David J. Weber, P.C.
Housecall Family Medicine

REGISTRATION

Patient Name_______________________________________ Social Security # ____________________________
Last Name First Name Middle Initial

Address____ City______________ State __________ Zip _________

This address must match the patient's address of record on file with the Social Security office.

Home Phone ( ) __________________ Cell Phone ( ) ___________________ Birthdate _________________

Sex M F Marital Status_____________ Race______________ Ethnicity Hispanic or Non-Hispanic (Circle)

Language English or Other ________________ Est. Height ________________ Est. Weight _______________

In case of emergency who should be notified? _____________________________ Phone ( ) _________________

Preferred Pharmacy ______________________ Address__________________________ Phone ( ) ____________

Current Home Health or Hospice Agency Name ____

Who should we contact for scheduling purposes?___________________________ Phone ( ) ________________

Whom may we thank for referring you? ____

NEXT OF KIN

Name______________________________ Home Phone ( ) ______________ Cell Phone ( ) ______________

Address____ City______________ State __________ Zip _________

Email Address ____Relation to Patient_________________________

Preferred Method of Contact Email Home Phone Cell Phone (Please circle one)

In the event that you are not able to make decisions for yourself, who do you designate as the person to make medical decisions for you?

Name ____ Phone ( ) ________________

PRIMARY INSURANCE

(PLEASE INCLUDE COPIES OF ISURANCE CARDS FRONT/BACK)

Do you have a Medicare Advantage MCO? _______________ If so, please list _____________________________

Medicare ID or Insurance ID # ____ Group #______________

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No

Subscriber Name ______________________ Birth date ___________________ Relation to Patient ____________

Address (if different from patient's) _______________________________Phone ( )________________________

City____ State___________________ ZIP _____________

Insurance Company__________________________________ Social Security # ___________________________

Subscriber or Member ID# __________________________________ Group # ____________________________

Effective Date(s) of Insurance ____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ____________________ and assign directly to Housecall Family Medicine all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Housecall Family Medicine may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed.

____ ___________________________________
Signature of Patient, Parent, Guardian or Personal Representative Date

PREVIOUS PHYSICIANS AND HOSPITALIZATIONS

Please List

MD Name/Facility ____ Phone ( ) ______________________

MD Name/Facility ____ Phone ( ) ______________________

MD Name/Facility ____ Phone ( ) ______________________

MD Name/Facility ____ Phone ( ) ______________________

IMMUNIZATIONS

Please List

______________________________ ____________________________ ________________________________

______________________________ ____________________________ ________________________________

ALLERGIES TO MEDICATION

Please List

______________________________ ______________________________ ________________________________

______________________________ ______________________________ ________________________________

ADVANCE DIRECTIVE

Have you been informed about your right to an advance directive? Yes No

Would you like information concerning advance directives? Yes No

Please read carefully before signing

ASSIGNMENT OF BENEFITS

Authorization To Release Information: I hereby authorize Housecall Family Medicine to give my insurance company any and all medical information necessary in processing any medical insurance claims.

Authorization To Pay Benefits To Physician: I hereby authorize payment directly to Housecall Family Medicine for any medical benefits otherwise payable to me. I understand the following insurance policy: Patients who carry health insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. Even though an insurance claim is filed, the patient will receive a statement each month if the account has a balance due. This office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. You are responsible for payment of your account within the limits of our credit policy. After three months from the time the claim is submitted the account becomes due. You or the responsible party is responsible for any expense incurred through the collecting of this account, including court costs, reasonable attorney fees, and collection fees should we have to go through a collection agency or court in order to collect on your account balance.

AUTHORIZATION TO TREAT

I hereby give my full permission, consent, and grant authorization for our physicians to assess my physical condition, and to render treatment according to generally accepted standards of care. This treatment may include, but is not limited to,various diagnostic tests or procedures, inquiries, medical history, or any other procedures deemed necessary by the physician(s).

Print Patient Name: ______________________________________

______________________________	____________________	____________
Signature of patient, or person authorized to sign for patient	Relationship to patient	Date

______________________________	____________________	____________
Signature of responsible party	Relationship to patient	Date

David J. Weber, P.C.
Housecall Family Medicine
407 Stonewall Street, Memphis, TN 38112 • Phone (901)278-6963 • Fax (901) 274-5224

AUTHORIZATION FOR RELASE OF INFORMATION

I, ________________________________do hereby authorize ________________________________to release protected
Patient Name **Name of previous physician or facility**

healthcare information to:

David J. Weber, M.D.
407 Stonewall Street
Memphis, N 38112
Phone (901) 278-6963
Fax (901) 274-5224 (please fax all requested information to this number)

The information released shall be limited to the following time period: ___________________, and the following specific part or parts of the health care information.

