# TREASURE VALLEY HEALTHCARE & HOUSECALLS

GENERAL CONSENT TO TREATMENT & ASSIGNMENT OF BENEFITS PACKAGE

House Calls
Primary Care that Comes to You

## CONSENT TO TREAT

I, _____, ("Patient") voluntarily consent to care and treatment by Treasure Valley Healthcare & Housecalls ("PRACTICE") and its affiliated physicians, practitioners, and staff, including but not limited to outpatient medical, surgical, nursing, and therapeutic care; diagnostic, laboratory, and radiological tests and procedures; administration of pharmaceuticals or anesthesia; and such other care as deemed reasonably necessary or advisable by the attending physician, practitioner or staff member.

I hereby agree and consent to the following;

1. If PRACTICE personnel suffer a needle stick or are exposed to blood or body fluids, I consent to testing for any blood-borne disease for the protection of PRACTICE personnel.
2. **CONSENT TO MEDICATION HISTORY**. I understand that by signing this consent form I am giving my healthcare provider permission to collect and giving my pharmacy and my health insurer permission to disclose information about my prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescriptions medications to treat AIDS/HIV, pain management and mental health medications.
3. **CONDITIONS FOR TREATMENT AT PRACTICE**. In consideration for the care and treatment that Patient will receive or has received at PRACTICE, I agree to the following:
    a. Payment. I agree that I am responsible for any co-payments, deductibles or other charges for services to Patient that are not paid by insurance, government programs, or other payers, except as prohibited by applicable law or any agreement between my insurance company and PRACTICE.
    b. I agree to make such payments according to PRACTICE's regular terms of payment.
    c. Where appropriate, I agree to submit and cooperate with PRACTICE in submitting claims to entities from which payment may be obtained, including any government program, insurance company, or other third parties.
    d. I understand that I will remain responsible for any amount not paid by insurance or a third party. If the Patient's account becomes delinquent, I agree to pay interest and fees according to PRACTICE's policies, including but not limited to reasonable costs of collection, collection agency fees, attorney's fees, and court costs.
    e. I agree that any overpayments collected for Patient's admission or treatment on this occasion may be applied directly to any delinquent account of Patient.
4. **Assignment and Authorization**. I hereby assign and authorize direct payment to PRACTICE of any payments or other benefits to which I or the Patient may be entitled from any government program, insurance company, or other entity that is or may be liable for costs associated with Patient's care. I agree that this assignment will not be withdrawn or voided at any time until Patient's account is paid in full. To the extent such authorization is required by applicable regulations, I hereby authorize Practice or any other holder of medical information about the Patient to release such information to the Centers for Medicare and Medicaid Services and its agents as necessary to determine benefits payable for services provided to Patient. This authorization shall not modify or limit Practice's right to use or disclose protected health information as otherwise allowed by applicable law or Practice's Notice of Privacy Practices.
5. **Billing Practices**. I understand and agree that any quote of charges for services rendered and/or insurance benefits available are estimates based upon the best information available at the time. PRACTICE may amend such quotes and I will be responsible for charges for services actually rendered. I understand and agree that PRACTICE will require payment of all accounts at the time the services are rendered unless PRACTICE has expressly agreed to contrary arrangements.

Where insurance is available, PRACTICE will bill and allow a reasonable time for the insurance company to pay. I will be responsible for any amount not covered by insurance. Should payment not be received, the Patient and I will be billed for all charges and interest. **Payment is due upon receipt of the bill**.

6. **NO GUARANTEE**. I understand and agree that the practice of medicine is not an exact science and that no guarantees have been made to me regarding the results of Patient's care or treatment at PRACTICE. PERSONS FOR WHOM PRACTICE IS NOT LIABLE. I understand that PRACTICE is only responsible for the acts of its employees acting within the scope and course of their duties. I understand that persons who are not employed by PRACTICE may be involved in my care or treatment, including but not limited to other practitioners, laboratories, diagnostic testing facilities, contractors, vendors, product technicians, etc. I understand that PRACTICE is not liable for the acts or omissions of non- employees or PRACTICE\employees acting outside the course and scope of their duties.

