For Senior Living Staff

NEW PATIENT CHECK LIST

Protocol to establish a patient with Access Medical Care.

To establish a new patient promptly and schedule an appointment with our Nurse Practitioner, we must have all the information below. Contact with us can be through phone, fax or email.

(There may be a delay in scheduling if all information is not provided.)

- New patient intake form- fully completed and signed by resident or POA • Copy of front/back of insurance cards (**MUST HAVE-** to confirm eligibility)
- Full address, phone, and fax number where patient resides.
- Copy of complete MAR for provider to review and sign for refills.
- Code status.
- Medical history. Copy of any recent medical exams. Name of previous MD. Copies of any recent lab work.
- Pharmacy information; Name, Address, and phone/fax numbers.

Access Medical Care | 2469 Corrales Rd Bldg. A, Ste A Corrales, NM 87048 | Phone (505) 450-8709
Fax: 505-508-1514 | www.roadrunnerhealthcare.com

For Patients and Families

Practice information on Access Medical Care

Our medical providers are Certified Nurse Practitioners.
We specialize in providing primary medical care to homebound geriatric patients. Services are provided in private homes, assisted living communities or group homes.

We schedule visits Mon-Sat for routine care every 4-6 weeks, (per insurance guidelines) and try to accommodate sick visits as they arise.

Our office may be contacted Mon-Fri 8am-5pm
Currently, we do not have on-call services, including weekends, holidays, or after-hours availability. However, please leave a voice message and you will be contacted on the next regular business day.

In the event of an emergency or acute illness please call 911 or seek emergency medical attention and contact us for follow-up.

To avoid medication issues, please notify us Mon-Thurs of refill needs so you receive them before the weekend.
(**Please request refills one week prior to last dose**)

We collaborate with local companies to ensure our patients receive the services they need.

-Durable Medical Equipment Providers -Home Health Agencies- Tricore Laboratory -
-Mobile diagnostic testing and phlebotomy- Pharmacies- Hospice Agencies- -Referrals to Specialists if needed-

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CREDIT CARD OR BANK AUTHORIZATION

(This is needed for any copays or other fees not covered by insurance).

Name: _____

Billing Street Address: _____

Street Address (cont.): _____

City: _____ State: Postal Code: _____

Country: _____ Email: _____

Address: _____

Direct Telephone: (____) -

CREDIT CARD INFORMATION

Credit Card Type: □ MasterCard □ Visa □ American Express □ Discover Card

Number: _____

Expiration Month: _____ Expiration Year: _____ Security Code: _____

BANK INFORMATION

Routing Number Account Number

_____ _____

TERMS OF AGREEMENT

I authorize Roadrunner Home Health to charge my credit card _____ for services provided for patient_____

_____

NAME & SIGNATURE DATE

For Office Use Only

Service Fees: _____

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New Patient Intake Form

Patient Name:_____ **M** **F**

DOB:_____ **SS#**_____

Patient Address: (Where Physician will see patient)

_____

Street City State Zip

Move in date:_____ (required if new resident)

Phone:_____ **Email:**_____

Facility Name:_____ **House:** _____

Phone:_____ **Fax:**_____

Insurance Info: PLEASE PROVIDE A COPY ON INS CARDS (FRONT & BACK)

Primary:_____ ID#_____ Group#_____

Secondary:_____ ID#_____ Group#_____

Responsible Party:_____ **Relationship:**_____

Emergency Contact:_____ **Relationship**:_____

Phone:_____

Address:_____

Street City State Zip

Email:_____

Financial POA/ Medical POA (circle one)

Pharmacy: _____

Name Location

Phone:_____ Fax:_____

_____

Allergies:

Medication/Food

_____

_____

_____

Preventative Care (Colonoscopy, mammogram, etc,.)

_____

_____

_____

Medical History:

_____

_____

_____

Surgical History:

_____

_____

_____

Vaccinations: _____

Medications: Name/Dose/Directions (**Please Provide copy of current Med List**)

_____

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This form is so that you can update any of your information that may have changed and provide us with any records that we do not have on file. It is important that we stay informed of any medical preferences and health care decisions, known as “Advanced Directives”, that you may have put in writing so that we can do our best to honor them. Please note this is not a legal document: use this questionnaire to indicate whether you have authorized an agent to make health care decisions on your behalf and whether you have made any end-of-life decisions.

It is important to provide Access Medical Care with a signed copy of the documentation for these decisions, such as the New Mexico Advanced Directives form. Please attach copies to this form after completed and return them together. Or, alternatively, you can indicate if you would like us to contact a family member of your health care agent to geta copy of your directives. Lastly, advanced planning is an ongoing process, and we encourage you to continue discussing these issues with your doctor as needed. We will continue this process annually to make sure your information stays up to date.

Who participates in your medical care?

