TPHC
Texas Physician House Calls

2925 Skyway Circle North, Irving, TX 75038, Tel: 972 675 7313 Fax : 972 675 7310
www.texashousecalls.com

Documentation of Face-to-Face Encounter

Patient name and Identification Aaron Jackson

I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter that meets the physician face-to-face encounter requirements with this patient on: (insert date that visit occurred)

12	10	13
Month	Day	Year

The encounter with the patient was in whole or in part for the following medical condition which is the primary reason for home health care: (List medical condition)

HTN, Pain, anxiety, constipation,

I certify that, based on my findings, the following services are medically necessary home health services:

- ✓ Nursing
- _____ Physical Therapy
- _____ Occupational Therapy
- _____ Speech-language Pathology
- X Home health aide
- _____ Medical Social Work

To provide the following care/treatments: (Required only when the physician completing the face to face encounter documentation is different than the physician completing the plan of care):

Monitor BP, Pain + anxiety, assist i ADLs
monitor/assist i Suprapubic catheter management

My clinical findings support the need for the above services because:

Pt is functionally a quadriplegic due to S/P GSW in 2011. In addition, he has hypertension; multiple pain management issues

Further, I certify that my clinical findings support that this patient is homebound (i.e. absences from home require considerable and taxing effort and are for medical reasons or religious services or infrequently or or of short duration when for other reasons) because

Pt is functionally quadriplegic S/P GSW in '01

Physician's Signature A Mitchell PA-S Scott

Printed Name Aaron Mitchell Date of Signature 12/10/13

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In general, the HIPPA privacy rule gives the individual the right to request restriction on uses and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home

PLEASE PRINT

Patient Information Date

Last name: Jackson	First Name: Aaron
Date of Birth: 11/23/73	Age: 40 Sex: M
Address: 7330 Brierfield Dr	City, State, Zip: Dallas TX 75232
Material Status: (M) S D W	Social Security # 433-17-5552
Home #:	☐ Ok to leave message with detailed information ☐ Leave message with call back number only
Cell #: 214-256-6247	☐ Ok to leave message with detailed information ☐ Leave message with call back number only
Work #:	☐ Ok to leave message with detailed information ☐ Leave message with call back number only
EMAIL ID: N/A	☐ Ok to leave message with linked information by any family member

Employer (Guardian's employer): N/A		Employer Phone number/ext.
Employer address:		Occupation:
Spouse/Parent Name:	Employer:	Employer Phone number/ext.
Spouse/Parent Soc. Sec #:	Date of Birth:	Occupation:
Primary Insurance:	ID#:	Group #:
Secondary Insurance:	ID#:	Group #:
Emergency Contact: LaKiesha Jackson		Phone #: 214-466-9815

All co-pays and/or balances must be collected in full at the beginning of each visit. Please remember that the insurance is considered of reimbursement and all deductibles and percentages due by the patient are to the paid before each visits. I understand that if I do not pay services as rendered that account will be forwarded to a collection agency and I will be responsible for any fees as a result of collection activity.

Agreed ~~LaKiesha Jackson~~ Date

Signature of Responsible Party

LaKisha Jackson

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HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA **requirements** officially began on April **14,** 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange or information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional services and care. Additional information is available from the U.S. Department of Health and Human Services. WWW.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide service or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal purse of providing care means that such records may be left, at least temporarily, in administrative area such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the **office** for the handling of charts, patient records, PHI another documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, text, US mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might and valuable or informative.
3. The practice utilizes & number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of H1PAA
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payer in normal performance of their duties.
5. You agree to bring any concern or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patient with access to their records in accordance with state and federal laws.
8. We may charge, add, delete or modify any of these provision to better serve the needs of the both the Practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are obligated, internal policies to conform to *your* request.

I, x Aaron Jackson date_____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain, in force from this time forward.

Name _____ Date:_____

DOB:_____ Age:_____

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Patient Name : _____

CONSENT FOR TREATMENT

As a condition of being admitted for treatment as an outpatient of the Texas Physician House Calls, (TPHC) I agree to-the following:

1. **Consent of Treatment:** I voluntarily request and consent to Treatment by TPHC, I authorize the treating physician(s) and their assistants and TPHC to perform medical treatment and technical procedures, to administer drugs, and to render **care** as their judgment may indicate to be necessary or advisable.

   I understand that the services provided to me by TPHC are provided by doctors or physician assistants, podiatrists, psychologists, psychiatrists, physical therapist nurse practitioners.

