How to Determine Homebound Status

- Patient is bedbound.
- Patient transfers via mechanical lift device to chair (wheelchair, reclining chair, commode etc.)
- Patient transfers with assist of two to chair.
- Patient transfers with mod/max assist of one to chair.
- Patient transfers with stand-by assist of one to chair.
- Patient is chair-bound.
- Patient requires (***Min to Max***) assist with (***Most to All***) ADLs/IADLs.
- Patient is unable to ambulate further than 20 feet without frequent rest periods due to (***poor endurance, pain, SOB*** etc.)
- Patient requires assistive device for ambulation (***FWW, Quad cane, crutches***)
- Patient requires assist of one to ambulate.
- Patient requires stand-by assist of one to ambulate.
- Unsteady gait, poor ambulation with history of falls (***2 falls in the last month***)
- Significant to severe weakness following hospital stay.
- Impaired mobility due to (***recent fracture, surgery, arthritis, paralysis, paresis***)

In Good Health
1508 Tombras Ave Chattanooga, TN 37412
OFFICE: 423-867-4969 FAX: 423-867-4971

WELCOME TO IN GOOD HEALTH

Bruce Pendley, MD	Randy Heisser, MD	J. Michael Mazzolini, MD	Joy Boggess, MD
Laurie Davis, DNP, FNP	Greg Joyner, FNP	Becky Neumann, FNP	Susan Ross, FNP
Tammy Moore, FNP	Hannah Chong, FNP	Rebecca Henderson, FNP	Debbie Kibwage, FNP

Thank you for choosing In Good Health for you or your family's healthcare needs. The first step to becoming a new patient with us is to complete the new patient paperwork. This completed paperwork is required before we can schedule your appointment.

Once we receive the paperwork, it is reviewed by our medical director. This is to ensure that we will be able to provide you with the appropriate level of care that you require. If approved, we will contact you with an appointment date.

When returning the paperwork, please include a photo of the front and back of your insurance card. If you have power of attorney, we will need a copy of those documents as well.

When completing the new patient paperwork, we ask that you complete every page of the paperwork in its entirety.

A few things we ask that you remember include:

- On the personal information page: If we are allowed to speak to others about you, please indicate who they are and how to contact them. **This includes family, caregivers, and power of attorneys.**
- On **YOUR** past medical history: Please list **all** other doctor's that you see and **why** you see them.
- The medication list: A **complete** list of medications or MAR is **MANDATORY**. We cannot review your paperwork without this list. Please also list the name and phone number of your pharmacy.

You may return the paperwork by faxing, mailing, or emailing it to ldavis@alwaysingoodhealth.com You may also turn it in to our receptionist at our office. If you have any questions, please do not hesitate to call our office. We look forward to providing your healthcare needs!

With warmest regards,

Cassie Nichols, EMPT/Supervisor

NEW HOME PATIENT CHECKLIST

- ❖ Copies of Insurance Cards

- ❖ Did you complete entire packet?
  - Did you complete the first page (page 4)with all your contact and insurance information?
  - Did you complete the second page (page 5) with all your family medical history?
  - Did you complete the second and third page (page 5 and 6) with YOUR medical history?
  - Did you sign all the pages that ask for your signature?

- ❖ Medication List: Did you include the dose and frequency? Do you require a 90-day supply? What pharmacy do you use?

  _____

  _____

- ❖ Home Health: Have you had or currently have home health? If so, which one?

  _____

  _____

- ❖ Is there a specific reason you need to be seen? If so, what is it?

  _____

  _____

- ❖ Do you use Durable Medical Equipment? If so, what company did you use?

  _____

  _____

- ❖ Do you have a Power of Attorney? If so, who is it?

  _____

  _____

***** POWER OF ATTORNY- We will be unable to honor the POA (Power of Attorney) unless we have a copy of the documents to keep on file, so please include a copy of the documents if applicable*****

NEW PATIENT

Patient Name Last _____ First: _____ MI _____

DOB: _____ Sex: _____ Age: _____ Marital Status: _____ Social Security #: _____

Street Address: _____

City: _____ State: _____ Zip _____

Phone(s): Home _____ Work: _____ Cell: _____

Please Check All That Apply:

I authorize In Good Health to:

_____ Leave a message on my answering machine regarding appointments.

_____ Mail information to my home address regarding appointments.

_____ Speak with a family member or other individual when returning your call or concerning appointments.

*****Please specify whom we may speak with:**

Name: _____
Phone Number: _____
Relation: _____

Name: _____
Phone Number: _____
Relation: _____

Name: _____
Phone Number: _____
Relation: _____

Name: _____
Phone Number: _____
Relation: _____

Insurance Information:

Primary Insurance

Company Name _____

Address _____

Policy in name of _____

DOB _____ SS# _____/_____/_____

Group # _____

Policy # _____

Secondary Insurance

Company Name_____

Address _____

Policy in name of _____

DOB _____ SS# _____/_____/_____

Group #_____

Policy #_____

___ Yes ___ No Do you currently have any Advanced Directives?

___ Yes ___ No Are you interested in information about Advanced Directives?

PATIENT HISTORY

Patient Name: _____ DOB: _____ Date: _____

Social History:

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed

Do you live alone or with someone? ___ Alone ___ With (Name & Relation)_____

_____

Facility: _____ Location: _____

_____

Alcohol:	___ None	___ Socially	___ Moderate	___ Heavy
Education:	___ Elementary	___ Middle School	___ High School	___College Graduate
Your Habits:	___ Caffeine	___ Illicit Drugs	___ Tobacco, if yes how much? _____	
Employment:	___ Student	___ Part Time	___ Full Time	___ Retired
	___ Unemployed			
Exercise:	___ 3 times a week or less		___ Greater than 3 times per week	
	___ Does not exercise			

Family History : (mother, father, siblings, children, grandparents)

___ Alcoholism	___ Alzheimer's	___ Arthritis	___ Asthma
___ Bleeding Disorders	___ Blood Clots	___ Cancer , what kind_____	
___ Circulatory problems	___ COPD	___ Depression	___ Diabetes
___ GERD	___ Stomach Problems	___ Heart Disease	___ Hepatitis
___ High Cholesterol	___ HIV / Aids	___ High blood pressure	___ Migraines
___ Kidney Disease	___ Liver Disease	___ Low Blood Sugar	___ Obesity
___ Lung Disease	___ Psychiatric Disorders	___ Seizures	___ Stroke
___ Substance Abuse	___ TB	___ Thyroid Disorders	___ Ulcers

___ Other: _____

MY Medical History:

___ Anemia	___ Aneurysms	___ Angina	___ Anxiety
___ Arrhythmia	___ Arthritis	___ Asthma	___ ADD
___ Autoimmune Disorder	___ Bell's Palsy	___ Bipolar Disorder	___ Blood Clots
___ Bleeding Disorders	___ Bronchitis	___ Cancer, what kind _____	
___ Crohn's Disease	___ Circulatory problem	___ Congestive heart Failure	___ DVT
___ Constipation	___ COPD	___ Coronary Artery disease	___ Depression
___ Diabetes	___ Elevated Liver enzymes	___ Emphysema	___ GERD
___ Erectile Dysfunction	___ Headaches	___ Heart Disease	___ HIV / Aids
___ Heart Murmur	___ Hepatitis A,B or C	___ High Cholesterol	___ Migraines
___ High Blood Pressure	___ Kidney Disease	___ Liver Disease	___ Obesity
___ Low Blood Sugar	___ Lung Disease	___ Mental Disorders	___ Parkinson's
___ Mitral Valve Prolapse	___ Nervous Disorder	___ Panic Disorder	___ Seizures
___ Stomach Disorder	___ Stroke	___ Substance Abuse	___ TB
___ Thyroid Disorder	___ Unexplained Weight Loss of more than 10 lbs		

PATIENT HISTORY
(continued)

Allergies to Drugs and Reactions they Give You

_____

_____

_____

Food Allergies: _____

_____

_____

Major Operations and Specialists:

Name	Location	Phone Number	Procedure

Patient Name_____ Date: _____

MEDICATION LIST

ADMITTING MEDICATION LIST

Patient Name: ______________________ DOB: __________ Pharmacy: ______________

Medication Name	Dosage	How is it Taken (morning & night, once a day etc.)	Reason it is Taken (blood pressure, cholesterol, diabetes etc.)

In Good Health
1508 Tombras Ave Chattanooga, TN 37412
OFFICE: 423-867-4969 FAX: 423-867-4971

Patient Name: _____ DOB: _____

Home / ALF

AOB / Financial Policy for In Good Health

The information in this financial policy is meant to educate the patients of the requirements regarding payment for services rendered. If you have any questions please feel free to speak to the office manager.

