Doctors Home Visits, Inc
Donald K. Zeigler, MD

Thank you for your interest in Doctors Home Visits, Inc. (DHV), the office of Donald Zeigler, MD, Janice Burgess, NP, and Rachel Krumrie, NP. DHV provides primary care services for the elderly and disabled homebound patients. Our providers and staff value our patients and care deeply about the aging and disabled population. DHV serves patients in Bledsoe, Bradley, Hamilton, Marion, Meigs, Rhea, and Sequatchie counties. We use several resources to assist us in providing quality care to our patients, i.e., home health agencies, mobile radiology, mobile lab, and DME companies. There may be times we refer the patient to another physician (specialist) or diagnostic facilities if services cannot be provided in the home.

We accept most insurances with the exception of Humana HMO.

Please complete the attached forms and return them to our office at the address below or by fax with a copy of the front and back of your insurance card(s).

If you have any questions or would like to make an appointment, please call our office at 423-451-7623.

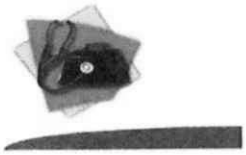
Kelley Painter

Office Manager

Doctors Home Visits, Inc.

Doctors Home Visits, Inc., PO Box 1615, Soddy Daisy, TN 37384-1615
Phone: 423-451-7623, Fax: 423-451-7677

Name_____ Dob_____



Patient Demographic Form

Date:_____

Please Print Clearly

PATIENT INFORMATION

Last Name | First Name | Middle Initial | Nickname/AKA

Date of Birth | Social Security | Gender ☐Male ☐Female

Marital Status ☐Single ☐Divorced ☐ Married ☐ Separated ☐Widowed ☐ Other

Race (Optional) ☐American Indian/ ☐Alaskan Native ☐ Asian/Pacific Islander ☐ Other ☐Caucasian ☐Hispanic ☐African American

Home Address | Apt # | City | State | Zip Code

Home Phone | Work Phone | Other Phone

Email Address

Language other than English

PHYSICIAN REFERRAL INFORMATION

Referred By

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship ☐Self (If self, skip to Emergency / Next of Kin) ☐ Spouse ☐ Parent ☐ Other

Last Name | First Name | Middle Initial

Date of Birth | Social Security Number

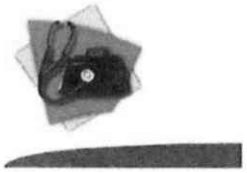
Home Address | Apt # | City | State | Zip Code

Home Phone | Work Phone | Cell

Employer

Employer Phone

Name_____ Dob_____



EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name First Name Relationship to Patient

Address Apt # City State Zip Code

Home Phone Work Phone Cell Phone

OTHER CONTACT INFORMATION - NOT LIVING WITH PATIENT

Last Name First Name Relationship to Patient

Address Apt # City State Zip Code

Home Phone Work Phone Cell Phone

INSURANCE INFORMATION

Primary Insurance ID# Group #

Secondary Insurance ID# Group #

Policy Holder Name Policy Holder DOB Policy Holder Address

Policy Holder SS#

Insurance Company Phone Number

PATIENT AUTHORIZATION

I authorize the release of any medical information necessary to process any claim. I authorize payment of medical benefits to the physician for services rendered.

CONSENT FOR EVALUATION AND/OR TREATMENT

By signing below, I am giving my consent to the practice of Doctors Home Visits, Inc. for evaluation and/or treatment. Once I have been examined, I understand that I will be informed of any medically recommended diagnostic procedures and/or treatments and given the option to accept or decline.

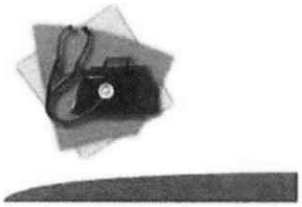
Patient Signature: _____ Date: _____

Parent/Guardian Signature (if applicable): _____ Date: _____

Relationship to Patient (if applicable): _____

- If copies of insurance cards are not attached, please complete Patient Insurance Form
- Attach or fax completed form and front and back of insurance cards to 423-451-7677

Name_____Dob_____



MEDICAL HISTORY FORM

Weight: _____ Height:_____

Past Medical History

Please check (X) the box next to any illnesses or problems that you have had or are having now.