   TPHC will maintain a record of the care and services you receive. This consent only covers your protected health information created while you are a patient of TPHC. Your protected health information pertains to your diagnosis and or treatment by TPHC, Including but not limited to information-concerning medical illness (except for psychotherapy notes), *use* of alcohol or drugs or communicable diseases such as Human Immunodeficiency Virus ("HIV"), and Acquired Immune Deficiency Syndrome ("AIDS"), laboratory test results medical history, treatment history, treatment progress or any other such related information

   By signing this form, you consent to TPHC's use and/or disclosure of pre existing health information about you for treatment, payment, health care operations and as otherwise allowed by law. Our *Notice of Health. Information Practice provides information about how TPHC and physician on its medical staff may use and /or disclose protected* health Information about you for treatment, payment, health care operations and as otherwise allowed by law.

2. **Authorization to Release Medical Information** : I authorize TPHC any treating physician to furnish requested information from patient medical and other records to
   a. Any insurance company or third party payer for the purpose of _____ payment on the account of TPHC or a treating medical provider.
   b. Any other persons or entities financially responsible for the patients treatment and;
   c. Representatives of governmental agencies in accordance with law. Such [information may include, but Is not limited to Information about communicable diseases such as AIDS. I authorize release of information from or the review of the patient records for medical audit, utilization reviews, or quality assurance reviews. I authorize TPHC to release information from our copies of the patient medical records to the referring physician or to any skilled nursing facility or health care facility which I may be transferred.
   d. Lastly, only the designated person listed are authorized to read or have access to or be included in patient care conference or discussers on my behalf. I understand that this documents does not supersedes traditional power of attorney yet it is my intent that only the person(s) listed are herby granted access to my records

   _____

3. **Assignment of Insurance Benefits** : I Assign to TPHC all right to file and interest in any payment due me for services described herein as provided in a insurance policy or employee benefit plan, I further assign all rights to payment due to me for physician services under said policies to physicians which provide treatment for me while I am an TPHC patient I understand I am responsible for providing to TPHC all insurance Information available at the time of this hospital visit to allow for verification: I agree to pay any amounts due the hospital or physicians that are not covered by insurance.

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4. **Medicare / Medicaid Assignment of Benefit:** I certify that the information given by me in applying for payment under the Social Security Act is correct. I authorize the release of information concerning me to the Social Security Administration or tis intermediaries or carriers as well as any information needed for filing a Medicare claim. I request that payment of authorized benefit be made on my behalf. I assign benefits payable for services to the physician or organization submitting a claim to Medicare for me.

   Medicaid : I understand that Medicaid recipients are responsible for payment for any medical services received that are beyond the scope of the Texas Medicaid program, as determined by the Texas Department of Health and Human Services. All such payments are due and payable at time of discharge.

5. **Additional Understandings:**
   a. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me with respect to the results of any examination or treatment to be performed by TPHC .
   b. I authorize TPHC to use its discretion to retain or dispose of any issue removed during any treatment or diagnostic procedure.

I have read this Contract and agree to its terms.

Signature of Patient Aaron Jackson

Patient is unable to sign because:

_____

_____

Signature of Legal Representative (If Applicable)

_____

_____

Printed Name of Person Signing & Relationship to Patient Date

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I authorize Texas Physician Housecalls (TPHC) to release / obtain (circle one) medical information concerning

Patient :_____ Date of Birth_____ SSN_____

Address : _____ Date of Service _____

City : _____ State_____ Zip _____ Phone :_____

This information is to be released to / obtained from (circle one)

Name : _____

Address : _____ City / State _____ Zip _____

Phone / Fax # _____

Please release the following information indicated by an X"

( ) History & Physical ( ) Consultation ( ) Assessment

( ) Lab Results ( ) Radiology result ( ) Treatment Plan

( ) Billing Records ( ) All Records

( )Discharge Summary ( ) Medications ( )Other _____

This information is necessary for the following purpose:

( ) Follow up Care ( ) Patient Requesting Disclosure ( ) Disability Benefits ( ) Attorney /Legal

( ) Insurance ( ) Transfer of care ( ) Other (Please Explain) _____

Please release my information via: email Pick-up Fax (#

The patient or the patient's representative must read the following statements.:

I, the undersigned, understand that I may revoke this consent at any time in writing, except at the extent that period has been taken in reliance on it and that in any event this consent shall expire 6 months after the last date of service (Otherwise, specified date_____). I understand that the provision of my health care and the payment for *my* health care will not be affected if I do not sign this form. Upon, co ,Texas Physician Housecalls (TPHS) can no longer use or disclose my Information for the above purposes without anew authorization, I understand that information used or disclosed pursuant to this authorization may be subject to no-disclosure by the recipient and no. longer protected by federal privacy regulations. I understand my health care and payment for healthcare will not be affected if I do not sign this form.