Insurance and Demographic Information
Please notify our staff if you need to update your demographic or insurance information at each visit. We will need a copy of your insurance card if there are any changes. IGH asks that you let us know if there are any changes in name, address, phone numbers, or insurance. If so, it will be necessary to complete a new patient information form. If we do not get the correct insurance information and your claim for service is denied, you will be responsible for the entire amount due. You will then need to work with your insurance company to get reimbursed for what you have paid to IGH. You will also be required to update a patient information form and insurance information every year. This gives IGH permission to bill your insurance and release information to your insurance company in order to get payment for services rendered and to continue treatment.

What Payment is Required?
You will be required to pay for any co-pays or deductibles not met at each office visit. If you do not have insurance you will be required to pay the full amount due at each visit.

Forms of Payment
We accept cash, check, check card, money order, cashier's check, Visa, MasterCard, Discover card, and American Express.

Broken Appointment Charge and Policy
There is a $25.00 charge for appointments not cancelled 24 hours before the scheduled appointment time. This must be paid before the patient is seen at the next office visit along with any applicable co-pay. Insurance does not pay for this charge and it will not be billed to them.

Patient is responsible for total charge. We do not look to a third party for payment.
As a courtesy to our patients, we will gladly file a claim to your insurance carrier. However, if the insurance company does not pay your claim, in a timely manner, you are responsible for any amount due. The insurance you carry is a contract between you and your insurance carrier and IGH is not a party to the contract. We will be glad to assist you to get the full benefit of your insurance.

Medicare
Currently we are not accepting any new Medicare patients in the office; however, we are accepting new HOME PATIENTS with Medicare. For existing Medicare patients we do accept Medicare assignment and agree to comply with the agreement of such; however you will be responsible for any deductible or coinsurance, if you do not have a supplement to your Medicare coverage.

Patient Name: _____ DOB: _____

Office Policy on Insurance Assignment
We will verify your insurance before your appointment and periodically afterwards to be sure your coverage is active. We will collect your deductible and co-pays as appropriate. We will file a claim to your insurance company on your behalf, however please understand this is done as a courtesy to our patients and if the insurance does not pay the claim the patient becomes responsible for any unpaid balance due for services rendered. Ultimately it is the responsibility of the patient to make sure our providers are on your insurance network. If we are not on the network for your insurance carrier you will be notified before your visit and you will be responsible for payment in full or an estimated amount that is not covered if you have out of network benefits.

Fees Due if Your Account is Sent to Collections
You will be responsible for any collection fees and/or attorney fees in the event your account is turned over for collections. This amount will be up to 50% of the amount due in addition to your balance and any attorney fees or court costs. If your account is turned over to collections you will be dismissed from IGH and you will have to find another primary care physician for treatment. You will not be able to return to IGH until proof of the entire amount owed is paid in full.

Fee for Random Drug Screens
IGH does reserve the right to perform random drug screening and this is not covered by most insurance companies. When it is time for a random screening you will be asked to sign a waiver stating that you understand that your insurance company does not pay for this service and you will be required to pay $25.00 for this test.

If You Are Referred to Another Specialists or Provider
If you are referred for treatment to another provider, for continuum of care, please understand that you will be billed separately by that provider and/or facility. It is ultimately your responsibility to make sure that provider is on your insurance network. If the provider is not you should call your insurance company and get a list of providers that are on your network and we will refer you to a different provider that is covered by your insurance.

Charge for Insufficient Funds Check
If a patient writes a check that is returned unpaid by the bank there will be an additional charge of $35.00, which is due before that patient is seen again. No checks will be accepted 6 months from that patient if it is the first time a check is returned. If this is the second time, the fee of $35.00 must be paid before the patient is seen and we will no longer accept checks at all. The patient must pay by cash, money order, or credit card from that point forward.

Payment Arrangements
If it becomes necessary for payment arrangements to be made on balances of coinsurance amounts due, please see the billing manager to discuss this matter. If at any time your account becomes delinquent over 90 days and you have not made consistent payments every 30 days your account will be turned over to collections and you will be required to find another primary care physician.

****I have read and understand the Financial Policy of IGH. I agree to comply with the policy. I understand if I have any questions I can speak with the billing manager or office manager.****

_____ _____
Signature of Patient/Guarantor Date

Patient's Name: _____ DOB: _____

Assignment of Benefits / Financial Responsibility

1. I understand that I am responsible for charges not covered or reimbursed by my current insurance agents. I agree, in the event of non-payment, to assume the cost of interest, collection and legal action (if required).

