Seek Wellbeing® Housecalls Practice

Welcome Letter

Welcome to Seek Wellbeing® Housecalls! We appreciate your trust in us and willingness to create a partnership that will support you in accomplishing your health-related goals.

Who We Are

Johanna Gaskins
DNP, APRN, AGNP-C

Anita Maybach
MD, PC.

Hours of Operation and Contact Information

Monday-Friday from 8:30 a.m. - 5:00 p.m.
Please contact Johanna Gaskins for assistance with any questions you may have at: info@seekwell-being.com or (202) 888-4959.

Insurance

For the benefit of our Patients, we are in-network with most insurance companies; however, you will want to check with your insurance carrier to verify if we are on their list of providers. If your insurance company requires you to select a primary care provider, please call them immediately and select Johanna Gaskins as your new PCP. As part of our contract with these companies, we are legally required to collect co-pays and deductibles from you. All bills from our practice will come from BrightStone, LLC or Seek Wellbeing® Housecalls.

We strive to meet all your health care needs and provide you with the highest quality care.
Your satisfaction is of the utmost importance to us!

Seek Wellbeing® Housecalls Practice

Patient Information

Date: _____

Patient Name: _____

Facility/Home Address: _____ Room/Apt. #: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ SSN: _____

Primary Phone Number: _____

Gender: Male O Female O Marital Status (Optional): _____

Email Address: _____

Emergency Contact

Name: _____

Primary Phone Number: _____ Relationship: _____

Address: _____

City: _____ State/Zip: _____

Email Address: _____

Power of Attorney *(only if different than Emergency Contact)*

Name: _____

Primary Phone Number: _____ Relationship: _____

Address: _____

City: _____ State/Zip: _____

Email Address: _____

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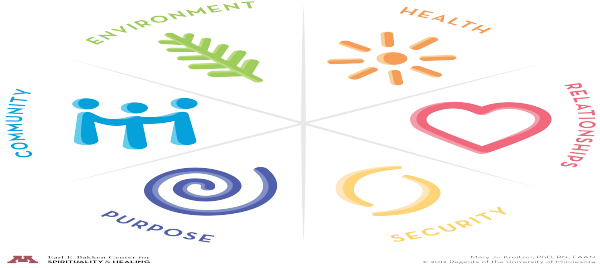

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Insurance Information

May we routinely share your medical information with your power of attorney and emergency contact? O Yes O No

Insurance*

Primary: _____

ID# _____ Group # _____

Secondary: _____

ID# _____ Group # _____

**** Please return a photocopy of the FRONT AND BACK of your insurance card(s) with this packet***

NOTE: It is very important that you are specific when stating whom your coverage is through. Simply stating "Medicare" when you have BCBS Medicare Advantage will lead to delays and/or non-coverage of services.

Where should bills for deductibles, co-pays and non-covered items be sent?*

Name: _____

Primary Phone Number: _____ Relationship: _____

Address: _____

City: _____ State/Zip: _____

*I (or my Power of Attorney/Responsible Party) further understand that I (or my Power of Attorney/Responsible Party) will be billed for any deductibles and/or co-pay amounts as required by the Health Care Financing Administration, and I (or my Power of Attorney/Responsible Party) hereby agree to pay any and all such amounts promptly.

Is this the same address on file with your insurance company? O Yes O No

Seek Wellbeing® Housecalls Practice

In-House Physician Services Authorization

Resident Name: _____

Facility Name: _____ Room # _____

I hereby authorize **Johanna Gaskins, AGNP** to be my Primary Care Provider.

_____ _____

Signature of Patient or Power of Attorney Date

_____ _____

Signature of Responsible Party *(if different than Patient or POA)* Date

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In-House Physician Services
Medical Records Release

I hereby give my permission to release all medical records, including psychiatric records to Seek Wellbeing® Housecalls Practice for continuity of care.

Patient Name: _____

Date of Birth: _____ SSN: _____

Address: _____

City: _____ State/Zip: _____

Applicable time period: _____

_____ _____

Signature of Patient or Power of Attorney Date

_____ _____

Signature of Responsible Party *(if different than Patient or POA)* Date

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Medicare Assignment of Benefits

Patient Name: _____ DOB: _____

Facility: _____ SSN: _____

Medicare/Medicare Advantage #: _____ Medicaid #: _____

Secondary Insurance: _____ ID #: _____

I request that payment of authorized Medicare, Medicaid and Secondary Insurance benefits be made on my behalf to Seek Wellbeing® Housecalls Practice for any services provided and documented by Seek Wellbeing® Housecalls Practice. I authorize any holder of medical information to release to the Health Care Financing Administration, and its agents, any information needed to determine these benefits and/or the benefits payable for related services. The intent of this paragraph is to authorize any insurance provider/company that may be billed for co-insurance to pay Seek Wellbeing® Housecalls Practice directly. I permit a copy of this Authorization to be used in place of the original. I understand that this is a lifetime authorization.

_____ _____

Signature of Patient*+ Date

_____ _____

Signature of Power of Attorney or Responsible Party+ Date

_____ _____

Witness Date

***If someone other than the Patient signs the authorization (e.g. a Power of Attorney), the reason for the Patient's inability to sign and the relationship between the Patient and the responsible party must be stated below:**

_____

_____

_____

+ I (or my Power of Attorney/Responsible Party) further understand that I (or my Power of Attorney/Responsible Party) will be billed for any deductibles and/or co-pay amounts as required by the Health Care Financing Administration, and I (or my Power of Attorney/Responsible Party) hereby agree to pay any and all such amounts promptly.