Anemia	Yes___ No ___	Bleeding Disorder	Yes___ No ___
Gout	Yes___ No ___	Blood Clots_____	Yes___ No ___
High Cholesterol	Yes___ No ___	High Blood Pressure	Yes___ No ___
Heart Disease	Yes___ No ___	Peripheral Vascular	Yes___ No ___
Heart Attack	Yes___ No ___		
Seizures	Yes___ No ___	Stroke_____	Yes___ No ___
Asthma	Yes___ No ___	Emphysema/COPD	Yes___ No ___
Tuberculosis	Yes___ No ___		
Diabetes	Yes___ No ___	Neuropathy	Yes___ No ___
Kidney Disease	Yes___ No ___	Urinary Disorder	Yes___ No ___
Kidney Stones	Yes___ No ___		
Cancer _____	Yes___ No ___	Arthritis_____	Yes___ No ___
Alcoholism	Yes___ No ___	Hepatitis/HIV_____	Yes___ No ___
Skin Ulcers	Yes___ No ___	Wounds	Yes___ No ___
Stomach Ulcers	Yes___ No ___	Gastrointestinal	Yes___ No ___
Gerd	Yes___ No ___		
Dementia	Yes___ No ___	Psychological	Yes___ No ___
Depression	Yes___ No ___	Anxiety	Yes___ No ___
Glaucoma	Yes___ No ___	Teeth Disorder/Loss	Yes___ No ___
Thyroid	Yes___ No ___		

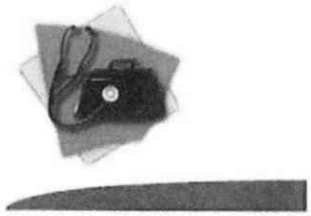
Other: _____

Please Explain any yes answers: _____

_____

Please List recent hospital visits: _____

_____



Name_____Dob_____

Fractures

Please list all fractures and the year of the accident.

_____ _____

_____ _____

_____ _____

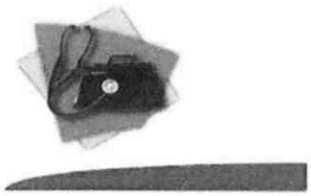
Other (Describe): _____

Surgeries

Please list all surgical procedures which you have had, and the year performed.

Type	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Name_____Dob_____



Allergies:

If you do not have allergies, please check (X) none.

None: _____

Please list allergies:

Name:_____ Type/Reaction: _____

Name:_____ Type/Reaction: _____

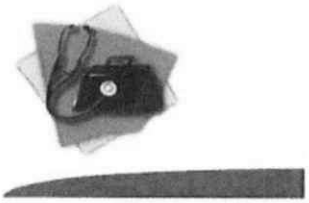
Name:_____ Type/Reaction: _____

Name:_____ Type/Reaction: _____

Pharmacy:_____**Number**: _____

Medications:
List all medications you take including all over the counter, vitamins, herbs, and supplements. Attach additional list if necessary:

Name	**Dose**	**Times per day**	**Name**	**Dose**	**Times per day**



Name_____Dob_____

Social History

Tobacco Use

Current Smoker: Yes _____ No _____ Year Quit _____

Cigarettes: # Packs/day _____ Number of years of use _____

Other tobacco use:_____

Any recreational/illicit (including marijuana) drug use:_____

Alcohol Use

Current alcohol use: Yes _____ No _____ Year Quit _____

Beer/Wine: #_____ times per week

Shots/Liquor: _____times per week

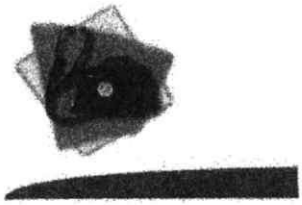
Exposure to any recent environmental toxins/inhalants including secondhand smoke? _____

Who lives in your house that can care for you or for whom you have to care? _____

