515 W. Main Street, Suite 115, Allen, TX 75013
Phone: (214) 491-4191 | Fax: (469) 519-0407
WillisSeniorHousecalls.com

WILLIS
Senior Housecalls

GENERAL INFORMATION

DATE/ (mm/dd/yyyy) **_____**

Patient's Name: _____
Last/ First

D.O.B. _____ **Age: _____**

Address: _____
(Street, apt. #)

City: _____ State: TX _____ Zip Code:_____

Phone #

SSN: _____ **Sex: M F**

Marital Status: M S D W

Emergency Contact: _____ _____ (_____) - _____- _____
Relationship to patient Phone #

Name of Insurance: _____ **Member ID/ Group ID**: _____

Preferred Pharmacy: _____**E-mail**: _____

Pharmacy Phone: _____

I hereby authorize Willis Senior Housecalls and/ or agents to use my general information (address, phone (text messages), and email) to contact me to facilitate anything related to my medical care.

PERSON RESPONSIBLE FOR PAYMENT

_____
Last Name First and Middle Name

Relationship to patient
◯ Mother ◯ Father ◯Other

_____
SSN: _____ **Sex**: M F

_____ **Age**_____
D.O.B (mm/dd/yyyy)

Address_____
(Street, apt #)

Employment _____

(_____) - _____- _____
Work phone

City: _____ **State**: _____ **Zip code**: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I request that payment of authorized insurance benefits from any applicable insurance carrier be made on my behalf to Willis Senior Housecalls for any services furnished me by that provider. I authorized medical information needed to determine these benefits or the benefits payable for the related services to be released to the insurance company and its agents. I understand that even though I have some type of insurance coverage, I am responsible for the payment of services. Please note: It is the policy of this office that any parent who requests treatment for the child is responsible for the payment of all subsequent fees.

Name: _____ Signature: _____

Relationship: _____ Date: _____

I certify that the information given by me in applying for payment under title XVLlll of the Social Security Act is correct. I authorize any holder of medical or other information about me to the centers for Medicare and Medicaid Services or its intermediaries or carriers any information needed or for this or a related Medical claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician and/ or midlevel (Nurse Practitioner or Physician Assistant) provider services to the provider or organization furnishing the services or authorized such provider or organization to submit a claim to Medicare for payment to me. I understand that I am responsible for any health insurance deductibles and coinsurance.

FINANCIAL RESONSIBLITY

I understand that regardless of my assigned insurance benefits, I am responsible for the total charges for all services rendered and I agree to honor the current Clinic payment policy. I understand that, in the unable to pay in full at the time service is rendered; Willis Senior Housecalls may inquiry of my credit history to evaluate my credit worthiness. I further understand that unpaid patient accounts may accrue interest (1.5%)per month/ 18% per year) and I agree to pay any such interest charges in addition to any amount unpaid by any insurance coverage. I further understand that should this account become delinquent and it becomes necessary for the account to be referred to as attorney or collection agency for collection suit, I agree to pay all reasonable attorney fees and/ or collection expense.

INSURANCE ASSIGNMENT

In consideration of services rendered or to be rendered, I hereby irrevocably assign and transfer to Willis Senior Housecalls, Allen, Texas any benefits under sickness liability, auto or accident insurance, and any other coverage for the payment of such services rendered. I agree to cooperate, aid and assist the clinic in procuring all possible insurance benefits, including initiation and fulfillment of all policy provisions such insurance companies may require for payment. I understand it is my responsibility to the provider for charges not paid pursuant to this assignment.

I hereby authorize the staff of Willis Senior Housecalls to administer such care/ treatment as it is necessary based on the clinical providers assessment and diagnosis. I understand that such care may include medical and surgical treatment, and laboratory, and radiologic test. I certify that no guarantee of assurance has been made to the results that may be obtained.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize staff of Willis Senior Housecalls to disclose necessary information from my medical record to the following parties when requested for the purpose as stated herein: to any health care provider for the purpose of providing continuing professional care and to any insurance company or third party payer (or their agent/s) for the purpose of obtaining payment to employees, offices and attending clinical providers are released from legal responsibility or liability for the above information to the extent indicated and authorized herein. I understand this released specifically includes any and all blood and related tests including test results reflecting presence of HIV, HBV and other diseases, all of which I specifically authorize to be so released.

_____	_____	_____
Signature of Patient or Representative	Relationship to patient	Date
_____	_____	_____
Responsible Party (if different)		Date

WILLIS
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Advanced Practice Nurses Consent for Medical Treatment

Willis Senior Housecalls has an advanced practice nurse to assist in the delivery of primary health care. Willis Senior Housecalls provides adult primary care services to patients in their place of residence. Willis Senior Housecalls is owned and operated by David L. Willis, a certified Geriatric Nurse Practitioner. Willis Senior Housecalls Medical Director and overseeing physician is Michael Williams, DO.

Geriatric (Gerontological) Nurse Practitioners (GNPs) are certified nurse practitioners with advanced specialty education in health issues that impact older adults and their resultant consequences on physical, cognitive, psychological and social function. They have established competence in the diagnosis, treatment and management of acute and chronic conditions often found among older adults and generally associated with aging. Should you desire to be seen and treated by a physician only you should make an appointment with another clinic. I have read this document and hereby agree the medical services of a nurse practitioner for my health care needs.

Patient's Name Date

Patient's Signature Date of Birth

In April of 2003, new federal requirements regarding privacy of information for health care patients took effect. HIPAA, the Health Insurance Portability and Accountability Act requires that all medical providers, insurance companies, and others, put in place controls to ensure the your personal medical information is safe.