Please use this section to inform us of any family or friends who you would like us to share your medical information with. For example, are there other individuals in your household that may have to help you with any doctor’s instructions? Please provide their name, phone number and relationship. (If additional space is needed, please attach a separate page).

Name:_____ Relationship:_____

Phone Number:_____

Name:_____ Relationship:_____

Phone Number:_____

Advanced Directives: Please let us know about any Advanced Directives you may have signed.

Power of Attorney (POA):

Name:_____ Relationship:_____ Phone:_____

Address:_____

Do Not Resuscitate Order (DNR)

Yes- I have a DNR (please provide a copy) No-I do not have a DNR

Assignment of Benefits and Authorization to Provide Treatment

An Access Medical Care Nurse Practitioner will see you in your home or assisted living facility to provide medical care. Services include medical exams, evaluation, and treatment of acute and chronic health conditions; lab tests or diagnostic testing (a fee of $30 for mobile phlebotomist or diagnostic tech to go to your home. Fee due at time of service) prescriptions, on-going monitoring, and treatment to detect problems before they become critical. Visits are typically every 4-6 weeks.

Access Medical Care bills third parties for "Medically Necessary Visits", as would any healthcare provider. Our medical services are reimbursed by Medicare or other insurance in the same way as if you went to a doctor's office.

Last Name	First Name	MI	SSN#
Address			
City	State	Zip	

I, _____, authorize Access Medical Care LLC, to release to the Social Security Administration and Centers for Medicare and Medicaid Services (CMS), intermediaries or carrier, or any other commercial insurance company, any information needed for this or a related health care service claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefit either to myself or the care provider who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

I understand that Medicare of other insurances are considered a method of reimbursing the patient for fees paid to the physician and are usually not designed to pay the entire fee. Because insurance companies vary in amounts, they pay for services, it is my responsibility to pay the portion of the bill not paid by my insurance company (unless otherwise restricted by law or agreement Access Medical may have with the insurer).

I also hereby grant my permission for practitioners by Access Medical Care to assess and treat me in my home or on-site clinic for medical problems. I understand that the Nurse Practitioner is a licensed health care professional in the State of New Mexico.

Signature:_____ Date:_____

Relationship:_____

RELEASE OF INFORMATION:

I hereby authorize your agency to release to or receive from hospitals, physicians or other agencies involved in my care all medical records and information pertinent to my care. I hereby give permission for the review of my medical record by the agency's accrediting and/or other regulatory bodies. Please release all medical records to:

Access Medical Care LLC
2469 Corrales Rd. Building A Suite C
Corrales NM 87004

Telephone: 505-450-8709
Fax: 505-508-1514

Physicians: _____

Patient Signature: _____

Printed: _____

Legal Guardian: _____

Printed: _____

Relationship to Patient: _____

Agency Staff: _____

Printed: _____

Date: _____

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.

Access Medical Care is required by law to maintain the privacy and confidentiality of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Health Information

- We may disclose your health information to other healthcare professionals for the purpose of treatment, payment or health operations.
- We may disclose your health information to comply with state Worker's Compensation laws, as necessary.
- We may disclose your health information to a family member or other responsible party about your medical condition if they participate in your care.
- We may disclose your health information to public health authorities with the intent of preventing or controlling disease, injury, or disability; reporting child or adult abuse or neglect; medications; and reporting disease or infection exposure, as required by law.
- We may disclose your health information to a law enforcement official if necessary for law enforcement.
- We may disclose your health information to coroners or medical examiners.
- We may disclose your health information during any administrative or judicial proceeding.
- We may disclose your health information to our military, national security, prisoner, or government benefit purposes.
- In the event Access Medical Care is sold or merges with another organization, your health records will become the property of the new owner.

Your Health Information Rights

You have the right to:

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised however that Access Medical Care is not required to agree to the requested restrictions.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location, upon request.
- You have the right to inspect and copy your health information.
- You have the right to request that Access Medical Care amend your protected health information. Please be advised, however, that Access Medical is not required to amend your protected health information. If your request is denied, you will be given the reason for denial, as well as information on how you can disagree with the denial.
- You have the right to receive an accounting of disclosures of your protected health information made by Access Medical Care.
- You have the right to receive a paper copy of this notice and privacy practices at any time upon request.

Changes made to this form and the privacy practices:

Access Medical Care reserves the right to amend these notices at any time, making the new provision effective for all information it maintains. Until she amendment is made, Access Medical Care is required to comply with these notices.

Complaints:

Questions or concerns about your privacy rights, or complaints about how Access Medical Care has managed your health information should be reported to the office manager, Jennifer at 505-321-7295. If you are not satisfied with your response to your concerns, you may submit a formal complaint to:

DHHS Office of Civil Rights

200 Independence Ave., SW

Room S09F HHF Building

Washington, DC 20201