List other assistance/family support system that may not live with you? _____

Family History

	Living	**Age at Death**	**Cause of Death**	**If Yes, List Current Diagnoses**
Mother:	Yes/No			
Father:	Yes/No			
Siblings:	Yes/No			
Others (Relation):	Yes/No			



Doctors Home **Visits, Inc**

Donald K. Zeigler, MD

To help reduce narcotic misuse, state of Tennessee requires physicians to obtain routine urine drug screens (UDS) on patients who are prescribed scheduled narcotics. We may collect urine drug testing prior to scripts being written and also will run the Tennessee Controlled Substance report at the time scripts are written. Drug testing will be obtained a minimum of twice a year; however, Doctors Home Visits, Inc. reserves the right to obtain UDS' when physician deems necessary.

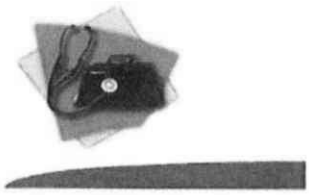
Please read, sign, date the bottom, and return to the address below.

If you have any questions, you may call the office during normal business hours.

Sincerely,

Kelley Painter
Office Manager
Doctors Home Visits, Inc.

Doctors Home Visits, Inc., PO Box 1615, Soddy Daisy, TN 37384-1615
Phone: 423-451-7623, Fax: 423-451-7677



DOCTORS HOME VISITS, INC.

NARCOTIC MEDICATION AGREEMENT

You have agreed to receive narcotics for the treatment of your pain. It is important you have an understanding of the risks and responsibilities that go along with this treatment. Please **read and sign** this agreement/contract below. If you have any questions regarding this information or the office policy regarding the prescribing of narcotics, please request clarification.

I, _____ , understand any medical treatment is initially a trial, and that continued prescription is based on evidence of benefit. I understand the goal of using narcotics is to decrease my pain and increase my functional level. If my pain does not significantly decrease and/or my function increase, the medication will be stopped.

I am aware the use of such medicine has certain risks associated with use, including, but not limited to:

- sleepiness or drowsiness
- nausea
- vomiting
- dizziness
- allergic reaction
- slowing of reflexes or reaction time
- sexual dysfunction tolerance to
- constipation
- itching
- analgesia withdrawal
- confusion
- slowing of breathing rate kidney or liver disease
- physical dependence addiction
- possibility the medicine will not provide complete relief.

The overuse of narcotic medication can result in serious health risks including respiratory depression or even death.

This medication will be strictly monitored, and all of my medications should be filled at the same pharmacy as all other prescriptions prescribed by your Doctors Home Visit provider. (Should the need arise to change pharmacies our office **MUST** be informed). The pharmacy I have selected is:

Pharmacy: _____

Address: _____

City: _____ ST: _____ Zip: _____

Phone: _____ Fax: _____

Day of Month prescription(s) are due: _____

I understand I must call the office one week prior to my refill date and the office will either escribe all narcotic prescriptions to the patient's pharmacy on file or schedule an appointment for testing. No refills will be given after hours or on the weekend. You must call during regular business hours, 8:00 am to 4:30 pm.

I understand the pharmacy **cannot** receive this medication by phone. I will not call the office to have a prescription called into the pharmacy.

I am responsible for making and keeping scheduled appointments. Early refill requests will not be honored. More than two requests for early refills may result in medication being stopped or dismissal from practice.

I will take the narcotic medication only as prescribed. Any changes **must** first be discussed and agreed upon with the provider of Doctors Home Visits, Inc. at the time of scheduled visit.

Name_____Dob_____

Medications **will not** be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If my medication has been stolen and I complete a police report regarding the theft, an exception may be made with copy of police report. It is expected you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them,

I agree only my Doctors Home Visit provider will prescribe my narcotic medication. I will not obtain or use narcotics or other controlled substances from a source other than Doctors Home Visits, Inc. I will instruct my other physicians to confer with Doctors Home Visits, Inc. provider for any changes or need for additional narcotic medications. If it is brought to the attention of the clinic other providers are prescribing medications for me, Doctors Home Visits, Inc. reserves the right to discontinue prescribing medications and/or discharge me from the practice.

