LITTLE BLACK BAG HOUSE CALLS, LLC

901 Indiana Ave, Ste 540
Wichita Falls, TX 76301
Phone: (940) 249-5253 Fax: (940) 249-5002

DATE: _____

CRICLE ONE: Mr. / Ms. / Mrs.

PATIENT'S NAME: _____ D.O.B:___/___/_____

SEX: M/F: _____ SOCIAL SECURITY#:_____

ADDRESS:_____ CITY/STATE:___/___ ZIP:_____

PHONE # ( )_____ CELL: ( )_____

EMERGENCY CONTACT: _____ RELATIONSHIP:_____

DX:_____

ALLERGIES:_____ PHARMACY:_____

MEDICARE # _____ MEDICAID #_____
EFFECTIVE DATE: _____ EFFECTIVE DATE: _____

PRIMARY CARE PHYSICIAN:_____
HOME CARE/HOSPICE AGENCY:_____

PLEASE READ CAREFULLY& SIGN BELOW:

I **UNDERSTAND** _____ IS **NOT** A PHYSICIAN AND I AGREE TO **AUTHORIZE** ROUTINE CARE SERVICES RENDERD BY LITTLE BLACK BAG HOUSE CALLS, LLC. MY SIGNATURE BELOW INDICATES THAT I UNDERSTAND THE LIMITATIONS OF THE SERVICES. I AM **INSTRUCTED** TO CONTACT THE HOSPITAL/ER (**911**) IN THE CASE OF AN EMERGENCY AND I WILL NOTIFY MY PRIARY CARE PROVIDER OF ANY CHANGES IN MY CONDITION.

_____

PATIENT SIGNATURE **DATE**

Patient Rights and Responsibilities

Our Practice is committed to providing quality health care. It is our pledge to provide this care with respect and dignity. In keeping with this pledge and commitment, we present the following Patient Rights and Responsibilities:

You have the right to:

- A personal clinician who will see you on an on-going, regular basis.
- Competent, considerate and respectful health care, regardless of race, creed, age, sex or sexual orientation.
- A second medical opinion from the clinician of your choice, at your expense.
- A complete, easily understandable explanation of your condition, treatment and chances for recovery.
- The personal review of your own medical records by appointment and in accordance with applicable State and Federal guidelines.
- Confidential management of communication and records pertaining to your medical care.
- Information about the medical consequences of exercising your right to refuse treatment.
- The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency situation.
- Be free from mental, physical and sexual abuse.
- Humane treatment in the least restrictive manner appropriate for treatment needs.
- An individualized treatment plan.
- Have your pain evaluated and managed.
- Refuse to participate as a subject in research.
- An explanation of your medical bill regardless of your insurance and the opportunity to personally examine your bill.
- The expectation that we will take reasonable steps to overcome cultural or other communication barriers that may exist between you and the staff.
- The opportunity to file a complaint should a dispute arise regarding care, treatment or service or to select a different clinician.

You are responsible for:

- Knowing your health care clinician's name and title.
- Giving your clinician correct and complete health history information, e.g. allergies, past and present illnesses, medications and hospitalizations.
- Providing staff with correct and complete name, address, telephone and emergency contact information each time you see your clinician so we can reach you in the event of a schedule change or to give medical instructions.
- Providing staff with current and complete insurance information, including any secondary insurance, each time you see your clinician.
- Signing a "Release of Information" form when asked so your clinician can get medical records from other clinicians involved in your care.
- Telling your clinician about all prescription medication(s), alternative, i.e. herbal or other, therapies, or over-the-counter medications you take. If possible, bring the bottles to your appointment.
- Telling your clinician about any changes in your condition or reactions to medications or treatment.
- Asking your clinician questions when you do not understand your illness, treatment plan or medication instructions.
- Following your clinician's advice. If you refuse treatment or refuse to follow instructions given by your health care clinician, you are responsible for any medical consequences.
- Keeping your appointments. If you must cancel your appointment, please call the health center at least 24 hours in advance.
- Paying copayments at the time of the visit or other bills upon receipt.
- Following the office's rules about patient conduct; for example, there is no smoking in our office.
- Respecting the rights and property of our staff and other persons in the office.

