



Freedom of Choice & Consent to Treat for Assisted Living Residents

It has been explained to me by the staff of _____

House Calls SCHC and I understand that:

- I may select the clinician of my choice, provided that such clinician has been given, or obtains, staff privileges at the facility. If I choose a clinician's services other than those provided by the clinicians of SC House Calls, (SCHC) providers, I may still choose to consent to two (2) semi-annual on-site visits by SCHC clinicians as a convenient means by which to assist in fulfilling the facility's regulatory requirements, while continuing to utilize my clinician of choice for my ongoing medical needs. When my clinician of choice is unavailable, the facility will have the right, after informing me, to seek an alternate clinician to assure provision of appropriate and adequate care and treatment.
- While continuing to utilize my clinician of choice for my ongoing medical needs, I may choose to see an SCHC clinician for acute sick visits if I desire and request such visit for convenient means and the SCHC clinician has enough of my medical history to make appropriate decisions
- I consent to allowing telephone communications from SCHC.

PROVIDERS SERVICE The following indicates my choice:

- I choose to utilize SC House Calls for all my physician, physician assistant and/or nurse practitioner service needs
- I choose **not** to utilize the services provided by SC House Calls, but I **do** consent to the two (2) semi-annual regulatory visits
- I have been given a copy of the HIPPA Authorization/Disclosure; Privacy Act and the Grievance forms.
- I choose to continue utilizing my practitioner of choice, but consent to SC House Calls providing acute sick visits if I am unable to see my clinician of choice in a timely manner
- I choose to **not** utilize the services provided by SC House Calls and I **do not** consent to the two (2) semi-annual regulatory visits or acute visits.

List clinician of choice only if SC House Calls clinicians are not selected:

Name: _____ Phone Number: _____

Address: _____ Fax Number: _____

Resident Name: _____

Signature: _____

Date: _____

Resident or Representative



Patient Information

First Name Middle Name Last Name

SSN: _____ Date of Birth: _____ Sex: M F

Marital Status (check one): Single Married Divorced Widowed Life Partner Separated Unknown

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Ethnic Origin (check one): American Indian Asian Black Hispanic White Other

E-Mail Address: _____ Primary Language: _____

Emergency Contact Information

Name: _____ Date of Birth: _____

Relationship to Patient: _____ Phone Number: _____

E-Mail Address: _____

Guarantor Information (Financially Responsible Party)

Please check here if information is same as above

First Name Middle Name Last Name

SSN: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Guarantor's Relationship to Patient: _____

Guarantor's E-Mail Address: _____

Primary Insurance Information

Please attach a copy of all insurance cards

Release Information

I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I understand that I am responsible for any amount not covered by my insurance. I request that payment of authorized Medicare benefits be made to my physician.

Signature of Patient/Representative _____ Date: _____



Patient Health Assessment

Patient Name _____

Date of Birth _____

General

- Chills
- Depression/Nervousness
- Fever
- Forgetfulness
- Headache
- Loss of Sleep
- Loss of Weight
- Numbness
- Sweats

Gastrointestinal

- Appetite Poor
- Bloating
- Bowel Changes
- Constipation
- Diarrhea
- Excessive Thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal Bleeding
- Stomach Pain
- Vomiting and/or with blood

Eye/Ear/Nose/Throat

- Bleeding Gums
- Blurred Vision
- Crossed Eyes
- Difficulty Swallowing
- Double Vision
- Earache/Ear Discharge
- Hay Fever
- Hoarseness
- Loss of Hearing
- Nosebleeds
- Persistent Coughs
- Ringing in Ears
- Sinus Problem
- Vision - Flashes/Halos

Genito-Urinary

- Blood in Urine
- Frequent Urination
- Lack of Bladder Control
- Painful Urination

Tobacco History

Ever used tobacco products? Yes No
 What kind? _____
 How many years? _____
 Date quit? _____

Women Only

<input type="checkbox"/> Abnormal Pap Smear	Date of Last Pap Smear _____
<input type="checkbox"/> Bleeding Between Periods	Date of Last Period _____
<input type="checkbox"/> Breast Lump	Are you Pregnant? _____
<input type="checkbox"/> Extreme Menstrual Pain	Date of Last Mammogram _____
<input type="checkbox"/> Hot Flashes	Number of Live Births? _____
<input type="checkbox"/> Nipple Discharge	Number of Miscarriages? _____
<input type="checkbox"/> Painful Intercourse	How often do you examine your breasts? _____
<input type="checkbox"/> Vaginal Discharge	Name of OB/GYN _____
<input type="checkbox"/> Other	

Men Only

<input type="checkbox"/> Erection Difficulties	How often do you do a Testicular exam? _____
<input type="checkbox"/> Lump in Testicles	Last Prostate Blood Test (PSA)? _____
<input type="checkbox"/> Penis Discharge	Last prostate/rectal exam? _____
<input type="checkbox"/> Sore on Penis	
<input type="checkbox"/> Other	