I will inform my Doctors Home Visits, Inc. provider of any changes in my medical condition, any changes in any prescription and/or over the counter medication I take, and of any adverse effects I may experience from any of the medications I take.

I agree to tell my Doctors Home Visits, Inc. provider my complete and honest personal drug/medication usage and history.

I will not use any illegal "street drugs" while receiving medications from Doctors Home Visits, Inc.

I will communicate fully and honestly with my provider about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine helps to relieve pain.

Routine blood work and random drug screens will be a part of my treatment plan. I agree to have them done on the day the provider requests.

The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide my health care for purposes of maintaining accountability.

If the responsible legal authorities have questions concerning my treatment, as might occur, for example, if I were obtaining medications from multiple pharmacies, all confidentiality is waived, and these authorizers may be given full access to my records.

It is a felony to obtain narcotic medications under false pretenses. This could include getting medication from more than one doctor, misrepresenting myself to obtain medications, using them in a manner other than prescribed or diverting the medications in any other way (selling).

I know narcotic medications will be stopped if any of the following occurs:

- I trade, sell, or misuse the medication.
- The clinic finds I have broken any part of this agreement.
- I do not provide urine or blood test when asked.
- My blood or urine test shows the presence of medications the staff are not aware of, the presence of illegal drugs, or does not show medications 1 am receiving a prescription.
- I get narcotics from sources other than Doctors Home Visits, Inc. any member of the professional staff of Doctors Home Visits, Inc. feels it is in my best interest narcotic treatment is stopped.
- Any aggressive behavior toward provider or staff
- I consistently miss scheduled appointments.

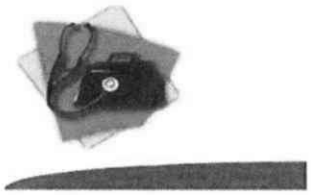
It is understood failure to adhere to this agreement may result in cessation of therapy with controlled substance prescribing (no narcotic prescriptions will be written) by Doctors Home Visits, Inc. providers.

I have read the Narcotic Medication Agreement and without question understand all of this agreement. By signing this agreement, I affirm I have read, understand, and accept all of the terms of this agreement.

Patient signature: _____Date: _____

Provider: _____ Date: _____

Doctors Home Visits, Inc., PO Box 1615, Soddy Daisy, TN 37384-1615
Phone: 423-451-7623, Fax: 423-451-7677



Name_____Dob_____

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act — 45 CFR Parts 160 and 164)

I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information ("PHI") described below to my agent identified in my durable power of attorney for health care named _____.

Authorization for release of PHI covering the period of health care (check one)

- ○ From (date)_____ to (date) _____ OR
- ○ All past, present, and future periods.

I hereby authorize the release of PHI as follows (check one):

- ○ My complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse). OR
- ○ My complete health record *with the exception of the following information* (check as appropriate):
- ○ Mental health records
- ○ Communicable diseases (including HIV and AIDS)
- ○ Alcohol/drug abuse treatment
- ○ Other (please specify):_____ .

In addition to the authorization for release of my PHI described in paragraphs 3a and 3b of this Authorization, I authorize disclosure of information regarding my billing, condition, treatment, and prognosis to the following individual(s):

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

Name_____Dob_____

This authorization shall be in force and effect until nine (9) months after my death or, (Date or event) at which time this authorization expires.

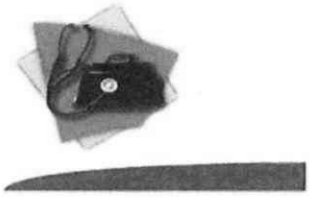
I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

1. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
2. 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.
3. By signing below, I agree I have been given and had the opportunity to read the Doctors Home Visits, Inc. Notice of Privacy Practices.

A copy of Doctors Home Visits, Inc Notice of Privacy Practices is available upon request.