I have fully read, understand, and agree to this Consent of Treatment and Assignment of Benefits. I certify that I am either the Patient or the Patient's legally authorized representative, and have authority to execute this Consent and Agreement on behalf of Patient. I have had the opportunity to ask questions concerning this Consent of Treatment and Assignment of Benefits and have had my questions answered to my satisfaction.

_____ _____

Patient or Patients Representative Signature Date

**If Patient Representative**:

Printed Name: _____ Relationship: _____

**Patient Information**:

Patient Name: _____ Facility: _____

Address: _____

Phone: _____ Date of Birth: _____

Email: _____

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## HIPAA Privacy Authorization Form

Effective Date: July 8, 2020

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. Authorization. I authorize _____ (previous primary care provider) (health care provider) to use and disclose the protected health information described below to a business entity known as Treasure Valley Healthcare & Housecalls (individual seeking the information).

2. Effective Period. This authorization for release of information covers all past, present, and future periods of health care.

3. Extent of Authorization. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

4. Use. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. Termination. This authorization shall be in force and effect until the death of Patient, at which time this authorization form expires.

6. Revocation Rights. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. Benefits. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. Disclosure. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Patient or Patients Representative Signature Date

**If Patient Representative**:

Printed Name: _____ Relationship: _____

Address: _____

Phone: _____

Email: _____

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## TVHC Medical History Form

Patient Name: _____ DOB: _____

Address: _____

Person completing medical history form: _____

Relationship to patient: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

**Current/Past Medical Problems**: Example: Stroke, Heart Trouble, High Blood Pressure, High Cholesterol, Thyroid Problems, Eye Problems, etc. Current or Past Medical Problems. Please include approximate date of onset of diagnosis.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

**Past Surgeries**: Example: Gall Bladder removal, Appendectomy, Hysterectomy with or without ovaries removed, cataract surgery, prostate surgery, heart surgery, angioplasty, colonoscopy, etc. Please include surgeon / hospital and approximate date if known

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

**Allergies and reaction**: Example: rash, swelling, trouble breathing, etc. List all Allergies, Including Medications Reaction.

1. _____
2. _____
3. _____
4. _____

**Medications**: Please list both prescription and over-the-counter medications (such as pain relievers, constipation medicine, heartburn medicine, vitamins, etc.) and how many times a day medication is taken. For as needed medication, please give an estimate of how often you take it (once every other day, once a week, once or twice a month) Add another sheet with additional medications if necessary. Please also include strength (mg or mcg). Facilities may attach MAR.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

**Pharmacy Preferred**: _____

Phone #:_____ Location: _____

**Family History**: Please list medical problems of close family members (example: dementia, cancer (and what type), heart disease, stroke, hypertension, depression, etc.). If anyone has died, please list the age of death and the cause of death. Please include aunts, uncles if applicable.

Father: _____

Mother: _____

Brother(s): _____

Sister(s): _____

**Family History (continued)**

Children: _____

_____

Other: _____

_____

**Social History**:

Tobacco Use: □ Never □ Quit □ Current Smoker

Packs per day on average: ____ Years smoked: ____ Quit Date: _____

Type: □ Cigarette □ Cigar □ Pipe □ Chewing

Alcohol Use: □ None _____ Number of drinks per week

Has drinking alcohol ever been a problem for you □ Yes □ No

If treatment sought, please list: _____

Illegal Drug Use: □ No □ Yes Type: _____

Sexual Activity: □ Not Currently □ No □ Yes Is protection used: _____

**Lifestyle**:

Describe anyone who cares for you (List support system / care providers): **(Marking yes to "Do you Authorize" authorizes staff of Treasure Valley Healthcare & Housecalls to speak with them regarding your medical information)**

| Name | Relationship | Phone | Do you give Authorize | |
|---|---|---|---|---|
| _____ | _____ | _____ | YES | NO |
| _____ | _____ | _____ | YES | NO |
| _____ | _____ | _____ | YES | NO |
| _____ | _____ | _____ | YES | NO |

