patient Name: _____ DOB: _____

Address: _____ SSN: _____

City: _____ State _____ Zip _____ SEX: _____

Home Phone: _____ Cell: _____ Email: _____

Facility: _____ Phone: _____ Fax: _____

Insurance Information:

Primary: _____ ID # _____ Group # _____

Secondary: _____ ID # _____ Group # _____

Tertiary: _____ ID # _____ Group # _____

Responsible Party: _____ **Relationship:** _____

Address: _____

City: _____ State _____ Zip _____

Home Phone: _____ Cell: _____

Email: _____

(If you have a POA please complete every section.)

() Financial POA

() Healthcare POA

Emergency Contact: _____ Relationship: _____

Phone: _____ Email: _____

Preferred Pharmacy: _____

Phone: _____ Fax: _____

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Medical Information:

Allergies:

_____

_____

_____

Current Medical Issues:

_____

_____

_____

_____

_____

Current Medications (Please include strength and directions.):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Name:_____

2921 Osuna RD Albuquerque, NM 87113 (505)898-2468 Fax (505)898-1518

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Family History: (Check any Illness that any Blood relatives have ever had): Please Circle

Allergies/ Asthma:	Mother	Father	Brother	Sister
Cancer	Mother	Father	Brother	Sister
Lung	Mother	Father	Brother	Sister
Depression	Mother	Father	Brother	Sister
Anemia	Mother	Father	Brother	Sister
Glaucoma	Mother	Father	Brother	Sister
Kidney	Mother	Father	Brother	Sister
Hypertension	Mother	Father	Brother	Sister
Heart Condition	Mother	Father	Brother	Sister
Blood Clotting	Mother	Father	Brother	Sister
Diabetes	Mother	Father	Brother	Sister
Alcoholism	Mother	Father	Brother	Sister
Stomach	Mother	Father	Brother	Sister

Father Living:____ Deceased:_____ Age:_____ Mother living:_____ Deceased:_____ Age:_____
Brothers: _____ # Living:_____ Deceased:_____ Sisters:____# Living:_____ Deceased:_____

Your Medical History: (Check all you have ever had):

	Asthma		Allergies		Anemia		Blood Disease		AIDS
	Diabetes		Cancer/Tumor		Epilepsy		Glaucoma		TB
	Genetic Disease		Alcoholism		Kidney Disease		Stomach Problems		Hernia
	Ulcers		Arthritis		Heart Trouble		Colitis		Eye Trouble
	Skin Trouble		Lung Disease		Stroke		Pneumonia		Liver Disease
	Convulsions		Hepatitis A, B,C		Migraine		Thyroid Disease		Gallbladder
	Blood Transfusion		Breast Lump		High Blood Pressure		High Cholesterol		

Patient Name:_____

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Hospitalizations/ Operations:

Date	Type of Surgery/ Reason for Hospitalization	Surgeon/ Hospital

Social History (please answer the following questions as completely as you can):

Do you smoke: YES NO How much: _____ How Long:_____ When did you quit:_____

Do you drink Alcohol: YES NO How much/Often: _____

Do you use Recreational street drugs: YES NO Which ones/ How much:_____

Do you take caffeine: _____ Coffee _____ Soda _____Tea Other:_____ How much daily:_____

Are you sexually active: YES NO How many partners: _____ Do you use protection: YES NO

Functional Assessment: **Please check each box**

	Bathing/showering		**Personal hygiene**		**Using toilet**
	Walking		**Transfer**		**Housework**
	Eating		**Meal Preparation**		**Shopping**
	Dressing		**Using Telephone**		**Laundry**
	Personal business		**Driving**		

Do you need a walker, crutches, or wheelchair? If yes, indicate which._____

Other medical Equipment? Specify._____

Do you have Home Health? YES NO What Agency?_____

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Patient Name:_____

Previous Doctor:_____

Which Hospital do you want to go to:_____

Advanced Directives: (Please indicate which ones are current):

HCP (Health Care Proxy) **YES** **NO** **Who:_____**

POA (Power of Attorney) **YES** **NO** **Who:_____**

DNR (Do Not Resuscitate Order) **YES** **NO**

DNI (Do Not Intubate) **YES** **NO**

No Directives at this time **YES** **NO**

Patient Signature:_____ Date:_____

POA or Proxy:_____ Date:_____

Patient Name:_____ Date:_____

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Assignment of Benefits and Authorization to Provide Treatment

A House Calls Practitioner will see you in your assisted living facility or our on-site clinic to provide medical care. Services include medical exams, evaluation and treatment of acute and chronic health conditions, lab tests (there may be a fee of up to $30.00 for the mobile phlebotomist/diagnostic tech to go to your home; that fee is due at the time of service), prescriptions, on-going monitoring and treatment to detect problems before they become critical. Visits are typically every 4-6 weeks.