_____ Date: _____

Signature of Patient



Statement of Patient Financial Responsibility

Patient Name:_____ DOB: _____

Doctors Home Visits, Inc. appreciates the confidence you have shown in choosing us to provide your health care needs. The service you have elected to participate in implies a monetary responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay. Thank you for your cooperation in this matter.

Consent for Treatment and Authorization to Release Information

I hereby authorize Doctors Home Visits, Inc., through its appropriate personnel, to perform or have performed upon me, or the above-named patient, appropriate assessment, and treatment procedures.

I further authorize Doctors Home Visits, Inc., to release to appropriate agencies any information acquired in the course of my or the above-named patient's examination and treatment.

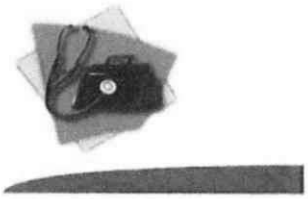
Cancellation / No Show Policy

In order to serve our patients better, we have instituted a cancellation policy. We require 24-hour notice for all cancellations. As a courtesy, reminder calls are made 3 days prior to your appointment to allow you to contact us in the event you need to cancel or reschedule your appointment. We ask that you provide us with the same courtesy. If appointment is not confirmed within 24 hours of the appointment, the appointment will be cancelled and rescheduled. This will provide opportunity patients on waiting list to be seen for that time slot. If the patient has 3 consecutive unconfirmed appointments, the patient may be discharged from the practice.

I understand if the provider arrives for visit and I am not available (excluding unforeseen circumstances, i.e., hospital, death in family), I may be charged an additional $25 trip charge. If I cancel a total of four appointments within a one-year period, I may be discharged from care.

The Practice will notify you in writing, via certified mail, if you are discharged from care.

Name_____Dob_____



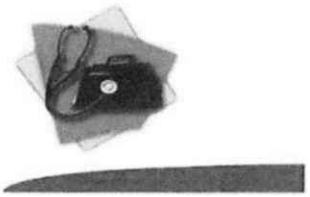
Self-Pav

If at any time my insurance lapses, or I do not have health insurance, I will be responsible for services rendered here at Doctors Home Visits, Inc. I agree to pay Doctors Home Visits, Inc. the full and entire amount of treatment given to me or to the above-named patient on EACH VISIT.

I have read the above policy regarding my monetary responsibility to Doctors Home Visits, Inc. for providing Primary Care services to me or the above-named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Doctors Home Visits, Inc., the full and entire amount of bill incurred by me or the above-named patient; or, if applicable any amount due after payment has been made by my insurance.

Patient/Guarantor Signature: _____ Date: _____

Name_____Dob_____



Authorization to Release Medical Records

Name of Patient _____ Date(s) of Service _____

Date of Birth_____ Social Security Number _____ _____

I, _____the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

PATIENT INFORMATION IS NEEDED FOR:

- ⬭ Continuing Medical Care
- ⬭ Insurance
- ⬭ Legal Purposes
- ⬭ Military
- ⬭ Personal Use
- ⬭ School
- ⬭ Social Security/Disability
- ⬭ Other:

INFORMATION TO BE RELEASED OR ACCESSED:

- ⬭ History & Physical
- ⬭ Operative Reports
- ⬭ Lab/Path Reports
- ⬭ Consultation Report
- ⬭ Discharge/Death Summary
- ⬭ X-Ray Reports/Images
- ⬭ Emergency Room Record
- ⬭ Face Sheet
- ⬭ Other:_____ _____

Please list previous providers, specialists, and/or hospitals on the back of this form.

The above information may be released to Doctors Home Visits, Inc., PO Box 1615, Soddy Daisy, TN 37384-1615, 423-451-7623 Office, 423-451-7677 Fax.

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

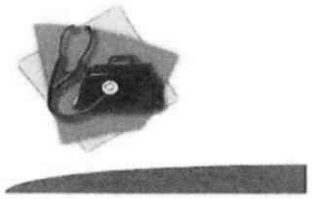
I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. The authorization will expire six (6) months from the date of my signature unless I revoke the authorization prior to that time.