History & Physical	Discharge Summary	X-Ray
Operative Report	Clinic Visit	Lab
ED Record	Psychosocial Assessment	Demographic Information
Insurance Information	All information in chart	Other ___________________

I understand that this authorization is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain services, however withholding of healthcare information may affect my healthcare. I also understand that if the person or organization I authorize to receive the information described above is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. The expiration period for this authorization is ____________________; if I have not designated a time period it will expire six (6) months after the date of my signature below and it covers only treatment prior to the at date. I may revoke this authorization at any time by notifying the office manager of Housecall Family Medicine, in writing. Revocation will only be effective if the release of information has not already occurred or is already in progress. I understand that I may see and copy the information described on this form if I ask for it, and I can obtain a copy of this form after I sign it if I desire.

I also understand that Title 42 of the Cod of Federal Regulations covers any disclosure of healthcare information concerning diagnosis and treatment of alcohol or drug abuse. If such information is contained in my records, I hereby authorize the release of such information. I also authorize the release of any information in my health care record related to diagnoses and/or treatment of psychiatric or mental illness, any stage of infection with HIV (AIDS) virus, or sexually transmitted disease.

I understand that by signing this authorization I am releasing Housecall Family Medicine from all legal liability that may arise from the release of the information requested.

____ ____________________
Signature of patient or authorized individual Date

____
Relationship if signed by other than patient

Caregiver
Conservator
Healthcare Power of Attorney
Guardian
Caregiver

____
Address of Patient

____ ____________________
City State Zip Phone Number

____ ____________________
Witness Date Date of Birth

To our patients: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

David J. Weber, P.C.
Housecall Family Medicine
Notice of Privacy Practices
(Summary Notice – **Practice's Copy**)

PLEASE REVIEW THIS PAGE, SIGN BELOW, AND <u>RETURN THIS PAGE TO THE STAFF PERSON WHO GAVE IT TO YOU</u>.

Under This Top Page, You Should Have Received A Longer Notice Document. If You Did Not, Please Request One From Our Staff Person Who Provided This Page To You.

Please keep the longer Notice document and take it home with you. YOU MAY REVIEW THE LONG-FORM NOTICE EITHER NOW OR LATER. In either case, let us know if you have any questions after reviewing it.

***UNDERSTANDING YOUR MEDICAL RECORD/HEALTH INFORMATION*:**

Each time you visit a health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. The doctors and staff of our practice use and maintain this health information relating to the care you receive from us.

The longer Notice attached to this page contains information to help you understand what is in your medical record and how your health information is used. This helps you ensure the accuracy of such information, and lets you better understand who, what, when, where, and why others may have access to your health information.

Please sign below to acknowledge your receipt of the attached long-form Notice:

____
Patient name (*please print*)

____
Signature or initials of patient or personal representative*

* If personal representative, please list relationship

____
Relationship to patient

____
Date

David J. Weber, P.C.
Housecall Family Medicine

PATIENT'S RESPONSIBILITIES

1. Remain under the medical provider's care while receiving home care services.
2. Inform our office of any and all changes in physicians involved in the care of the patient. Unless agreed upon in advance, Housecall Family Medicine ("HFM") will become the primary care provider ("PCP") for the patient and assume all duties and responsibilities of a PCP, including signing home health plans of care and other orders, consulting other specialists, approving any durable medical equipment and maintaining a comprehensive medical chart with all consultants' advice approved before implementation.
3. Provide HFM with complete and accurate health history.
4. Provide HFM with all requested insurance and financial information, and notify us immediately upon any changes.
5. Sign the requested consent and release forms for insurance billing and in accordance of the Privacy Act.
6. Participate in care by asking questions and expressing concerns.
7. Provide a safe home environment in which medical care can be given. This may include allowing recommended changes in home environment.
8. Notify HFM of any changes in address or phone numbers.
9. Comply with all agreed upon therapy and notify HFM immediately if unable to comply with provider recommendations.
10. Accept full responsibility for any refusal of recommendations.
11. Treat all members of HFM with respect and consideration.
12. Advise the HFM of any dissatisfactions or concerns about the care given.
13. Agree to pay the $75 travel and administrative fee at or before the time of service. **This fee is not covered by any insurance plans.** We accept Visa or Mastercard for this charge.
14. Be respectful of the stated office hours. Routine calls should be made between 9:30 A.M. and 4:30 P. M. Monday – Friday, except on Thursdays, when the office closes at 12:30 P. M.
15. I have read and understand HFM's Office Policies and accept them without exception.

