Freedom of Choice & Consent to Treat for Care Management Program

It has been explained to me by the staff of Agape Senior Primary Care Inc., dba SC House Calls (SCHC) and I understand that I am consenting for treatment by the staff of SCHC to treat me under a variety of programs that may include Chronic Care Management (CCM); Transition Care Management (TCM) and/or Palliative Care Management (PCM).

Our program is not designed to replace your relationship with your primary care provider but to add an adjunct in treatment options while you are homebound or unable to obtain timely office visits.

Please initial the following that you understand these items

___I understand that I may receive a bill for a portion of my deductible or co-pays per my insurance plan.

___I understand that SCHC will share my healthcare protected notes with my primary care provider.

___I understand that SCHC can provide me with an electronic or paper copy of my care plan upon request if I am utilizing the CCM program.

___I understand that I may choose to stop these visits by notifying our Care Center: **800-491-0909**

___I consent to allowing telephone communications from SCHC.

___I have been given a copy of the HIPPA Authorization/Disclosure; Privacy Act and the Grievance forms.

Please initial the following items that you are electing to utilize SCHC for Care Management

___I choose to utilize SCHC for all my primary care needs while appropriate for In-home care.

___I choose to continue to utilize my primary care provider in the community but consent to SCHC providing care management visits if I am unable to see my provider of choice in a timely manner.

___I consent to allowing SCHC to assist my Home Health provider; Hospice provider or Ambulance Company with regulatory visits to ensure continuity of care.

My Primary Care Provider is: _____ Contact Number: _____

My Home Health Provider is: _____ Contact Number: _____

My Ambulance Provider is: _____ Contact Number: _____

Patient Name: _____

Patient or Representative Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Authorization for Release of Information

SCHC is authorized to release protected health information concerning the above named patient to the entities/persons noted below. The purpose is to inform the patient or designee of health matters, as per the patient instructions.

Patient Name: _____
First Middle Last

Date of Birth: _____ Social Security Number: _____

ENTITY TO RECEIVE INFORMATION
(Check each person/entity that you approve to receive information.)

DESCRIPTIOIN OF INFORMATION TO BE RELEASED
(Check each item that can be given to the person/entity on the left in the same section.)

Voice Mail-Home: _____
Voice Mail-Mobile: _____
Voice Mail-Office: _____

Results of lab test/X-Rays
Change in Medication
Other: _____

Spouse (Name): _____
Parent/Guardian (Name): _____

Family Billing Information
Financial Matters
Medical Information as Follows: _____

Information to Employer
Information to School Official

Appointment Information
Absent Information
Other: _____

Rights of Patient:

I understand that I have the right to revoke the authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in the Notice of Privacy Practices previously provided me, by sending written notification of Privacy officer. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this information may be subject to re-disclosure by the recipient and may longer be protected by federal state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will be conditioned on signing. This authorization shall be in effect until revoked by the patient.

Signature: _____ Date: _____

SC House Calls

Authorization for the Use and Disclosure of Protected Health Information

I hereby authorize SC House Calls to use or disclose my protected health information as described below. I understand that the information I authorize a person/facility to receive may be re-disclosed and no longer protected by state and federal regulations.

Patient Name: _____
First *Middle* *Last*

Address: _____ *Telephone Number:* _____

_____ *Date of Birth:* _____

E-mail: _____ *Social Security Number:* _____

*Name of person/facility authorized to **release** the information:* _____

Address: _____ *Telephone Number:* _____

_____ *Fax:* _____

*Name of person/facility authorized to **receive** the information:* **SC House Calls**

Practice/Provider: _____

Address: _____ *Telephone Number:* _____

_____ *Fax:* _____

Purpose of Disclosure: _____ *Dates of Treatment:* _____

INFORMATION TO BE USED/DISCLOSED (Please check all that apply):

◯ History and Physical	◯ Discharge Summary	◯ Operative Report	◯ Immunization Record
◯ Progress Notes	◯ Laboratory Report	◯ Radiology Report	◯ Entire Medical Record
◯ Billing Summary	◯ Consultation Report	◯ Pathology Report	◯ Other (Specify)_____

I understand that in the event I was treated for drug or alcohol abuse, psychiatric condition, communicable diseases including HIV/AIDS this information will be included as part of my medical record to the above-named person/facility.

SCHC may not condition treatment, payment, enrollment or eligibility for benefits on signing this authorization.

This authorization is subject to cancellation/revocation at any time, by the patient or legally qualified representative, provided that the cancellation is made in writing except to the extent that:

1. The facility has already acted on your request prior to receiving the request to cancel the authorization; or
2. If the authorization was given to release records to your insurance company in order to obtain insurance coverage.

This authorization will automatically expire in 90 days unless otherwise stated. **Expiration Date:** _____

_____ _____
Signature of Patient or Legally Qualified Representative Date

_____
Relationship of Legally Qualified 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: _____

SC House Calls

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

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

Men Only

□	Erection Difficulties	How often do you do a
□	Lump in Testicles	Testicular exam? _____
□	Penis Discharge	Last Prostate Blood
□	Sore on Penis	Test (PSA)? _____
□	Other	Last prostate/rectal exam?

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 □ _____
- Diabetes □ _____
- Stroke □ _____
- Cancer □ _____
- Type of Cancer □ _____
- Heart Attack □ _____
- Heart Surgery □ _____
- Osteoporosis □ _____
- Arthritis □ _____
- Alcoholism □ _____
- Asthma □ _____
- Epilepsy □ _____
- Mental Illness □ _____
- Substance Abuse □ _____
- Thyroid Disease □ _____
- Blood Clots □ _____
- Depression/Suicide □ _____
- Alzheimer's □ _____
- Glaucoma □ _____
- High Cholesterol □ _____
- Liver Disease □ _____
- Kidney Disease □ _____
- Stomach Problems □ _____
- Reflux Disease □ _____
- Other □ _____

Alcohol/Drug History

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

SC House Calls

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.

Agape Primary Care, Inc., dba 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.

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.

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.

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.