Date: _____ Signature: _____
Patient or Legally Authorized Representative

_____ _____
Printed Name of Patient or Legally Authorized Representative Relationship

Send Records to: Doctors Home Visits, Inc., PO Box 1615, Soddy Daisy, TN 37384-1615, Off 423-451-7623, Fax 423-451-7677

Name_____ Dob_____



List all previous providers, specialist, and/or hospitals

Name of provider

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

Address (Street, City, State and ZIP) Fax Number

Name of provider

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

Address (Street, City, State and ZIP) Fax Number

Name of provider

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

Address (Street, City, State and ZIP) Fax Number

Name of provider

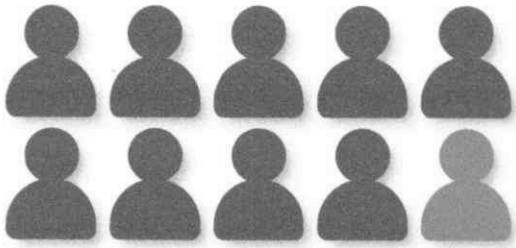
(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

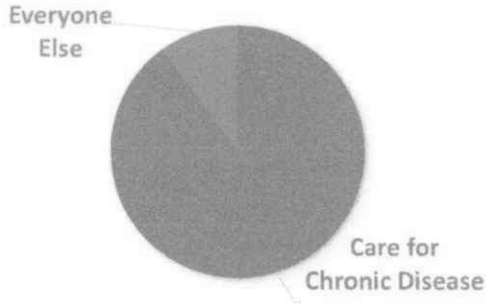
Address (Street, City, State and ZIP) Fax Number

Are you or a loved one living with Chronic Disease?

9 IN 10

Adults age 60 or older are living with Chronic Disease.





$3.7 TRILLION

Spent annually on persons with Chronic Disease.

Doctors Home Visits Care Management

Our Care Management program enables individuals living with chronic disease to receive a higher level of care, reducing ER visits and hospitalization, improving quality of life and patient satisfaction.

Our Care Managers provide:

High-Touch Clinical Support

Preventive Care Monitoring

Disease Management and Education

Patient-Centered Care Planning

Call our dedicated Care Management team and learn how Doctors Home Visits' Care Management can improve your life today.

(423) 451-7623

ccm@dhv.comcastbiz.net

Agreement to Receive Medicare Chronic Care Management Services

As of January 1, 2015, Medicare covers Chronic Care Management services provided by my primary care provider per calendar month. I understand that my primary care provider, Doctors Home Visits, Inc, is willing to provide such services to me, including the following:

- Access to my care team 24-hours-a-day, 7-days-a-week, including telephone access and other non-face-to-face means of communication (i.e., email),
- The ability to get successive, routine appointments with my designated primary care provider.
- Care management of chronic conditions, including timely scheduling of all recommended preventative care services, medication reconciliation, and oversight of my medication management
- Creation of a comprehensive patient-centered care plan for all my health issues that are specific to me and congruent with my choices and values,
- Management of my care as I move between and among health care providers and settings, including the following:
    - Referrals to other health care providers
    - Follow-up after I visit an emergency department,
    - Follow-up after I am discharged from the hospital or other facility (i.e.: skilled nursing facility)
- Coordination with home and community based providers of clinical services.

I understand that as part of these services, I will receive a copy of my care plan.

I also understand that I can revoke this agreement at any time (effective at the end of the calendar month) and can choose, instead, to receive these services from another health care provider after the calendar month in which I revoke this agreement. Medicare will only pay one healthcare professional to furnish me Chronic Care Management services within a given calendar month.

I understand these Chronic Care Management services are subject to the usual Medicare deductible and co-insurance applied to medical services. Supplemental coverage subject to respective benefits.

My signature also authorizes my primary care provider to electronically communicate my medical information with other treating providers as part of the care coordination involved in Chronic Care Management services.

This designation is effective as of the date below and will remain in effect until revoked.

Patient Name (print): _____ Date: _____

Patient or Guardian Signature: _____ Date: _____