Willis Senior Housecalls requires that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital, and insurance company.

By signing this form, consent to our use and disclosure of protected health information about your treatment, payment, and health care operation. You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Signature of Patient: _____ **Date**:

Name of Patient: _____ **Date of birth**: _____

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents, or other to call and request the results of tests and procedures. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your test results released to a family member you must sign this form. Signing this form will only give consent to release laboratory and radiology results to family members indicated below. This consent will not allow Willis Senior Housecalls to release any other information to these family members.

You have the right to revoke this consent in writing, except where we have already made disclosures in reliance to your prior consent.

1.) _____ Relation to patient: _____ Date: _____

2.) _____ Relation to patient: _____ Date: _____

Patient name: _____ **Patient Signature**: _____ **Date**: _____

Authorization to Leave Messages with Household Members/ Answering Machine

From time to time it is necessary for representatives of Willis Senior Housecalls to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the patient that medical staff would like to discuss lab or procedure results, or to ask a patient to call WSH regarding an issue or concern. The purpose of this consent is to leave massages with members of your household or on your answering machine. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Name: _____ **Date**: _____

Consent and acknowledgement of Receipt of Privacy Notice

I understand that as part of provision of healthcare service, Willis Senior Housecalls, create and maintain health record and other information describing among other things, my health history symptoms, diagnosis, treatment, examination, and test results, prescription drug history, and any plans for future care or treatment.

I have been provided with a notice of privacy practice that provides a more description of the use and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of revised notice to the address I have provided. I understand that I have the right to request restriction as to how my information may be used or disclosed to carry out treatment, payment or healthcare operation (Quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restriction requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purpose of treatment, payment and healthcare operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

_____
Full Name

_____
Date

_____
Signature

_____
Date of Birth

_____
Guardian/POA

WILLIS
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Release to Photograph, X-Ray & Ultrasound

Willis Senior Housecalls requests patients to allow photographing of patients for identification purposes, X-rays taken if necessary and ultrasound to be used in diagnosis or identification of specific illnesses or conditions. The Photograph, X-Ray & Ultrasound images will not be distributed outside the medical practice unless collaboration with other physicians or practitioners is medically necessary.

_____ _____

Full Name Date

_____ _____

Signature Date of Birth

Patient Consent Agreement for Chronic Care Management (CCM) and Remote Patient Monitoring (RPM) Services

My provider has recommended that I receive Chronic Care Management (CCM) services and/or Remote patient monitoring. Since I have been diagnosed with two or more chronic conditions, which are expected to last at least twelve months, and place my health at risk of decline I qualify for services to monitor my conditions.

I understand that CCM services include: 24/7 access to a member of my care team via phone or other non-face-face means; a designated practitioner or care team member with whom I am able to get successive routine appointments; systematic assessment of my health care needs; processes to ensure timely receipt of preventative care services; oversight of my medication regimen; a jointly created and comprehensive care plan that is congruent with my choices and values; management of care transitions across all of my providers and settings; coordination with home and community based clinical service providers.

I understand with RPM services this includes reporting important clinical data either by self -reporting and/or wearing/utilizing a device that records specific things as designated by my provider such as blood pressure, weight, glucose and blood oxygen levels. I understand that I am responsible to report data as instructed by my provider.

By signing this agreement, I consent to receive these services and agree to the following:

My provider has explained to me the availability and the elements of the CCM/RMP services that are relevant for my condition(s). I consent to receive CCM/RPM services from the provider listed above and/or any associates he/she may designate to assist in providing me with CCM/RPM services.

I understand that I have the right to stop CCM/RPM services at any time (effective at the end of a calendar month) with this provider and the effect of a revocation of this agreement. I may revoke this agreement verbally by notifying my provider and/or nurse.

After revocation of this agreement, I may opt to receive CCM/RPM services from another healthcare provider in the month following revocation of this agreement. I understand that Medicare permits only one practitioner to furnish and be paid for these services during a calendar month. I understand that I will receive a written or electronic copy of my comprehensive care plan upon my request.

I authorize electronic communication of my medical information with other treating providers. My provider has explained to me any potential cost-sharing obligations that may apply when receiving CCM/RPM services.

Patient Name Date of Birth

Patient Signature Date

Willis Senior Housecalls PLLC
Authorization to Release Medical Records

Name of Patient _____ Date(s) of Service _____

Date of Birth _____ Social Security Number _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

PATIENT INFORMATION IS NEEDED FOR:

Continuing Medical Care	Military	Social Security/Disability
Insurance	Personal Use	Other: _____
Legal Purposes	School	_____

INFORMATION TO BE RELEASED OR ACCESSED:

History & Physical	Consultation Report	Emergency Room Record
Operative Reports	Discharge/Death Summary	Face Sheet
Lab/Path Reports	X-Ray Reports/Images	Other: _____

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

TO:

Willis Senior HouseCalls, PLLC 214-491-4191

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

515 W. Main Street, Ste 115 Allen, Texas 75071 469-519-0407

Address (Street, City, State and ZIP) Fax Number

FROM:

_____

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

_____

Address (Street, City, State and ZIP)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire one (1) year from the date of my signature, unless I revoke the authorization prior to that time.

Signature: _____ Date: _____

Patient or Legally Authorized Representative

_____ Relationship to Patient: _____

Printed Name of Patient or Legally Authorized Representative