DEMOGRAPHICS

First Name: _____Last Name: _____

Date of Birth: _____ Gender: ☐ Female ☐ Male

Race: _____ Ethnicity: _____

Email: _____ Phone: ( ) _____

Address: _____

Address: _____

City: _____ State: VA Zip Code: _____

Preferred Method of Communication

☐Phone May Leave Message

☐Phone Do not leave a Message

☐Email

☐Text

INSURANCE COPPIES OF THE FRONT AND BACK OF THE CARDS REQUIRED

Primary

Name of Company: _____

ID Number _____ Group Number _____

Secondary

Name of Company: _____

ID Number _____ Group Number _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Email: _____ Phone: ( ) _____

Address: _____

Address: _____

City: _____ State: VA Zip Code: _____

MEDICAL POWER OF ATTORNEY

Name: _____ Relationship: _____

Email: _____ Phone: ( ) _____

Address: _____

Address: _____

City: _____ State: VA Zip Code: _____

Primary Care Provider	
Name	**Phone Number**

Specialty Providers		
Specialty	**Provider Name**	**Phone Number**

Preferred Pharmacy		
Name	**Address**	**Phone Number**

Allergies ☐ No known Drug Allergies	
Item	**Reaction**

Medications			
Drug	**Dose**	**Route**	**Frequency**

MEDICAL HISTORY: Please check off if you have had any of the following					
	Trauma		Cirrhosis		Seizures
	Falls		GERD		Severe headaches, migraines
	Blindness		Gallbladder disease		Stroke
	Cataracts		Heartburn		TIA
	Glaucoma		Hemorrhoids		Bipolar disorder
	Wears glasses/contacts		Hepatitis		Depression
	Hearing aids		Hiatal hernia		Hallucinations, delusions
	Allergic Rhinitis		Jaundice		Suicidal ideation
	Sinus infections		Ulcer		Suicide attempts
	Dentures		Hernia		Goiter
	Aneurysm		Incontinence		Hyperlipidemia
	Angina		Nephrolithiasis		Hypothyroidism
	DVT		Other kidney disease		Thyroid disease
	Dysrhythmia		STDs		Thyroiditis
	HTN		UTI(s)		Type I DM
	Murmur		Arthritis		Type II DM
	Myocardial infarction		Gout		Anemia
	Other heart disease		M/S injury		Cancer
	Asthma		Dermatitis		Hepatitis
	Bronchitis		Mole(s)		HIV
	COPD - Bronchitis/Emphysema		Other skin condition(s)		Tuberculosis (dz)
	Pleuritis		Psoriasis		Tuberculosis (exposure)
	Pneumonia		Epilepsy		

Other Medical History

.Surgical History - Please check any that apply:			
	Aneurysm repair		Inguinal hernia repair
	Appendectomy		Knee arthroplasty
	Back surgery		Laminectomy
	Bariatric surgery/gastric bypass		LASIK
	Bilateral tubal ligation		Nasal surgery
	Breast resection/mastectomy		Pacemaker/defibrillator
	CABG		Prostate surgery
	Carotid endarterectomy/stent		Prostatectomy
	Carpal tunnel release surgery		PTCA/PCI
	Cataract/lens surgery		Rotator cuff surgery
	Cesarean section		Sinus surgery
	Cholecystectomy/bile duct surgery		Skin cancer excision
	Dilation and curettage		Spinal fusion
	Hemorrhoid surgery		TAH-BSO
	Hip arthroplasty		Tonsillectomy/Adenoidectomy
	Hip replacement		TURP
	Hysterectomy		Vasectomy

Other Surgical History

Family History - Blood relative	
	Unknown
	Arthritis
	Cancer
	Dementia
	Diabetes
	Heart Disease
	Hypertension
	Kidney Disease
	Stroke

Social	
	Arthritis
	Cancer
	Dementia
	Diabetes
	Heart Disease
	Hypertension
	Kidney Disease
	Stroke

Alcohol Use	
	Do not drink
	Drink daily
	Frequently drink
	Hx of Alcoholism
	Occasional drink

Tobacco Use	
	Never smoker
	Current everyday smoker
	Current some day smoker
	Former smoker
	Heavy tobacco smoker
	Light tobacco smoker
	Smoker, current
	Status unknown