2. I authorize my insurance carrier to release information regarding my coverage to In Good Health, LLC (IGH). I also authorize agents of any hospital, treatment center or previous physicians to furnish IGH copies of any record of my medical history, services or treatments. I also authorize for the release of any medical information and/or reports related to my treatment to any federal, state, or accreditation agency or any physician (_____**Patient's Initials**) or insurance carrier as needed. I also agree to a review of my records for purpose of internal audits, research and qualified reviews within IGH.

3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to IGH. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my payment as claims for service. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representatives, I will endorse such payments to IGH.

This agreement / consent will remain in effect unless revoked by me in writing. I have read the above statements and accept the terms.

I acknowledge that I have been given the opportunity to read and understand the Notice of Privacy Practices.

Patient Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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.

We are required by law to maintain the privacy of your health facts and to provide you with notice of our legal duties and privacy practices. We must follow the terms of the notice in effect right now, but we reserve the right to change the terms. If there is a change, we will provide you with a written, revised notice upon request.

As a client of ours, facts about you must be used and disclosed to other parties for treatment, payment, and health care operations. These uses and disclosures require your consent, and include, but are not limited to the following information:

- A release of information contained in financial and or medical records.
- Diseases spread by person to person, such as Human Immune Deficiency Virus (HIV) and Acquired Immune Deficiency syndrome (AIDS)
- Drug and or alcohol abuse
- Psychiatric diagnosis and treatment records
- Laboratory test results
- Medical History
- Treatment progress
- Data from OASIS data sheet (home health)
- Any other related facts

We may release the above to:

1. Your insurance company, Medicare, Medicaid, or any other person who will pay your bill for services or who will process your bill for services in order for us to receive payment.
2. Any person from a program or an insurance company, who performs billing, quality, and risk management tasks, such as insurance auditors, and state Risk Management.
3. Any hospital, nursing home or other health care facility where you may have testing done or to which you may be admitted.
4. Any assisted living or personal care facility where you live.
5. Any doctor providing your care.
6. Family members and other people who are a part of your plan for service, in such programs as CSHP, EPSDT, home health, hospice, etc.
7. State and Federal agencies acting on behalf of programs, Medicare and or Medicaid, including state surveyors or auditors for programs such as CSHP, EPSDT, PCS, WIC, STD/HIV, home health, hospice, etc.
8. Other health care people to start treatment.

We may contact you to:

1. Provide appointment reminders or news about other health programs we provide.
2. Discuss diagnostic results or treatment plans regarding your health care.

We are allowed to use or disclose facts about you without consent in the following situations:

1. In emergency treatment situations if we try to obtain consent as soon as possible after treatment.
2. Where significant barriers to communicating with you exist and we determine that the consent is clearly inferred from the situation.
3. Where we are required by law to provide treatment and we ae unable to obtain consent.
4. Where the use or disclosure is required by law.

5. For certain public health activities, such as reporting births, deaths, injuries, diseases, etc.
6. Where we reasonably believe you are a victim of abuse, neglect, or domestic violence to a government agency authorized to receive abuse, neglect, or domestic violence reports.
7. Health care oversight activities
8. Certain legal administrative proceedings
9. Certain law enforcement purposes
10. To coroners, medical examiners, and funeral directors in certain situations (home health, hospice, etc.)
11. For organ, eye, or tissue donation purposes (home health, hospice, etc.)
12. For certain research purposes.
13. To avoid a serious threat to health and safety.
14. For specialized government functions, including military and veterans' activities, national security and intelligence activities, protective services for President and others, medical suitability determinations, correction institutions and custodial situations.
15. For Worker Compensation purposes.

We are allowed to use or disclose facts about you without consent or authorization provided you are informed in advance and given the chance to agree to, restrict or forbid the disclosure in the following situations:

1. The use of a directory of people served by us (clinics schedules, patient schedules)
2. To a family member, friend, or other person you choose who may assist in your care of payment for care.

Other uses and disclosures will be made only with your written approval. That approval may be withdrawn in writing at any time, except in limited situations.

YOUR RIGHTS

You have the right, subject to certain conditions, to:

1. Request restrictions on certain uses and disclosures of facts about you by filling out our request form. However, we are not required to agree to the requested restrictions.
2. Receive confidential communication of protected health data by giving us another address or means of receiving health data.
3. Inspect and copy protected health data by filling out our request form.
4. Amend protected health data by filling out our request form.
5. Receive a list of disclosures made of your protected health data by filling out our request form.
6. Obtain a paper copy of this notice upon request, if you agreed to receive this notice by email, fax or website.