I understand that the above information may include records / reports from other health care providers involved in any care or treatment. I Have read this authorization and understand what information will be used or disclosed, who may use and disclose the information and the recipient(s) of that information

* 1 understand any of the above requested information may include results of sexual transmitted diseased acquired immunodeficiency syndrome (AIDS) Human Immunodeficiency Virus (HIV) tests if any were performed. Further, I understand any of the above requested information may include results of alcohol drug substance abuse and /or diagnosis and treatment of psychological disorders

I understand that I may see and obtain a copy of the information described on this form if I ask for it, and that I get a copy of this form after I sign it

TO THE PARTY RECEIVING THIS INFORMATION: This information is being disclosed to you from records where confidentiality may be protected by federal and /or state level. If so, regulations 42 CFR, part 2, prohibit further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation.

Dawn Jackson

SIGNATURE Of Patient or Authorized Party **Date** **RELATIONSHIP to Patient**

WITNESS : _____

REASON Patient is not Signing _____

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Medication Use Agreement

I, _____ understand that I have pain that has not been adequately controlled with other medications and that my function is limited by the pain. I understand that the intent of the medication is to increase my ability to do more, though the medication is unlikely to eliminate the pain.

I will take the medication only as prescribed; I will not take any sedatives, alcohol or other pain medications without the prior approval of any doctor.

I understand that the medication will be prescribed only by **Dr.Ketha / TPHC / Sumana Ketha MDPA** and only according to the agreed-upon schedule. Prescriptions will be provided only during regularly scheduled appointments. Refills will never be provided by telephone.

I will not seek or accept any medications for pain other than those prescribed by my doctor. "Medications for pain" includes prescriptions from other doctors, medications borrowed or accepted from family or friends, and any illicit or street drugs.

Medication refills will be provided as written prescriptions only. No refills will be given prior to the next schedule appointment date. If I do not keep my appointment, I will not receive a refill. Two (2) appointment cancellations with less than one workday's notice or two (2) no-show appointments may constitute grounds for immediate termination of this agreement.

I understand that my doctor is under no obligation to provide these medications to me, and that she or he reserves the right to discontinue these medications at any time. At my doctor's discretion, I agree to cooperate with random drug testing, which may be requested at any time. If I refuse, I understand the medication will be stopped.

I understand the lost or stolen medication will not be refilled under any circumstances. It is my responsibility to protect and secure any medications. This includes keeping the medication out of reach of children. A copy of police report will be required for any lost or stolen narcotics prescriptions.

I understand that my doctor may require specialist evaluation of my treatment, and I agree to keep appointments when my physician refers me. My doctor will send a report of my care and copy of this agreement when a referral is made.

In addition to the above agreements, I accept the right of my doctor's medical staff to terminate this agreement for any of the following reasons:

1. I seek or obtain any pain medication from a source other than my doctor.
2. I give, sell or in any way distribute prescribed medications to any other person(s),
3. I in any way attempt to forge or alter a prescription,
4. My medical condition declines to the point at which, in the judgment of my doctor, continued therapy with the medication presents a danger to my well-being or safety,
5. There is evidence that I am no longer receiving a reasonable therapeutic benefit from the medication, or my doctor determines that I am no longer a good candidate to continue the medication.

I agree to fill my prescription only at the pharmacy I listed below. If I change pharmacies, I will contact my doctor's office and provide them with the name, address and phone number of the new pharmacy. Under no circumstances will I obtain medications from more than one pharmacy at a time. In order to verify appropriate medication use, my doctor's office will provide my chosen pharmacy with a copy of this agreement.

I understand that any alternation in my medication prescriptions will require a new written agreement.

Pharmacy Name _____

Pharmacy Address _____

_____

Pharmacy Telephone _____

Medication Name, Dose and Directions _____

Number of Pills prescribed _____ Frequency of Appointments _____ days

I understand that by signing this agreement, I must abide by the rules reviewed above and that failure to abide by these agreements will result in the termination of medication prescriptions and possibly the termination of services from my doctor and his or her practice.