Cardiovascular

- Chest Pain
- High/Low Blood Pressure
- Irregular/Rapid Heartbeat
- Poor Circulation
- Swelling of Ankles
- Varicose Veins

Muscle/Joint/Bone

- Pain, weakness, numbness in:
 - Arms
 - Back
 - Feet
 - Hands
 - Hips
 - Legs
 - Neck
 - Shoulder

Skin

- Bruise Easily
- Hives
- Itching/Rash
- Changes in Mood
- Scars
- Sore that will not heal

Preventative Care

Tetanus Booster _____
 Flu Shot _____
 Pneumonia Vaccine _____
 Hepatitis Vaccine _____
 Colonoscopy _____

Medical History (Check the box if it applies to you and/or write in family relationship)

High Blood Pressure	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	_____
Type of Cancer	<input type="checkbox"/>	_____
Heart Attack	<input type="checkbox"/>	_____
Heart Surgery	<input type="checkbox"/>	_____
Osteoporosis	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	_____
Alcoholism	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	_____
Epilepsy	<input type="checkbox"/>	_____
Mental Illness	<input type="checkbox"/>	_____
Substance Abuse	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	_____
Blood Clots	<input type="checkbox"/>	_____
Depression/Suicide	<input type="checkbox"/>	_____
Alzheimer's	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	_____
High Cholesterol	<input type="checkbox"/>	_____
Liver Disease	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	_____
Stomach Problems	<input type="checkbox"/>	_____
Reflux Disease	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	_____

Alcohol/Drug History

Do you drink alcohol? Yes No
 How many drinks per week? _____
 Do you use drugs? Yes No
 How often? _____



Patient Health Assessment

Patient Name _____

Date of Birth _____

Please list disease related deaths, if applicable:

Mother's Age	_____	Cause of Death	_____
Father's Age	_____	Cause of Death	_____
Sibling's Age, if applicable	_____	Cause of Death	_____
Maternal Grandmother's Age	_____	Cause of Death	_____
Maternal Grandfather's Age	_____	Cause of Death	_____
Paternal Grandmother's Age	_____	Cause of Death	_____
Paternal Grandfather's Age	_____	Cause of Death	_____

Current Medications (use reverse side if necessary): _____

Preferred Pharmacy: _____

Telephone Number: _____

Allergies to medications and/or substances: _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, my minor child or person for whom I am Healthcare Power of Attorney/Power of Attorney, has changes in health.

Authorized Signature

Printed Name of Authorized Signature

Date



Joint 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.

SC House Calls (SCHC) licensed prescribing providers and non-licensed prescribing providers who provide services in any SCHC facility or patient residence; may use and/or share your health information for treatment, to obtain payment for treatment, for administrative purposes, to evaluate the quality of care that you receive and for any and all other purposes described in this notice.

Understanding Your Health Record/Information

A record is created each time you receive services from SCHC, a licensed prescribing provider or other healthcare provider associated with us. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment. It is communicated among the many health professionals who contribute to your care and enables you or a third-party payer to verify that services billed were actually provided. Your medical record is a legal document describing the care you received. It is a tool we use to educate health professionals and to assess and continually work to improve the care we provide and the outcomes we achieve. Your medical record may be a source of data for medical research, public health initiatives and facility planning.

The purpose of this Notice of Privacy Practices is to assist you in understanding what is in your medical record and who, what, when, where and why others may access your health information. This document will assist you in making more informed decisions when authorizing disclosures of your health information.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have rights afforded to you by The Health Insurance Portability and Accountability Act of 1996 (HIPAA), a federal regulation (42 CFR Part 164). These rights include:

- The right to request a restriction on certain uses and disclosures of your information. Agape Primary Care is not required to agree to a requested restriction. Requests for restrictions should be sent to the Agape Primary Care or the specific department maintaining your health information.
- The right to obtain a paper copy of our Notice of Privacy Practices upon request. The Notice of Privacy Practices may be obtained from Agape Primary Care registration areas.
- The right to inspect and obtain a copy of your medical record. Agape Primary Care charges a fee for copying medical records in accordance with South Carolina law. Copies may be obtained by contacting the Agape Primary Care or the specific department maintaining your health information.
- The right to amend or correct your medical record. However, Agape Primary Care is not required to agree to the requested amendment under certain circumstances. Requests for amendments should be sent to the Agape Primary Care or the specific department maintaining your health information.
- The right to obtain an accounting of certain disclosures of your health information. An accounting of disclosures can be obtained from the Agape Primary Care. We will provide you with one free accounting each year. For subsequent requests, we will charge a \$25 fee per request.
- The right to request communication of your health information by alternative means or at alternative locations. Requests for alternative communications should be made to Health Information Management or the specific department maintaining your health information.



