Physicians At Home, Inc.

The following packet is considered the Physicians At Home, Inc. New Patient Packet. The information disclosed in here is a binding agreement between the patient and Physicians at Home, Inc. in which the patient acknowledges PAH's policies and patient rights and responsibilities. We strive to earn the respect and trust of all of our patients, and in doing so remain transparent about the services provided to you. Please read the following subsections and sign the corresponding acknowledgement for all policies and agreements herein.

- ✓ **New Patient Packet Acknowledgement**
- ✓ **Financial Responsibility Consent**
- ✓ **Authorization to Release Health Care Information**
- ✓ **Controlled Substance Agreement**
- ✓ **Medication Refill Policy**
- ✓ **Medical Home Agreement**
- ✓ **Notice of Patient Privacy / HIPAA**

Physicians At Home, Inc
Physicians At Home Clinic
511 E 1st Street
Chandler, OK 74834
P: 405-654-0013
F: 405-654-0012

Physicians At Home, Inc.

Medication Refill Policy

- ALL refill requests are to be phone into our office at 405-654-0013.
- We ask that refill requests are phoned into the office seven days in advance.
- The maximum number of medication to be filled is a 90-day supply.
- All as-needed (prn) medication will only be prescribed for a max of 30 days.
- **Please do not phone your pharmacy to request refills.**

Your cooperation in ensuring that you receive your current medication timely is greatly appreciated. New prescriptions for controlled medications will not be issued for lost, stolen, or misplaced prescriptions. Nor will new prescriptions be issued if you take more than the prescribed amount.

By signing the consent form on page 11 you acknowledged receipt of this policy and agree to the terms and conditions.

Physicians At Home, Inc.

CONTROLLED SUBSTANCE AGREEMENT

The purpose of this agreement is to give you information about the controlled substances/medications you will be taking to assure you and your physician comply with all state and federal regulations concerning the prescribing of controlled substances. The physician's goal is for you to have the best quality of life as possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the physician/patient relationship and full agreement and understanding of the risks and benefits of using controlled medication.

1. You should use one physician to prescribe and monitor all controlled medications.
2. You should use on pharmacy to obtain all controlled prescriptions prescribed by your physician.
3. You should inform your physician of all medication you are taking, including herbal remedies, since controlled medication can interact with over-the-counter medications and other prescribed medications. This is especially true of cough syrup that contains alcohol, codeine or hydrocodone.
4. You will be seen on a regular basis and given prescriptions for enough medication to last from appointment until the following appointment.
5. Prescription for controlled medications will be done only during your visit or during regular office hours. No refills of any medication will be done during the evenings or weekends.
6. You may be asked to present all controlled medication and supplement medications prescribed by your physician in the original bottles during your appointment.
7. You are responsible for keeping your controlled medications in a safe and secure place, such as a locked cabinet or safe. You are expected to protect your medications from loss or theft. Stolen medications should be reported to the police and to your physician immediately. If your medications are lost, misplaced, or stolen, your physician may choose not to replace the medications or taper and discontinue the medications.
8. You may not give or sell your medication to any other person under any circumstances. If you do, you may endanger that person's health and violate the law. You may not obtain medication from another person, including friends and family members.

9. Any evidence of drug hoarding, acquisition of any controlled medication from other physicians including emergency room, uncontrolled dose escalation or reduction, loss of prescriptions, or failure to follow the agreement may result in termination of the doctor/patient relationship. Once terminated, you will receive 30 days of noncontrolled medications. During this 30-day period, it is the patient's sole responsibility to find a new primary care physician.
10. You will fully communicate your functional ability along with any side effects of the medication to your physician to the best of your ability at the initial and all follow-up appointments. This information allows your physician to adjust your treatment plan accordingly.
11. Controlled medications which have been previously discontinued should not be taken and should be disposed of properly and immediately.
12. You should not use any illicit substances, such as cocaine, amphetamine, etc. while taking these medications. This may result in a change to your treatment plan including safe discontinuation of your controlled medications when applicable or complete termination of the doctor/patient relationship.
13. Never consume alcohol when prescribed controlled medications.
14. You agree and understand that your physician reserves the right to perform regular and unannounced
15. There are side effects with controlled medications which may include, but are not limited to: skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema (swelling), sedation, or the possibility of impaired cognitive (mental status) and/or motor ability. Overuse of controlled medications can cause decreased respiration (breathing).
16. Physical dependence and/or tolerance can occur with the use of controlled medications. Physical dependence means that if the controlled medication is abruptly stopped or not taken as directed, withdrawal symptoms could include, but are not limited to: sweating, nervousness, abdominal cramps, diarrhea, goose bumps, and/or alterations in one's mood. Physical dependence does not equal addiction. One can be dependent on insulin to treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to insulin or prednisone.