_____ ___/___/___ _____ ___/___/___

Patient Signature **Date** **Physician signature** **Date**

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AUTHORIZATION OF DISCLOSURE OF INFORMATION

PATIENT NAME_____BIRTHDATE_____

ADDRESS CITY STATE ZIP

I HEREBY AUTHORIZE_____

ADDRESS CITY STATE ZIP

PHONE# FAX#

TO DISCLOSE MY PROTECTED HEALTH INFORMATION AS DESCRIBED BELOW TO:

ADDRESS CITY STATE ZIP

PHONE# FAX#

THE INFORMATION TO BE DISCLOSED IS LIMITED TO (CHECK ITEMS TO BE DISCLOSED):

□ Progress Note □ Labs □ X-Ray/EKG □ Officials visits
□ Hospital Visits □ Treatment Notes □ Other, please specify: _____

SPECIAL AUTHORIZATION FOR RELEASE OF RECORDS FOR MENTAL HEALTH/REHABILITATION, ALCOHOL OR DRUG ABUSE AND OR DEPENDENCY, HIV ANTIBODY TESTS AND/OR AIDS DIAGNOSIS AND TREATMENT.(please initial if apply).

_____ include information related to diagnosis and/or treatment for alcoholism and/or drug abuse and or dependency.
_____ include information related to diagnosis and/or treatment for mental health/rehabilitation.
_____ include information related to HIV test results and/or AIDS diagnosis and treatment.

*A listing of the statutory expectations of the release of HIV tests results without consent is available.
Purpose or Need of Disclosure.

_____At the request of the individual.

I understand that the health information disclosed as result of this authorization may no longer be protected by the federal privacy stands and my health information might be redisclosed without obtaining my authorization.
I understand that I have the right to.

- ► Receive a copy of this authorization.
- ► Refuse to sign this authorization and that treatment, payment, enrolment in a health plan or eligibility for health care benefits may not be contingent on my signing this authorization
- ► Revoke this authorization, expect on the extent that the person(s) and organization(s) listed above has already made in reference to this authorization.

I hereby release you, the physician, your practice, and your employees from and all liability for fulfilling the authorization request for release of medical information. I understand that his consent is revocable by me, in writing, at any time except to the extent that action has been taken in reliance on it. I also understand that this consent will expire either ninety (90) days after the date of this signature or automatically when the records/information requested on this form has been provided to the requester.

Signature of patient (Guardian) Date

Relationship of signed party Date

Prohibition of Redisclosure: This information has been disclosed to you from the records whose confidentially is protected by law. Any further disclosure is prohibited

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ADVANCED CARE DIRECTIVE

DO YOU HAVE AN ADVANCE CARE DIRECTIVE? Yes No

An Advanced care directive are specific instructions prepared in advance that are intended at direct a person's medical care if he or she becomes unable to do so in the future. This is also known as power of attorney, do not resuscitate (DNR), or living will.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's notice of privacy practice's which explains how may medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document upon request.

Signature of patient or personal representative _____ Relationship of patient or personal representative

Date_____

Release of information

This serves as an authorization for the following person(s) to sit in for the consult, provide information about my illness, and request information at any time in person or by phone.

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____ Date: _____

Patient signature

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FINANCIAL POLICY

The type of relationship we maintain with our patients is important to us in an effort to prevent misunderstanding; it has become necessary to implement the following guidelines:

Effective _____ , payment for our Medical Services will be due at the time the services are rendered. All charges are patient's responsibility regardless of insurance benefits. We file insurance as a way to assist you in reducing your out of pocket expenses. Therefore, if we are able to verify benefits in advance and get information relating to coverage and limitations, we require that you pay the deductibles and percentages not covered by insurance on the date of service. We are happy to file your insurance for the remaining portion they claim to cover. Please understand our difficulties in collecting money from insurance companies. We are simply the providers of medical services to you. Therefore, the more you low about your coverage, the better it is. Whenever there are claim disputes, we will request that you contact your insurance company for clarification.

If an insurance payment is not received within 45 days of the date of service, you will be required to pay the insurance portion regardless of the status of the claim. This balance will be due in our office 15 days from the date of the statement. If any insurance benefits are received after you have cleared your account, we will forward the insurance check to you. if a. balance remains after insurance pays, you will receive an explanation of benefits from your carrier that you can refer to for coverage information. If you need more detailed information regarding what was or was not paid, please call your insurance company.

METHODS OF PAYMENT & INTEREST RATE ON UNPAID BALANCES

We accept cash, Visa and MasterCard. We do charge an interest rate of 18% annually that begins on the date of services rendered. However, if the entire balance is paid in full by you and/or your insurance company within 45 days of treatment, we will waive the interest, if the balance is not paid within 45 days, the interest will be added to the balance.

COLLECTION

All accounts over 60 days old will be considered delinquent and payable immediately. if payment is not received by 90 days, the account will be referred to an outside collection agency or attorney's office and will be reported to the credit bureau. The patient or responsible party will be responsible for all attorneys and/or collection agency fees' and court cost. As always our primary goal is to provide the finest Family Medicine Care to all our patients. Thank you for your cooperation in assisting us in this process.

Aaron Jackson

Signature

Date