House Calls bills third parties for "medically necessary visits", as would any healthcare provider. Our medical services are reimbursed by Medicare in the same way as when you go to the doctor's office.

_____

Last Name First Name MI SSN#

_____

Address

_____

City State Zip Code

I, _____ authorize House Calls of New Mexico, LLC to release to the Social Security Administration and Centers for Medicare and Medicaid Services (CMS) or its intermediaries or carrier or any other commercial insurance company, any information needed for this or a related health care service claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the care provider who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

I understand that Medicare and other insurance is considered a method of reimbursing the patient for fees paid to the physician, but are usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately my responsibility to pay the portion of the bill not paid by my insurance company (unless otherwise restricted by law or agreement House Calls may have with the insurer).

I also hereby grant my permission for Practitioners employed by House Calls to assess and treat me in my home or on-site clinic for medical problems. I understand that the Practitioner is a licensed health care professional in the state of New Mexico.

_____

Signature of Patient or Responsible Party Date

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Annual Patient Questionnaire

This form is so that you can update any of your information that may have changed and provide us with any records that we may not already have on file. It is important that we stay informed any medical preferences and health care decisions, known as "advanced directives", that you may have put in writing so that we can do our best to honor them. Please note that this is not a legal document. Use this questionnaire to indicate whether you have authorized an agent to make health care decisions on your behalf, and whether you have made any end of life decisions.

It is important to provide House Calls with a *signed copy of the documentation* for these decisions, such as the New Mexico Advanced Directives Form. Please attach the copies to this form after you complete and return them together. Alternatively, you can indicate if you would like us to contact a family member or your health care agent to get a copy of your directive. Lastly, advance planning is an ongoing process and we encourage you to continue discussing these issues with your doctor as needed. We will continue this process annually to make sure your information stays up to date.

What Family and Friends are involved in your medical care?

Please use this section to inform us of any friends and family who you would like us to share your medical information with. For example, are there other individuals in your household that may have to help you with any doctor's instructions? Please provide their name, phone number, and relationship.

Advanced Directives

Please use this section to let us know about any advanced directive documents you may have signed.

Power of Attorney

Name	Relationship	Tel. No

Contact my POA for documentation at _____

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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.

House Calls of New Mexico is required by law to maintain the privacy and confidentiality of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Health Information

- We may disclose your health information to other healthcare professionals for the purpose of treatment, payment or health care operations.
- We may disclose your health information to your insurance provider for the purpose of payment.
- We may disclose your health information to comply with state Workers' Compensation Laws, as necessary.
- We may disclose your health information to notify a family member or other responsible party about your medical condition if they are involved in your care.
- We may disclose your health information to public health authorities with the intent of preventing or controlling disease, injury, or disability; reporting child or adult abuse or neglect; reporting domestic violence; reporting to the FDA problems with products or reactions to medications; and reporting disease or infection exposure, as required by law.
- We may disclose your health information to a law enforcement official if necessary for law enforcement.
- We may disclose your health information to coroners or medical examiners.
- We may disclose your health information In the course of any administrative or judicial proceeding.
- We may disclose your health information for military, national security, prisoner or government benefits purposes.
- In the event House Calls of New Mexico is sold or merges with another organization, your health records will become the property of the new owner.

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You're Health Information Rights

You have the right to:

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that House Calls of New Mexico is not required to agree to the requested restrictions.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location, upon your request. • You have the right to inspect and copy your health information.
- You have the right to request that House Calls amend your protected health information. Please be advised, however, that House Calls is not required to agree to amend your protected health information. If your request is denied, you will be given the reason for denial as well as information about how you can disagree with the denial.
- You have the right to receive an accounting of disclosures of your protected health information made by House Calls.
- You have the right to receive a paper copy of this notice and privacy practices at any time upon request.

Changes made to this form and the privacy practices:

House calls of New Mexico reserves the right to amend these notices at any time making the new provision effective for all information it maintains. Until such amendment is made, House Calls of New Mexico is required by law to comply with these notices.

Complaints:

Questions or concerns about your privacy rights, or complaints about how House Calls of New Mexico has handled your health information should be directed to the office manager by phone (505) 898-2468. If you are not satisfied with our response to your concerns, you may submit a formal complaint to:

DHHS Office of Civil Rights
200 Independence Ave. SW Room
509F HHH Building
Washington, DC 20201

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