Addiction is primary, chronic neurobiological disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control of drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases one's quality of life; where as appropriate use will result in improvement of one's quality of life.
Tolerance means a state of adaption in which exposure to the drug induces changes that result in diminution of one or more of the drug's effects over time.

17. If you have a history of alcohol or drug misuse/addiction, you must notify the physician of such history, since the treatment with controlled medications may increase the possibility of relapse.
18. You must agree to allow your physician to contact any healthcare professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about your care or actions if the physician feels it is necessary.

By signing the consent form found on page 11, you are acknowledging this agreement has been explained to you, and that you agree to the terms and conditions.

Physicians At Home, Inc.

Authorization and Assignment of Benefits Agreement

The undersigned, **via page 11**, hereby gives authorization to Physicians At Home, Inc, allowing them to furnish the Health Care Financing Administration, patients insurance company, attorney, or any representative thereof, with any all formation which may be requested regarding patients past or present physical condition and treatment. I hereby authorize Physicians At Home, to administer such medical care as may be deemed advisable for my diagnosis and treatment. I further authorize patient's insurance company, attorney, or Medicare to make payments directly to Physicians At Home, Inc for any medical or surgical expenses durable under the terms of the contract. I also agree that any balance not covered including deductibles, coinsurances, copays, or non-covered services will be paid by me, or upon my death, my estate, and photocopies of this form will be valid. I understand I am responsible for all charges of insurance coverage including court cost and attorney fees in the vent of collection actions.

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Physicians At Home, Inc.

This Medical Home Agreement Concept is an AGREEMENT between YOU and YOUR PROVIDER, to focus on meeting ALL of your Healthcare Needs.

As your Medical Home Primary Care Provider (PCP), we agree to:

1. Honor your rights as a patient, and treat you with dignity and respect.
2. We will focus on listening to your concerns, educating you on your health care needs and preventive services.
3. Focus on treating you as a whole person: physically, mentally and emotionally.
4. Focus on providing you with ***ongoing, quality*** and ***safe*** medical care, including prevention of future health complications.
5. Work to schedule timely office appointments for your chronic and urgent healthcare needs.
6. Be available to you 24 hours a day, by office appointment, phone calls and/or other electronic communication.
7. Provide you with other healthcare resources when we are absent or unavailable.
8. Provide you with referrals to specialist as deemed ***medically*** necessary by your PCP.
9. Provide you with treatment, medications, equipment and any other resources deemed ***medically*** necessary by your PCP.

As a Medical Home Patient, your responsibility is the following:

1. Work with us, as your ***PCP,*** to meet ***all*** of your health care needs.
2. Communicate with us about all your healthcare concerns and goals.
3. Report ***any*** changes related to your health, treatments, medications, etc.
   This includes use of ***all medications*** - prescription, over-the-counter, herbal and street drugs.
   This also includes any medical equipment being used or that has been ordered or recommended for use.
4. Call us ***before*** going to the Emergency Room, unless it is life threatening.
5. Notify us ***after*** any Emergency Room, Urgent Care Clinic or Hospital visit.
6. Schedule medical appointments in a timely manner, including ***follow-up*** appointments.
7. Keep appointments as scheduled with us and any appointments scheduled with a specialist.
8. If you cannot keep an appointment call ***before*** your appointment time to cancel or reschedule the appointment.
9. You may be dismissed from your PCP if you repeatedly miss appointments without notice or do not follow the responsibilities listed in the medical home agreement.

Your Healthcare is a TEAM Approach involving BOTH YOU and YOUR PROVIDER.

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Physicians At Home, Inc.

Acuerdo de centro de atención médica

*El **PRESENTE CONTRATO** de **Prestador de Servicios Profesionales** es un **ACUERDO** entre **USTED Y su Prestador de Servicios Profesionales y/o Proveedor a quien en lo sucesivo se le denominara "Proveedor"**, para satisfacer **TODOS** sus cuidados de salud.*

Como su médico o proveedor personal, acordamos:

1. Respetar sus derechos como paciente, tratándolo con dignidad y respeto.
2. Nos enfocaremos en escuchar sus preocupaciones, educarle en sus cuidados de salud y servicios médicos preventivos
3. Nos empeñaremos en tratarle como a una persona: física, mental y emocionalmente.
4. Nuestro propósito es proveer con **calidad continua** y **segura** de atención médica, incluyendo evitar enfermedades para el bienestar de su futura salúd.
5. Programaremos citas en un tiempo apropiado con urgencias de su salud y condición crónica.
6. Estaremos disponibles para Usted las 24 horas del día, a través de citas en consultorio, llamadas telefónicas y/u otros medios de comunicación electrónicos.
7. Proveerle con otros recursos en el cuidado de su salud si no estamos disponibles de inmediato.
8. Proporcionarle referencias a especialistas, según la recomendación **medicada** por su proveedor.
9. Ofrecerle un excelente tratamiento médico, así como medicamentos de calidad, equipo médico y cualquier otro recurso recomendado por su proveedor como le fue correctamente **medicado**.