As indicated by my initials, I have been informed of my Patient Rights & Responsibilities. _____

LITTLE BLACK BAG HOUSE CALLS

P: 940-249-5253 F: 940-249-5002

Consent to Treat & Financial Responsibility

Consent to Treat

I hereby authorize employees and agents of Little Black Bag House Calls, LLC to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

Patient Name (Please Print)

Signature of Patient, Parent, or Legal Guardian | Date

Financial Responsibility

I understand that for all cash customers, payment of services is due in full before the services are rendered. I hereby authorize payment of medical benefits directly to Little Black Bag House Calls and/or the attending provider for services rendered. Authorization is hereby granted to release information contained in the patients' medical record to the patients' medical insurance company (or its employees or agents) as may be necessary to process and complete the patients' medical insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ('AIDS') and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to Little Black Bag House Calls, LLC. I further understand that should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses by Little Black Bag House Calls, LLC, if any.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

Patient Name (Please Print)

Signature of Patient, Parent, or Legal Guardian | Date

Attach Supporting Documentation for Legal Guardian if necessary.

Authorization for Use or Disclosure of (PHI) Protected Health Information

I hereby authorize the use and disclosure of individually identifiable health information related to me, which is called (PHI), Protected Health Information, under a federal health privacy law, as described below. I also authorize Little Black Bag House Calls, LLC to send over the visit notes to my primary care provider following this visit. My PCP is: _____

I, _____, authorize Little Black Bag House Calls, LLC to release and obtain my private health information to/from (check all that applies):

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

Are there any restrictions on PHI to be disclosed: Yes / No If yes:

_____

_____

No one other than myself may have access to my medical records: Yes/No

May our office leave a message on your machine: Yes/No

The PHI will be disclosed to confirm appointments, to render caregivers counseling on my treatment, for prescription pick-ups, and any other reason to ensure I obtain optimum treatment and care while I am patient of Little Black Bag House Calls, LLC. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to attention Privacy Officer at 901 Indiana Ave, Ste 540, Wichita Falls, TX 76301. I understand that my revocation will not affect any actions taken by Little Black Bag House Calls, LLC prior to receiving my revocation. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may refuse to sign this authorization and that my refusal in no way affects my treatment. My provider will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. This authorization shall be effective one year from the date signed, or until revoked in writing. At which time this authorization to obtain and release this protected health information expires.

_____ _____

Patient Signature or Authorized Representative and Relationship Date

LITTLE BLACK BAG HOUSE CALLS

Patient History

Patient Name: _____ **Date:** _____

Have you ever had?	No	Yes		No	Yes	Are you experiencing?	No	Yes
Hypertension			Hepatitis			Chills		
Chest pain			Diabetes			Fever		
Heart Attack			Anemia			Shortness of Breath		
Irregular Heartbeat			Gout			Chest Pain		
Pacemaker			Thyroid Disease			Numbness		
Cardiac Defibrillator			Phlebitis			Extremity weakness		
Asthma			Stroke			Resting pain		
COPD/Emphysema			Cancer			Pain when walking		
Sleep Apnea			High cholesterol			Temporary blindness		
Kidney Disease						Slurred speech		

Little Black Bag House Calls, LLC in order to comply with "meaningful use", we are asking our patients to fill out the following questionnaire.

Race: Check One

	American Indian		Alaskan Native		Asian
	African American		White		Native Hawaiian/Pacific Islander
	Decline to report/Unreported				

Ethnicity: Check one

	Hispanic/Latino		Non-Hispanic/Latino		Decline to report/Unreported

Nationality: _____ ☐**Decline to Report**

Primary Language: _____ ☐**Decline to Report**

Social History	Current	Past	How Much?
Alcohol			
Illegal Drug Use			
Tobacco	☐Every Day Smoker ☐Some Day Smoker ☐Former Smoke ☐Never Smoked ☐Other: _____		

Past Surgeries	Date of Procedures

Patient Signature: _____ Date: _____

Medications and Providers

Patient Name: ______________________________ **Date:** ________________

Medication List

Medication Name	Strength	Frequency

Allergies:

____

____

Current Physicians

Physician Name	Specialty	Phone Number

Patient Signature: ______________________________ Date: ________________