My signature below affirms that I agree to abide by the patient responsibilities.

______________________________ ______________
Signature of patient or Power of Attorney Date

____
Relationship to Patient

David J. Weber, P.C.
Housecall Family Medicine

BILLING INFORMATION

Person Responsible for Account ______________________________ Relation to Patient ________________

Last Name First Name Middle Initial

Billing Address ________________________________ City ____________ State _____________ Zip _____

Phone ( )_________________________ Alternate Number ( ) _________________________________

Email Address____

Financial Power of Attorney Yes or No (Please circle one)

If no, please list name, address and phone number below:

____

____

ADMINISTRATIVE AND TRAVEL FEE CREDIT/DEBIT CARD INFORMATION

In accordance with our office policy, the patient's **$75** administrative and travel fee will **be paid by the responsible party on the day of each house call**. This fee is only charged one time per month in case the patient needs multiple visits over a short period of time.

This fee is not covered by any insurance plans.

The physician is not permitted to accept cash or checks unless prior arrangements have been made with the office manager. For this reason, we accept Visa and Mastercard. We will automatically charge your card on the day of each visit.

Name of patient ____

Name on credit card ____

Cardholder's address ______________________ City ___________ State _____________ Zip ________

(where you receive your statements)

Type of card (circle one): Visa Mastercard

Credit card number _______________________________________ Expiration date _____/____/______

V-Code on card (3digit code on back) ______________

Signature of cardholder ____

To our patients: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

David J. Weber, P.C.
Housecall Family Medicine
Notice of Privacy Practices
(Full-length Notice – **Patient Copy**)

You should have received a short-form summary notice to sign along with this full-length version. If you did not, please request one from our staff person who provided this form to you. If you have any questions after reviewing this information, please direct them to the person who provided this notice to you, or to our Privacy Officer (whose contact information is contained in this notice).

UNDERSTANDING YOUR MEDICAL RECORD/HEALTH INFORMATION

Each time you visit a hospital, physician, or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information is often referred to as your "medical record." This information and other information relating to your care are referred to in this notice as "Health Information." The doctors and staff of David J. Weber, P.C. (our "Practice") maintain Health Information relating to the care you receive from us.

The Health Information contained in your record is useful for a number of reasons. For example, this information:

- Serves as a basis for planning your care and treatment
- Provides a means of communication among the many health professionals who contribute to your care
- Describes the care you received
- Allows you, your insurance company or other third-party payer to verify that services are accurately billed
- Allows health care professionals and organizations involved in your care to conduct treatment, payment, and operational activities
- Contains information we will need to contact you about appointment reminders, treatment alternatives, or other health-related benefits

Understanding what is in your record and how your Health Information is used helps you to ensure its accuracy and to better understand who, what, when, where, and why others may access your Health Information. This, in turn, allows you to make more informed decisions about its use and disclosure.

YOUR HEALTH INFORMATION RIGHTS

Although your Health Information at our offices is the physical property of our Practice, you have certain rights relating to this information. As a patient, you are generally entitled to:

- Obtain a copy or summary of your Health Information or to inspect such information (a reasonable fee may be charged)
- Request an amendment to your Health Information where you feel there is an error
- Request a restriction on certain uses and disclosures of your Health Information (we will consider reasonable, appropriate requests, but are not obligated to agree to them)
- Obtain an accounting of certain disclosures of your Health Information (a reasonable fee may be charged to fulfill repeated requests for accountings)
- Request that communication of your Health Information made to you be made by alternative means or at alternative locations (for example, a certain postal address or phone number). Please be aware that it is our standard practice to use any or all of the information you have provided to us in order to contact you for purposes of treatment (for example, conveying test results), payment, and business operations (for example, scheduling appointments, providing reminders). We may use mailings and may leave messages on your answering machine, voice mail, or with others who may answer your phone for these purposes. Also, if contact information we have for you is no longer valid, we may contact other persons identified in your record (for example, family members, persons identified as an emergency contact) to obtain updated contact information on you. If you wish to limit or specify the means by which we contact you, you may request our Patient Request Form and return it to our Privacy Officer as provided below. You do not need to give a reason for your request. Our Practice will accommodate requests we determine to be reasonable
- Revoke a previous authorization to certain uses and disclosures of your Health Information by our Practice (that you may have provided under a written authorization), except where actions have already been taken relating to that authorization

