DOCTORS MAKING HOUSECALLS

2511 Old Cornwallis Road, Suite 200, Durham, NC 27713 | newpatient@doctorsmakinghousecalls.com | Phone: 919.932.5700 | Fax: 919.933.6881

Patient: _____ DOB: ____/____/_____

(Please Print Patient's Name)

Authorization

1) I authorize the release of my medical records to *Doctors Making Housecalls* upon its request for dates of treatment going back 2 years from the date below, including all discharge summaries, progress notes, consults, laboratory tests and imaging studies, for the purpose of continuity and coordination of care.
2) I authorize payment of my medical benefits to *Doctors Making Housecalls* for services rendered, and for *Doctors Making Housecalls* to give my insurance company any information about services rendered to me as necessary to process claims.
3) I understand and agree that I am financially responsible for all charges for services rendered to me, including balances owed after insurance payments, and authorize the use of my credit card for these charges.
4) I understand that
    - Trust is the foundation of a doctor/patient relationship.
    - The information that you provide us will be kept in the strictest of confidence.
    - While protecting your privacy is extremely important to us, there may be certain situations that may require us to use or disclose your healthcare information.
    - We will be using your health insurance information for payment. A claim may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures performed, and/or supplies used.
5) I want this authorization to expire only upon my death. I understand that I have the right to revoke this authorization by written notice to *Doctors Making Housecalls*. I also understand that disclosed information may be re-disclosed by the recipient named herein.

_____

Date (Signature of Patient or Patient's Power of Attorney)

Advanced Beneficiary Notice

As you know, Medicare does not pay for all your medical expenses, even some services that you or your physician have good reason to think you need. Medicare does not pay for the services listed below, which means you are responsible for payment at the time of service.

SERVICES	COST	REASON
Trip Fee – ***Waived in senior communities on scheduled visit days***		
• Weekdays	$95	Not a covered benefit
• Weekends	$120	Not a covered benefit
• Out-of-Area Surcharge	$25-$50	Not a covered benefit

NOTE: Approval will be automatic for urgent care visits requested by assisted living facilities (ALFs) in an effort to avoid an unnecessary trip to the emergency room; for non- urgent visits to ALFs, approval will be sought for each charge.

_____

Date (Signature of Patient or Patient's Power of Attorney)

Chronic Care Management Code

I have read the information regarding Medicare's Chronic Care Management Code and agree to it.

_____

Date (Signature of Patient or Patient's Power of Attorney)

Vaccination Services

Please check the box if you would like to receive the following vaccinations:

☐ Yearly Flu Shot ☐ T-Dap Non-Medicare covered

☐ One time dose of Pneumovax ☐ One time dose of Prevnar

I have received: Pneumovax (date received) _____ Prevnar (date received) _____

Additional On-Site Services

Please check the box if you would like to receive the following On-Site services when available:

☐ Podiatry Services ☐ Psych Services ☐ Dentistry Services Non- Medicare Covered

_____

Date (Signature of Patient or Patient's Power of Attorney)