What are your hobbies (past & present): _____

Past Occupation(s): _____

Years of Education: _____

Religion/Faith: Is your faith important to you and does it affect your health care decisions:

_____

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**Advance Directives** (please provide a copy of each for your chart):

□ Durable Power of Attorney for Healthcare (DPOA) □ Living Will □ Guardianship

□ Do Not Resuscitate Form

Name / Relationship / Phone # of DPOA / Guardian: _____

_____

Would you like information on Advance Directives? □ Yes □ No

**Insurance Information**: (please provide a copy of each for your chart):

**PRIMARY INSURANCE**:

Provider: _____ Carrier Payer ID: _____

Insurance Address: _____

Insurance ID #: _____

Insurance Group Name: _____ Group #: _____

Notes: _____

**SECONDARY INSURANCE**:

Provider: _____ Carrier Payer ID: _____

Insurance Address: _____

Insurance ID #: _____

Insurance Group Name: _____ Group #: _____

Notes: _____

**Billing Information**:

Address: _____

City: _____ State: _____ Zip Code: _____

C/O: (If applicable) _____

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**Immunizations**: Please indicate which immunizations you have had last date if known.

| | No | Yes | Date(s) |
|---|---|---|---|
| Influenza (Flu) | ____ | ____ | _____ |
| Pneumococcal (Pneumonia) | ____ | ____ | _____ |
| Zoster (Shingles) | ____ | ____ | _____ |

**Activities of Daily Living**: Please indicate the appropriate level of care required for each:

| | No Assistance | Partial Assistance | Total Assistance |
|---|---|---|---|
| Feeding | _____ | _____ | _____ |
| Bathing | _____ | _____ | _____ |
| Grooming | _____ | _____ | _____ |
| Toileting | _____ | _____ | _____ |
| Dressing | _____ | _____ | _____ |
| Transferring | _____ | _____ | _____ |
| Walking | _____ | _____ | _____ |

**Durable Medical Equipment**: Please list any medical equipment you have in the home such as a bedside commode, wheelchair, walker, hospital bed, tube feeding pump, suction machine, etc. Please list the name of the medical supplier and their phone number.

| | Equipment Supplier | Phone # |
|---|---|---|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |
| 5. _____ | _____ | _____ |
| 6. _____ | _____ | _____ |
| 7. _____ | _____ | _____ |

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**Recent Hospitalization**: Please list any hospitalizations in the past 2 years, the reason, and the hospital you were in.

| | Reason | Hospital | Date(s) |
|---|---|---|---|
| 1. | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ |
| 4. | _____ | _____ | _____ |

**Physicians / Specialists / Clinics**: Please list any recent doctors, their specialty (e.g. family practice, internal medicine, cardiology, neurology, etc.) and their phone number and fax number.

| | Physician / Specialty | Phone | Fax |
|---|---|---|---|
| 1. | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ |
| 4. | _____ | _____ | _____ |
| 5. | _____ | _____ | _____ |
| 6. | _____ | _____ | _____ |
| 7. | _____ | _____ | _____ |
| 8. | _____ | _____ | _____ |

Notes: Please list any other pertinent information you may have regarding your overall healthcare. If there are goals, or specific items you would like to address, please list that here.

_____

_____

_____

_____

_____

_____

We look forward to providing you with quality healthcare
and appreciate the faith you are placing in our team!

Treasure Valley Healthcare & Housecalls – Candice Adams, DNP, APRN, NP-C
Certified in Adult-Geriatric Primary Care – Phone: 208-577-8672 Fax: 208-209-6058

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## CHECKLIST

Checklist of item you will need to complete and/or provide to Treasure Valley Healthcare and Housecalls:

Forms to sign and return:

_____ **Consent to Treat**

_____ **HIPAA Privacy Authorization Form**

_____ **TVHC Medical History Form**

_____ **HIPAA Privacy Authorization Form**

Items to provide a copy of:

_____ **Drivers License** (Legal document with photo ID to verify patient)

_____ **Social Security Card**

_____ **Insurance Card(s) – Front and Back**

_____ **Advance Directives** (Durable Power of Attorney, Living Directive, DNR, Guardianship)