To exercise any of these rights, you must submit a request in writing. Please contact our Privacy Officer to obtain written request forms or to ask any questions you have regarding these rights. You can contact our Privacy Officer, Susan Weber at (901) 278-6963. Communications may also be sent by mail to: Privacy Officer, David J. Weber, P.C., 407 Stonewall Street, Memphis, TN 38112.

OUR RESPONSIBILITIES

Our Practice is required by law to take measures designed to protect the privacy of your Health Information and to provide you with this notice describing our privacy practices and legal duties. We are also required to abide by the terms of our current notice. We reserve the right to change our notice and privacy practices, and to make the new provisions effective for all protected health information we maintain, including your Health Information. Should our privacy practices change, we will post our revised notice at our offices. An updated version may also be obtained if you request a copy from our Privacy Officer or from staff during a visit to our offices.

We will not use or disclose your Health Information without obtaining your written authorization except as consistent with this notice or as otherwise required or permitted by law (for example, in emergency treatment situations).

Although other health care providers may provide treatment to you (for example, hospitals or other physician groups) and we may share your Health Information with them for treatment, payment, and certain operations purposes, we are not jointly managed with or owned by such providers. They are separate entities and will have their own policies and procedures for handling your Health Information.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If have questions and would like additional information, you may contact our Practice's Privacy Officer, You can contact our Privacy Officer, Susan S. Weber, at 901-278-6963. Communications may also be sent by mail to: Privacy Officer, David J. Weber, P.C., 407 Stonewall Street, Memphis, TN 38112. If you believe your privacy rights have been violated, please file a complaint with the Privacy Officer, as listed above, or with the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

EXAMPLES OF POSSIBLE USES AND DISCLOSURES OF HEALTH INFORMATION

We will use your Health Information for treatment. For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine your course of treatment. Members of your health care team will then record the actions they took and their observations. Our Practice may also provide copies of your Health Information to other health care providers who take care of you.

We will use your Health Information for payment. For example: A bill may be sent to you or your insurance company or other third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. Our Practice may also provide other health care providers involved in your care with information to assist in their billing and payment activities.

We will use your Health Information for our business operations: For example: Our Practice doctors and staff may use information in your health record to assess the care and outcomes in your case and others like it or to train students or other health professionals. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

Vendors: There are some services provided in our organization through contracts with outside vendors. For example, we might use a copy service to make copies of patient records for us. When such services are contracted, we may disclose your Health Information to our vendors so that they can perform the job we've asked them to do. To help protect your Health Information, we require vendors to agree in writing to safeguard Health Information, consistent with the same standards that we are required to observe.

Organized Health Care Arrangements: In some settings, we may be part of a clinically integrated care setting in which you typically receive health care from more than one health care provider (for example, a hospital). Also, we may participate in arrangements with other health care entities to conduct joint health care-related activities. In these settings and arrangements, your Health Information may be shared between us and the other providers or participants for treatment, payment, and certain operations purposes. These other providers or participants remain separate entities from us and will have their own policies and procedures for handling your Health Information.
Notification: We may use or disclose your Health Information to notify or assist in notifying a family member, personal representative, or other person responsible for your care, of your location and general condition in the event you are unable to care for yourself.

Communication with family: Unless you object and inform us of your objection, we may disclose to your spouse, other family members/relatives, or close personal friends, or to any person you have identified as being involved in your care, Health Information that is in our judgment relevant to that person's involvement in your care or payment for your care.

Note to persons under the age of 18: Good medical practice, payment requirements, or state law may make it necessary to tell your parent or guardian about your visit or provide them with all or part of your Health Information. If this is a concern to you, please discuss your concern with your doctor or our Practice's Privacy Officer before you receive services.

Limited data sets and de-identified information: In many instances where we use or disclose information for purposes of research, public health, or health care operations, certain information (names, social security numbers, etc.) will be removed to help protect the identity of the patient.