Drug Use	
	No illicit drug use
	IV Drug Use History
	Illicit drug use

Cardiovascular	
	Eat healthy meals
	Regular exercise
	Take daily aspirin

Implants	
	None
	Eye
	Inspire
	ICD
	Pacemaker
	Watchguard
	Knee
	Hip
	Shoulder

Vaccines	
	Decline Vaccines
	Covid- 19 - recent
	Influenza - Annual
	Pneumovax 23
	Prevnar 20 or lower
	Decline Vaccinations
	Prevnar 21
	RSV
	Shingrix

Assistive Devices	
	Braces
	None
	Braces
	Cane
	Walker
	Rollator
	Wheelchair
	Scooter

In the Last 6 months							
Falls		Emergency Room Visits		Inpatient Admissions		Rehab / SNF	
	1		1 Visit		1 Admit		1 Admit
	2-3		2-3 Visits		2-3 Admits		2 admits
	4 or more		4 or More Visits		4 or More Admits		3 Admits

Home Health Care	
	Yes
	No
Company	

Therapy	
	Physical Therapy
	Speech Therapy
	Occupational Therapy
Company	

Care Manager	
	Yes
	No
Company	
Care Manager Name	

Advanced Directives	
	Not Documented
	Full Code
	Comfort Measures
	DNR

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
Note: This entity is required by law to provide each patient with a copy of our Notice of Privacy Practices, obtain acknowledgment that the Notice was provided, and keep the acknowledgment in our records. You will be given a copy of this acknowledgment with the Notice of Privacy Practices for your records. **Document on practice Website** www.resmedkare.com **ACKNOWLEDGEMENT OF PATIENT** Residential Medical Kare, LLC, is required by law to maintain the privacy of and provide individuals with access to the Notice of our legal duties and privacy practices concerning protected health information. I, hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document and understand that I may obtain a copy for my records upon request.

Signature: _____ Date: _____

Release of Information
The patient or the patient's representative must read and agree to the following statements: I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law, including research-related treatment which may be conditioned upon this authorization. Residential Medical Kare, LLC may condition the provision of health care solely to create protected health information for disclosure to a third party upon my signature of this authorization. I understand that information released according to this authorization may lose the protections of federal privacy regulations due to re-disclosure by the recipient. Access to medical records may be subject to additional state and federal regulations. I understand that this disclosure may include information regarding drug and alcohol abuse, psychiatric and/or mental illness, accidents, disability, birth defects, cancer, and genetic information. I understand that I may revoke this authorization at any time by notifying the providing organization in writing. **TO THE PARTY RECEIVING THIS INFORMATION:** This information is being disclosed to you from records where confidentiality may be protected by federal and/or state laws. If so, regulations 42 CFR, Part 2, prohibit further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation.

Signature: _____ Date: _____

Consent for Services

Residential Medical Kare, LLC offers its patients face-to-face and telehealth services as deemed medically appropriate and under the guidance of state and licensure requirements in the Commonwealth of Virginia. Residential Medical Kare, LLC does not provide Emergency Services.

Office Hours: Monday through Friday from 8:00 AM to 5:00 PM EST.

Monday and Friday	Telehealth
Tuesday, Wednesday, and Thursday	On-site / Face to face

Provider- a Virginia Licensed Nurse practitioner who shall provide medical services to the client either in-person or via telehealth at home, in an independent, assisted living, or memory care setting.
Client- includes all parties signing for or on behalf of the person to whom services are provided / the patient.
Responsible Party- If this Agreement is executed by an attorney-in-fact under a power of attorney, herein referred to as Responsible Party agrees to be bound as Client by the terms of this agreement. The obligations created by this Agreement are joint obligations of the Client, Attorney-in-fact, and Responsible Party.
Care settings:
Home-Based: Patient residing in a location that is independent and not part of a residential community. Aging in place at home. Additional fees apply to this location as identified below.
Residential Community: Independent, Assisted, or memory care locations as part of a continuing care community.
Visit Modalities:
Face-to-face: In-person care is the "traditional" way to receive healthcare, counseling, and treatment. The provider will visit you at your living or clinic location.
Telehealth - the delivery of health care services using interactive phone/video conferencing to enable a health care provider to provide treatment to his/her patients and for patients to receive treatment without having to visit the office or travel long distances. The use of telehealth is at the medical discretion of the provider. As with any medical treatment, potential risks may be associated with telehealth. These risks include but may not be limited to: information transmitted may not be sufficient to allow for appropriate medical decision-making by providers. Patient / POA will: not record any telehealth sessions with the provider. Provider will not record telehealth sessions without my consent. This is so that your privacy can be protected.
Services:
New Patient Visit - The provider shall collect pertinent medical history, and perform a thorough assessment to diagnose, maintain, and treat identified problem(s). Medication