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Notice of Privacy Practices and Patient Consent for Use and Disclosure of Protected Health Information

O I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain Patient Rights regarding my protected health information.

O I understand that Seek Wellbeing® Housecalls Practice may use or disclose my protected health information for treatment, payment
or health care operations, including but not limited to providing health care to me, the Patient, handling billing and payment and taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

O Seek Wellbeing® Housecalls Practice has a detailed document called *The Notice of Privacy Practices*. It contains a more complete
description of your rights to privacy and how we may use and disclose protected health information. I understand that I have the right to read *The Notice of Privacy Practices* before signing this agreement. You may obtain a copy of The Notice of Privacy Practices at any time by contacting the office.

O I understand I will need to provide a copy of my POA, DNR and other important legal documents.

O I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Seek Wellbeing® Housecalls Practice. I understand that the revocation will not apply to the information that has already been released in response to this authorization.

O I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws and regulations. I also understand authorizing the use or disclosure of the information is voluntary. I need not sign this form to ensure health care treatment.

_____ _____

Signature of Patient Date

_____ _____

Signature of Power of Attorney or Responsible Party Date

_____ _____

Witness Date

My medical information may be disclosed to the following individuals or organizations:

_____ _____

Name Relationship

_____ _____

Name Relationship

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Additional Paperwork for Seek Wellbeing® Housecalls New Patients

QUESTIONS:

O Yes O No Are you able to afford all medications that have been prescribed to you?

O Yes O No Are you able to care for yourself regarding cooking, bathing, cleaning, etc.?

O Yes O No Have you ever forgotten to turn off the stove?

O Yes O No Have you ever forgotten to take your medications?

O Yes O No Have you ever forgotten to pay your bills?

O Yes O No Do you have a living will?

O Yes O No Do you have advanced directives?

O Yes O No Would you like to discuss advance care planning and what will happen in the event of a life-changing medical situation/event?

O Yes O No Seek Wellbeing® Housecalls Practice has permission to download your medication history?

CONCERNS:

Top 3 medical concerns you have:

1. _____
2. _____
3. _____

What are your families' top concerns about your health?

_____

_____

Social or spiritual concerns you have:

_____

_____

Do you have someone to speak to regarding your listed social/spiritual concerns? O Yes O No

SOCIAL HISTORY:

Height: _____ Weight: _____

O Yes O No Do you use tobacco?
Packs/day?_____# of Years?_____

O Yes O No Do you use alcohol?
# of drinks/week?_____

O Yes O No Do you use street drugs?
If so, which ones?_____

_____

O Yes O No Do you have a Living Will?

O Full Code O DNR O POA

What is your living situation?

O Alone O With spouse

O With other family O Senior Living Facility

O Other: _____

What are YOUR goals for your healthcare?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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_____

_____

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MEDICATIONS:

☐ Check here if not taking any medications

Please list the medication, with dosages and instructions that you currently use (a copy of current list acceptable). Please include over-the-counter and herbal medications. Attach additional pages if needed.

Medication Name	Dosage	Instructions

ALLERGIES:

☐ Check here if No Known Allergies

Please list any drug allergies you have. Attach additional pages if needed.

Drug	Reaction

IMMUNIZATIONS:

Name	None	Unknown	Date
Tetanus			
Pneumonia			
Zoster/Shingles			
Flu			
Other:			
Other:			

PREVENTIVE CARE:

Name	N/A	Unknown	Date
Colonoscopy			
PSA			
Smoking Cessation Counseling			
Mammogram			
Pap Smear			

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PAST MEDICAL HISTORY:

Check all that apply. Attach additional pages if needed.

- ☐ CVA / Stroke
- ☐ Hearing Loss
- ☐ Cataracts
- ☐ Asthma
- ☐ COPD / Emphysema
- ☐ CAD (Heart Disease)
- ☐ MI (Heart Attack)
- ☐ Atrial Fibrillation
- ☐ CHF
- ☐ HTN (High Blood Pressure)
- ☐ Reflux / Heartburn
- ☐ Dementia / Memory Loss
- ☐ Circulatory Issues
- ☐ High Cholesterol
- ☐ Diverticulitis
- ☐ Arthritis _____
- ☐ Skin Disorder _____
- ☐ Endocrine _____
- ☐ Diabetes Type 1, Type 2
- ☐ Cancer _____
- ☐ Anemia
- ☐ Other _____
- ☐ Other _____
- ☐ None / Healthy
- ☐ Unknown

PAST SURGICAL HISTORY/ HOSPITALIZATIONS:

Check all that apply and denote date. Attach additional pages if needed.

- ☐ Appendectomy _____
- ☐ Cataracts _____
- ☐ Gallbladder Removal _____
- ☐ Total Hysterectomy _____
- ☐ Partial Hysterectomy _____
- ☐ Tonsillectomy _____
- ☐ Heart Bypass/CABG _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ None
- ☐ Unknown

FAMILY HISTORY OF MEDICAL PROBLEMS:

Check all that apply. Attach additional pages if needed

Condition	Father	Mother	Grandparent
CVA / Stroke			
Hearing Loss			
Cataracts			
Asthma			
COPD / Emphysema			
Coronary Heart Disease			
Heart Attack			
Atrial Fibrillation			
Congestive Heart Failure			
Hypertension			
Reflux / Heartburn			
Diverticulitis			
Arthritis:			
Skin Disorder:			
Endocrine:			
Diabetes Type I			
Diabetes Type II			
Cancer:			
Anemia			
Other:			
Other:			
None			
Unknown			

Patient Name: _____ Reviewed and Approved By: _____

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