Research: Our Practice and its practitioners may become involved as a study site and serve as researchers for certain research trials. In order to provide you with useful information concerning the availability of such trials, we may review your medical record from time to time to see whether you might be eligible to participate in certain studies in which you may then have access to experimental treatments. If it appears that you may be eligible for participation in a trial, your doctor or a member of our privacy workforce will contact you to ask whether you may be interested and to provide further information. Beyond these preparatory activities, we will only use or disclose your health information for research purposes in limited circumstances -- for example, where you have signed a specific written authorization, where a research protocol has been designed and approved by a research IRB, or where other precautions have been used consistent with federal privacy regulations.

Deaths: We may disclose Health Information to medical examiners or funeral directors to permit them to carry out their duties.

Organ donor organizations: Consistent with applicable law, we may disclose Health Information to organ donor organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We, or persons working with us, may contact you to provide information about health-related products or services that may be of interest to you. Your Health Information may also be a source of data for our Practice's planning and marketing activities. If we desire to provide Health Information to third parties for their marketing activities, we will ask for your authorization in writing before doing so.

Food and Drug Administration (FDA): We may disclose to the FDA Health Information relative to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recall, repair, or replacement.

Workers compensation: We may disclose Health Information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: We may disclose your Health Information to public health or legal authorities charged with improving health (for example, by preventing or controlling disease, injury, or disability) when and to the extent required or permitted by law.

National security/military service: We may disclose Health Information for national security purposes. We may also disclose Health Information about Armed Forces personnel to appropriate military authorities in certain circumstances.

Correctional institution: If you are an inmate of a correctional institution, we may disclose to the institution or agents of this institution Health Information necessary for your health and the health and safety of others.

Law enforcement/Prevention of harm/Required by law: We may disclose Health Information for law enforcement purposes as required by law or in response to a valid subpoena or court order; or where, in our judgment, we believe there may be a threat of serious bodily harm to a patient or other person. Also, Federal or state law may require that your Health Information be released to an appropriate health oversight agency, public health authority, or other organization in certain circumstances.

THE POLICIES IN OUR NOTICE WERE FIRST EFFECTIVE AS OF: **April 14, 2003, and last revised September 3, 2013.**

David J. Weber, P.C.
Housecall Family Medicine

OFFICE POLICIES

We appreciate having you as a patient and we want to provide the best possible care. This information is designed to increase communication and help with meeting your needs.

APPOINTMENTS & HOUSE CALLS

Since we only make house calls to patients, there is no waiting room to consider or specific appointment time given when appointments are made. The physician will determine the frequency of house calls based on your medical condition. The receptionist will call you or your caregiver to confirm the appointment at least 24 hours before the date to ensure that you are expecting the doctor and to check the address where the house call will be made.

Before the doctor arrives for your house call, you should be prepared to be examined. Depending on the circumstances, you may require a full physical examination. Have a robe available and a place in your home where you can be examined comfortably while lying down. Provide the doctor with good lighting and a chair, as well. Have all of your medications out and organized so that the doctor can review your medicines with you. The physician will need a clean sink with paper towels to wash his or her hands, as well.

TELEPHONE CALLS

All routine calls, such as billing questions, prescription refills and routine notifications should be made between 9:30 A.M. to 4:30 P.M. Monday – Friday, except on Thursdays, when our office closes at 12:30 P. M. If you get our voice mail, leave a clear message. Your call will be returned promptly. As we all know, technology is not perfect and mistakes happen. If your call is not returned, please call again. We care about your health and well-being and want to discuss your questions and concerns.

Usually the physician will answer routine calls after the above mentioned office hours. If you believe your question needs to be answered sooner, please tell us. Our receptionist will try to locate the doctor as soon as possible. Should you find yourself in a true emergency such as massive bleeding, severe chest pain, stroke symptoms or others, call 911. If you are on hospice, call your hospice agency.

PRESCRIPTION REFILLS:

Prescription refills may be requested using the prescription refill option on our telephone system. It may be determined that the doctor needs to see you before refilling some medications in order to provide the best care. When you call for a prescription refill, please leave your full name, the name of the patient and his/her date of birth, name and address of your pharmacy, the name of the medication, and the dosage and frequency. If the physician approves the refill, the prescription will be available the following business day. **It is highly recommended that you notify us of your need at least one week prior to your medication running out.**

Some medications cannot be called or faxed to the pharmacy and must be **mailed or hand-delivered** each month. We will mail these prescriptions directly to your pharmacy. Please call in these requests at least 4 days before the patient runs out of the medication.