Joint Notice of Privacy Practices

Our Responsibilities

SCHC is required to:

- maintain the privacy of your health information
- provide you with a Notice of Privacy Practices describing our legal duties and practices with respect to information we collect and maintain about you
- abide by the terms of the Notice of Privacy Practices
- notify you if we are unable to agree to a requested restriction or if there is any unauthorized acquisition, access, use or disclosure of PHI that compromises the privacy and/or security of the information
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

SCHC reserves the right to change our health information practices, policies and/or procedures at any time and to make the new provisions effective for all protected health information we maintain. You will be informed of such changes at the time of your next visit when you receive our Notice of Privacy Practices. The most recent version of our Notice of Privacy Practices will be posted in each Primary Care location's registration/waiting area.

We may use and disclose your health information for purposes of Treatment, Payment and Health Care Operations.

Treatment

For example: Information obtained by a nurse, licensed prescribing practitioner, or other member of your healthcare team will be entered in your record and used to determine the course of your treatment. Your licensed prescribing provider will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the licensed prescribing provider will know how you are responding to treatment. We also will provide your licensed prescribing provider or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you are discharged from this hospital.

Payment

For example: A bill may be sent to you and/or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used. This information will be used for billing, claims management and collection activities to obtain payment for services provided to you.

Health Care Operations

For example: Members of the medical staff, the risk management and quality improvement teams may use your health information to assess the care and outcomes in your case and others like it. This information then will be used in an effort to continually improve the quality and effectiveness of the healthcare and services we provide.

Other Permitted or Required Uses and Disclosures of your Health Information

Appointments: SCHC may call or send information to remind you of an upcoming appointment or to reschedule an appointment. When appropriate, a message will be left on your answering machine. The content of that message will be kept as generic as possible so as to protect your privacy.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include answering services, collection agencies, medical record storage companies and a copy service we use when making copies of the medical record. When these services are contracted, we may disclose your health information to our business associate so that they can perform their job and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.



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Communication with Family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person whom you identify, health information relevant to that person's involvement in your care or payment related to your care. Generally, we will provide you the opportunity to object to such disclosures; however, in certain circumstances, we may use and disclose your health information for these purposes without providing you the opportunity to object.

Coroner: We may disclose health information to coroners, consistent with applicable law, to carry out their duties.

Correctional Institution: If you are an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Decedent Information: Protected Health Information is no longer protected after a period of Fifty (50) years; and information about the care and services rendered (prior to death) may be provided without authorization unless prohibited by the patient in advance. To prohibit such releases, please call (888)344-1810.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs or replacement.

Fundraising: Patients have the right to opt out of fundraising communications by contacting (888)344-1810.

Funeral Directors: We may disclose health information to funeral directors, consistent with applicable law, to carry out their duties.

Government Functions: Your health information may be disclosed for the purpose of protecting public officials, national security and intelligence activities and other specialized government functions, as necessary.

Marketing: We may use your information to contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. From time to time, your health care provider or designee may contact you to request your permission to participate in health education and/or promotion.

Military and Veterans: If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We also may release medical information about foreign military personnel to the appropriate foreign military authority.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, and inform them of your location and general condition.

Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant. This is to facilitate a patient or family's request to be an organ or tissue donor.

Post-Treatment Follow-up: SCHC may contact you to check on your health status or to ensure we have answered all of your questions. If you participate in post-treatment support groups, you may be given tools for your convenience that inform others of your diagnosis and/or treatment.

Private Payment Restrictions: Patients may request to restrict disclosure of PHI to a health plan if paying in full out of pocket at the time services are rendered.

Public Health: As required by federal, state and local law, we may disclose your health information to public health or legal authorities charged with preventing, reporting or controlling disease, injury, disability or for other health oversight activities.



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Required by Law or Law Enforcement: SCHC may use and disclose information about you as required by law. Your information also may be used and disclosed for law enforcement purposes, as required by law or in response to a valid subpoena. For example, we may disclose information for the following purposes:

- for judicial and administrative proceedings pursuant to legal authority,
- to report information related to victims of abuse, neglect and/or domestic violence,
- to assist law enforcement officials in their law enforcement duties and
- for purposes of governmental investigation.

Research: We may disclose information to researchers when their research has been approved by an Institutional Review Board and/or Privacy Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Serious Threat to Health or Safety: To avert a serious threat to health or safety, we may use and disclose medical information about you when necessary. Any disclosure, however, would only be to someone able to help prevent such a threat.

Telephone Contacts: We may contact you by telephone to provide you with test results, return your call, answer questions or obtain additional information.

Workers' Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to Workers' Compensation or other similar programs established by law.

Other uses and disclosures of your health information will be made only with your written authorization. You may revoke your authorization to use or disclose health information at any time except to the extent that action already has been taken.

For More Information or to Report a Problem

If you have questions or concerns about SCHC health information policies or practices, you can contact Agape Primary Care, Inc dba SCHC **high quality care line 1-888-344-1810 (toll free)**. If you believe your privacy rights have been violated, you may file a complaint with Agape Primary Care Inc. dba SCHC **high quality care line 1-888-344-1810**. There will be no retaliation for filing a complaint.