reconciliation will be done. The provider will order any home health care services, therapy, radiology, laboratory, or DME deemed medically necessary.
Follow-up Visit- routine, sick, urgent, routine annual wellness exams, cognitive assessments to ensure all medical issues have been addressed and resolved and address new concerns as necessary.
Coordination of care and Communication- All services above and beyond the normal scope of medical care including but not limited to communication with the patient's Family/Responsible Party as requested through phone calls, email, or reports. This also includes requests to fill out documents and medical-related forms. Coordination of care including communication will be considered part of the patient's visit and will be billed or charged accordingly.
Complex Care Management— If I qualify, agree to participate in CCM to develop a comprehensive care plan based on your diagnoses and treatment goals for all your chronic conditions. This plan coordinates the care you receive from all your healthcare professionals. I understand that there may be a copayment for this service.

Use and Disclosure of Medical Information - I understand that practices about the use and disclosure of my medical information are described in the current Notice of Privacy Practices as required by HIPAA and that I have been offered either on paper or read the complete notice available online at www.resmedkare.com

Termination of Services: Services may be discontinued by the Provider or the Patient / Client at any time with a (7) day written notice by email or mail.

Services Not Covered By Insurance, billable to the patient:

Item	**Fee**
Accounts past 30 days will be assessed interest monthly until paid	2.5 %
Credit card fees	3.5 %
Bounced check fee per occurrence of returned checks	$40
Capacity Letter	$100
Capacity-Related Services/Court Preparation Fees/Provide statement/testimony or any other court-related proceedings	$300/hr
Facility Move-in Paperwork / History and Physical	$350
Home-Based Visits Initiation fee	$ 500
Home-based monthly service fee. Billable on the first of the month	$ 250
Medical Forms and paperwork fee (i.e.: FMLA, VA assistance, long-term care insurance, Fast-Tran, etc.)	$ 50
Phlebotomy services - home-based	$65

Assignment of Benefits: I request payment of authorized Medicare and or other insurance benefits be made on my behalf for any services furnished to me by Residential Medical Kare, LLC and its independent contractors. I authorize Residential Medical Kare, LLC to provide my insurance company with any information about services rendered to me as necessary to process claims.

Copayments and non-covered services- Due at the time of services rendered and will be charged to the credit card or electronic fund transfer on file when the service is rendered.

Balances – I understand that I am financially responsible for all charges for services rendered to me by Residential Medical Kare, LLC and its independent contractors including any balances owed after insurance payments. Balances will be charged to the credit care or electronic fund transfer on file once claims are finalized for payment.

Information and Forms Required Before First Visit:

- Consent for Medical Care
- HIPPA Acknowledgement
- Insurance cards: Primary, Secondary – front and back
- Medical Health Questionnaire
- Release of Information
- Payment Authorization for balances, copayments, and services not covered by Insurance - Credit Card, or Electronic Fund Transfer (EFT).

I consent and authorize Residential Medical Kare, LLC and its independent contractors, to care for and treat me in my home or place or residence whether in-person or via Telehealth. I have read and understood the information above. I hereby give my informed consent for medical services in the course of my treatment. I agree with the above regarding the assignment of benefits and services not covered by insurance. I understand that my plan or care may change and if so, these changes will be discussed with me, and the final decision shall be mine. I agree to notify my Provider of any changes in my condition, any side effects of medications, or any other events related to my health and well-being. This authorization will expire only upon my death unless I revoke this authorization by written notice to Residential Medical Kare, LLC.

The patient or patient representative has read the above and must sign below.
I certify that all information provided is correct to the best of my knowledge.

Signature: _____ Date: _____

Pay: Copayments, Outstanding Account Balances, Services not covered by insurance, Home-based fees

Patient Name: _____ Date of Birth: _____

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION FORM

Bank Account Holder Name: _____

Bank Name: _____

Bank Routing #: _____ Bank Account #: _____

Bank Account Holder Signature:_____

Date:_____

.

CREDIT CARD AUTHORIZATION FORM ADDITIONAL

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover
Cardholder Name (as shown on card): _____
Card Number: _____ CVV: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I, authorize Residential Medical Kare, LLC to make an Electronic Fund Transfer (EFT) or charge my credit card for the above agreed-upon copayments, account balances and fees not covered by insurance. I understand this information will be saved to file for future transactions on my account.

Signature: _____ Date: _____