Información y responsabilidades del paciente:

1. Colaborar con nosotros como su proveedor para satisfacer todos sus cuidados de salud.
2. Comunicarnos sus preocupaciones de salúd y metas establecidas.
3. Informar cualquier cambio relacionado con su salud, nuevos tratamientos, medicinas, etc.
   Esto incluye el consumo de **todos los medicamentos** ya sea estos con receta o sin ella, así como remedios caseros, hierbales y drogas.
   Esto también incluye el uso de cualquier equipo médico que actualmente este utilizando o que se le haya ordenado o recomendado a utilizar.
4. Llamarnos **antes** de ir a la sala de emergencias, a menos que sea una condición mortal.
5. Notificarnos **después** de cada visita a la sala de emergencias, clínicas de cuidados urgentes u hospitales.
6. Programar citas con el tiempo apropiado incluyendo citas de **seguimiento.**
7. Mantener sus citas programadas con nosotros y con especialistas.
8. Si no puede llegar o quiere cancelar una cita, llame **antes** para cancelarla o reprogramarla.
9. Usted puede ser despedido del cuidado su proveedor si repetidamente falta a citas sin cancelar previa notificación o si no cumple con las responsabilidades enlistadas en el presente contrato.

"El Cuidado de su Salud es un acercamiento en Equipo que involucra a USTED y su Proveedor Médico"

By signing the consent form found on page 11, you are acknowledging this agreement has been explained to you, and that you agree to the terms and conditions.

Physicians At Home, Inc.

HIPAA NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers’ Compensation.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Physicians At Home, Inc.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with our Operations Director in person or by phone at 405-654-0013.

Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.

By signing the consent form found on page 11, you are acknowledging this agreement has been explained to you, and that you agree to the terms and conditions.

Physicians At Home, Inc.

Authorization to Release Healthcare Information

I hereby authorize Physicians At Home, Inc / Physicians At Home Clinic to collect the following information from my health records.

Information to be disclosed (please check items that can be disclosed):

- ✓ Complete Health Records
- ✓ Therapy Records
- ✓ Physician Office Visit/Exam Records
- ✓ Imaging Reports
- ✓ Operative Reports
- ✓ Hospital Records
- ✓ Laboratory Test Results
- ✓ Specialist Consultation Reports

Definition: I understand that this information may include, information relating to communicable diseases such as acquired immunodeficiency syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus), psychiatric care, treatment for alcohol, drug abuse, and /or genetic testing, and other personal information.

□ **YES** □ **NO** **I authorize the release of my STD results, HIV/AIDs, testing, whether negative or positive to the person(s) listed above. I understand that the person(s) listed will be notified that I must give specific written permission before disclosure of these test results to anyone.**

□ **YES** □ **NO** **I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed.**

□ **YES** □ **NO** **I authorize the release of all test results such as labs, x-rays, cat scans, MRIs, EKG, etc. to the person(s) listed above.**

Patient Name: ____

Date of Birth: ______________________ SSN: ________________________________

Patient Signature: ____Date:__________

(Other legal representative acceptable.)

Physicians At Home, Inc.

I, the undersigned patient, have received, fully read, understand and agree to the policies and contractual patient-provider relationships as disclosed in the New Patient Packet. These agreements and policies include:

- ✓ **Controlled Substance Agreement**
- ✓ **Medication Refill Policy**
- ✓ **Financial Responsibility /AOB Consent**
- ✓ **Medical Home Agreement**
- ✓ **Notice of Patient Privacy / HIPAA**
- ✓ **Authorization to Release Health Care Information**
- ✓ **New Patient Packet Acknowledgement**

I have received the controlled substance agreement and acknowledge.
I have received the medication refill policy and acknowledge.
I understand that all copays/coinsurances will be due at the time of services rendered.
I have received the medical home agreement and acknowledged.
I have received a copy of the Notice of Privacy Practice from Physicians at Home, Inc.
I authorize the release of health care information to Physicians at Home, Inc.

Patient Name: ____

Patient Signature: ____Date:__________

(Other legal representative acceptable.)