COMPLAINTS

You may complain to us and the Secretary of the US Department of Health and Human services if you believe that your privacy rights have been violated. There will be no retaliation against you for filing a complaint. The complaint must be filed in writing with us and must state the specific incident(s) including the date, what happened, and details of the incident. You may also contact our Compliance Officer at this office.

For details about filing a complaint with us, contact:
HIPAA Compliance Officer at: 423 - 867- 4969

In Good Health Notice of Privacy Practices

Patient's Name: _____ Date: _____

ACKNOWLEDGEMENT

I have read this notice or have had it explained to me. I understand if I have further questions regarding this notice I can contact the Secretary of the US Department of Health and Human Services.

_____ _____
Signature Date

This notice goes into effect 03-01-2003.

For Office Staff Use Only

The following good faith efforts were made to obtain acknowledgement:

1. A copy of the Privacy Notice was offered to the patient.
2. The Privacy Practices of IGH were discussed with the patient.

However, acknowledgement was not obtained because:

1. The patient refused to sign acknowledgement.
2. Other _____

_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

RE: _____
Patient's Name

_____
Date of Birth

_____
Social Security Number

Pursuant to federal HIPPA guidelines concerning my right to concerning my right to confidentiality, I hereby authorize the release of my medical records to:

__X__ IN GOOD HELATH

_____ Other: _____

Please include the last 3 office visit notes, all imaging & lab reports for the past year, a copy of my insurance card(s), and my patient information (demographic) sheet.

If I have been dismissed from your practice, please send documentation stating the reason for dismissal from your practice.

I understand no information may be disclosed by either agency to any other individual or agency unless by written consent. This statement may be revoked at any time by my written statement. I further understand there is a 10 workday turnaround time to pick up or send any records.

_____ _____
Signature of Patient or Legal Guardian of Patient Date

_____ _____
Signature of Witness Date

Patient Name: _____ DOB: _____

PATIENT CONSENT AGREEMENT:
CHRONIC CARE MANAGEMENT PROGRAM

Dear Patient,

As a patient with chronic conditions, you ay benefit from a new program that we are now offering Medicare patients. Our goal is to make sure you get the best care possible from everyone that is involved with your care, including our pharmacy partner. Together with our pharmacy partner: we can talk with you regularly on the phone about your symptoms, we can help you with the management of your medications, and we will provide you with a comprehensive care plan. Medicare will reimburse us for these services.

By signing this Agreement, you consent to _____ (referred to as "Provider") providing Chronic Care Management Services (referred to as "CCM Services") to you as more fully described below.

CCM Services are available to you because you have been diagnosed with two (2) or more chronic conditions that are expected to last at least twelve (12) months and that place you a significant risk of further decline. Sometimes other staff working with our practice under general supervision of your Provider will talk to you or handle issues related to your care, but please know that your Provider will supervise all care provided by our staff or other clinicians who may be involved in your care.

CCM Services include processes to ensure that you receive: timely preventative care services, medication reviews and monitoring, a plan of care covering your health issues, and assistance with care transitions if needed. The Provider will discuss with you the specific services that will be available to you and how to access those services.

We will bill Medicare for this chronic care management once a month. Our office will retain a record of managing your care if you ever have a question about what we have done each month.

Only one physician can bill for this service for you. Therefore, if another one of your physicians has offered to provide you with this service, you will have to choose which physician is best able to treat you and all of your conditions. Please let your physician or our staff know if you have entered into a similar agreement with another physician/practice.

You have a right to:

A comprehensive Care Plan from our practice to help you understand how to care for your conditions so that you can be as healthy as possible. You authorize electronic communication of your medical information with other treating providers as part of coordination of your care.

You may discontinue this service at any time for any reason. Because your signature is required to cancel your chronic care management services, please ask any of our staff members for the CCM termination form.

Our goal is to provide you with the best care possible, to keep you out of the hospital, and to minimize costs and inconvenience to you due to unnecessary visits to the doctors, emergency rooms, labs, or hospitals. We know your time and your health are valuable, and we hope that you will consider participation in this program with our practice.

I agree to participate in the Chronic Care Management program. ___ Yes ___ No

Patient Signature: _____ Date: _____