Our office does not accept professional prescription samples and we do not ever have these to give to our patients. Many studies have shown that samples increase the cost of medications in the long run and detract from the physician's judgment of which medication is best for you. We have no financial affiliation with any drug companies.

INSURANCE & PAYMENTS

We accept only Medicare as primary insurance for our patients. Charges for office visits are expected to be paid, including co-payments, at the time of service. If you have insurance and have not met your deductible for the fiscal year, we expect payment in full when services are rendered until the deductible has been met. **The Medicare fiscal year begins on January 1, at which time the deductible will be owed. For 2013, this amount is $147.00.**

If you have no secondary or "Medigap" insurance, you are responsible for the remaining balance once Medicare has paid the allowable amount. You will be billed for this amount once Medicare has submitted its payment to our office.

If you do not have insurance, full payment is expected in advance of your visit. If you have a balance on your account, it must be paid before your next visit.

Returned checks – if your check is returned for any reason, there will be a processing fee of $25.00 (or up to the legal limit) added to your account.

Delinquent bills may be forwarded to a collection agency. We reserve the right to add a processing charge to your account for the service. If bills are turned over to a collection agency, information necessary for collection will be shared with that agency and you will be dismissed from this practice.

We will call your insurance company if you need assistance with clarification of coverage, but we cannot guarantee the coverage quoted by the company. Our office will assist you, if needed, with this information, but ultimately, your insurance policy is an agreement between you and the insurance company and you are responsible for payment of the bill. We generally give insurance companies 45 days to submit payment and then you will be responsible, regardless of the outcome of claim(s). The best source of information regarding your insurance coverage for these types of services is your insurance company and benefit plan.

MEDICAID/TENNCARE

We do not accept Medicaid/TennCare as primary insurance. We will file crossover claims from Medicare if the patient is QMB eligible.

MOBILE SERVICES OFFERED

We are capable of doing many tests in the comfort of your own home. Routinely, we draw blood for laboratory testing and perform other basic diagnostic testing. There are many mobile services that cater to patients who cannot leave their homes. For example, physical therapy, occupational therapy, mobile x-rays, mobile ultrasounds, and mobile eye examinations can all be done in your home. We also have close association with certified Geriatric Care Managers, who often assist patients from a social services perspective. Our goal is to keep you, our patient, as comfortable as possible, without sending you unnecessarily to a hospital for these routine tests and services.

FORMS & LETTERS

We fill out disability forms and others as needed. There is a charge for these services - $15 for a single page, $25 for multiple pages. Please allow at least 48 hours or 2 business days for completion.

In order to protect your privacy, we require an authorized signature from you to release your medical records. The only exceptions would include a medical emergency or when required by law in specific circumstances. There will be a charge of from $15.00 to $50.00 for copying and handling records.

HOME HEALTH & HOSPICE

If you require home health services, we will be in charge of ordering the service and supervising all paperwork that is required of the agency. The doctor will be responsible for your plan of care and will communicate regularly with the nurses and staff of the agency to oversee your care. We work with all home health agencies in Memphis and let the patient suggest which agency they prefer. Dr. Weber performs medical consultations for Meritan Home Health Agency.

HOSPITALIZATION

Our physicians do not currently admit patients to any hospital; however, they will work with other physicians to provide you with a good continuum of care while you are in the hospital. It is your responsibility to notify our office if you are admitted to the hospital. The hospital will not do this for you. It is also your responsibility to notify us upon your discharge from the hospital.

DURABLE MEDICAL EQUIPMENT & SUPPLIES

We routinely order medical equipment and medical supplies for our patients, as needed. These orders are supervised and paperwork is completed by the physician.

LABS, X-RAYS & OTHER TESTS:

Labs, x-rays and other tests are reviewed promptly by your physician. You should receive a call within 48 hours for most tests. If you do not receive a call informing you of your results, the tests may have been lost or we may not have been able to contact you. It is encouraged and welcome for you to call our office if you do not receive a prompt phone call informing you of the results of your tests.

FEEDBACK & SUGGESTIONS:

We believe that we have an excellent team of individuals to help provide outstanding care to each patient. Our philosophy is that each of our patients receives the same quality of care we would want for our own parents and loved ones. We want to foster a feeling of cooperation and eliminate the usual adversarial relationship seen so often in today's medical environment. The key to success in achieving this goal is communication. So if you have a concern, question or problem, by all means let us know. No question is silly or dumb. Remember, we are all human beings, we all live on the same planet, and we desire happiness, prosperity and good health.