



Mary Snellings M.D.

5802 Berryhill Dr, Arlington, TX. 76017 *Office (682)321-7007 * FAX (682)321-7036

PATIENT INFORMATION

Please fill in all sections/blanks

Legal Name: Date of Birth:

Phone: Home: Cell phone:

Address: (where you will be seen)

Medicare Number: **Social Security Number:**

Primary Insurance: Member ID#:

Secondary Insurance: Member ID#:

Guarantor/Responsible Party Name & Number:

Guarantor Address:

Emergency contact Phone:

Power of Attorney (if appl) Phone:

Email Address:

Pharmacy name & phone #:

Pharmacy (secondary, name/phone #):

Home health agency name/number (if app):

Hospice Agency name/number (if app):

Do you currently have any of the following? (Check all that apply) DME

<input type="checkbox"/>	Infectious Disease – including COVID 19	<input type="checkbox"/>	Bedbound
<input type="checkbox"/>	Wound(s) (location)	<input type="checkbox"/>	Walker
<input type="checkbox"/>	Catheter/Urostomy	<input type="checkbox"/>	Cane
<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	Rollator
<input type="checkbox"/>	IV Line (type)	<input type="checkbox"/>	Crutches
<input type="checkbox"/>	Fall(s) in Past 6 months	<input type="checkbox"/>	Wheelchair
<input type="checkbox"/>	Colostomy/Ostomy	<input type="checkbox"/>	Oxygen
<input type="checkbox"/>	Staples/Sutures (location)	<input type="checkbox"/>	Special Transportation Required
<input type="checkbox"/>	Shunt Site	<input type="checkbox"/>	

PERSONAL MEDICAL HISTORY

Are you currently or have you ever been treated for: **check all that apply**

Height	Weight				
Anemia			Iron deficiency	aplastic	
Arthritis			Knees	elbows	pelvis multiple joints
Back problems			Low back pain	Scoliosis	Previous back surgery
Blood Pressure			Low	High	
Cancer			Breast	Colon	Skin Prostate Lung Other:
Cholesterol / triglycerides			High Cholesterol		
Cognition/Memory			Short term	long term	Dementia Alzheimer's Age-Related Mild Confusion
Psychological			Depression	Anxiety	Bipolar Schizophrenia Hallucinations
Diabetes			Insulin dependent	oral meds	diet controlled
Edema / swelling			Feet	Ankles	Legs Arms
Eye disease			Glaucoma	Macular degeneration	Cataracts Poor vision
Fainting / passing out / dizzy			Upon standing	All the time	History of Falls
Frequent infections			Bladder	Sinus	Lung Skin Intestinal
Gastrointestinal problems			Heartburn	Reflux	Ulcers Nausea Abdominal pain Diarrhea Constipation
Heart disease			Blocked arteries	Stents	Bypass Heart attack Congestive heart failure Atrial Fibrillation
Incontinence			Urine	Bowel	
Kidney/Urinary problems			Frequent Urination	Kidney failure	Dialysis Kidney Stones Chronic Kidney Disease BPH
Muscle problems			Muscle spasm	Muscle pain	Weakness
Osteoporosis			Fractures	Scoliosis	Kyphosis
Neuropathy			Burning pain	numbness in hands	feet/legs
Respiratory disease			Short of breath	Cough	COPD Asthma Smoker Seasonal allergies Oxygen
Seizures					
Skin problems			Rash	Wounds	Itching Dryness
Sleep disorders			Insomnia	Sleeping too much	Sleep apnea
Stroke / TIA			Paralysis	Weakness	Behavior Changes Impaired Speech Difficulty Swallowing
Thyroid disease			Hyperthyroidism	Hypothyroidism	
Serious Injury / broken bones			Location		
Weight changes / Appetite changes			Weight loss	Weight gain	Poor appetite

Other Physicians or Specialists:

Specialty:

Name:

Phone number:

FAMILY MEDICAL HISTORY:

Please list all medical problems of your immediate family (Mother, Father, Siblings):

Mother: _____
Father: _____
Sibling: _____

SOCIAL HISTORY:

Smoking Year Quit Alcohol

Marital status # of Children

Have you been in a hospital or a facility in the past year? Yes No

If yes, name and location of hospital/SNF/Rehab:

Reason for Hospitalization:

--

SURGICAL HISTORY: (list all previous surgeries)

Please indicate if you attend any of the following:

Dialysis (days/times and location)

Wound care clinic (days/times and location)

Adult Day Care (days/times and location)

Other routine outings

Please indicate if you are experiencing any of the following symptoms:

Memory:

- Repeating questions or stories
- Forgetting appointments, phone numbers, names, addresses
- Difficulty with multi-step tasks (cooking, grooming, dressing)
- Difficulty managing medications
- Permanently forgetting where things are placed
- Difficulty remembering current place of residence, month/year

Language:

- Increased difficulty finding words
- Inappropriate word substitutions
- Increased generic wording ("thing", "stuff", "you know what I mean")
- Word errors with no attempt to correct
- Totally inappropriate response
- Decreased spontaneous speech

Judgment:

- Difficulty managing bills, checkbook, money; spending money frivolously
- Difficulty planning activities that require decisions (meals, errands, traveling)
- Decline in person appearance (not wanting to bathe or groom, dressing inappropriately)
- Decline in social functioning
- Decline in recognizing safety issues (left food burning on the stove, hoarding, wandering)

Visual-spatial:

- Lost in own home/assisted living facility
- Lost while walking in own neighborhood
- Misidentify or fail to recognize familiar family or friends
- Difficulty finding things that are immediately in front of them

Personality/mood:

- Increased irritability
- Verbal or physical threats
- Screaming repeatedly
- Paranoia
- Delusions of theft
- Hallucinations
- Disinhibition (inappropriate jokes, inappropriate dressing or undressing, cursing)
- Cry for no reason
- Suicidal ideation
- Decreased concentration
- Loss of motivation
- Decreased enjoyment of activities
- Feelings of guilt or worthlessness

FAX COMPLETED FORM TO 682-321-7036, EMAIL TO INFO@DOCSATHOME.COM

Doctor's At Home

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Texas law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

Information regarding patient for whom authorization is made: Patient Name: _____ Date of Birth _____ Address: _____
Information regarding health care provider or entity authorized to disclose this information: Name: _____ Phone: _____ Fax: _____ Address: _____
Information regarding person or entity who can receive and use this information: Doctors at Home Phone: 682-321-7007 Fax: 682-321-7036 PO Box 172696 Arlington, TX 76017 info@docsathome.com
Specific information needed: <input type="checkbox"/> Medical Record from _____ to _____ <input type="checkbox"/> Medical Record including patient H&P, office notes, hospital records, lab results, radiology studies, cardiac studies, consults, and records received from other health care providers.
Reason for release of information: <input type="checkbox"/> Treatment/Continuing Medical Care <input type="checkbox"/> Other (<i>Specify</i>): _____

The individual signing this form agrees and acknowledges as follows:

- (i) **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.
- (ii) **Effective Time Period:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date: Month: _____ Day: _____ Year: _____.
- (iii) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
- (iv) **Special Information:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL and SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.
- (v) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:

Patient/Legal Representative: _____ Date: _____

If Legal Representative, relationship to Patient: _____



Mary Snellings MD
682-321-7007 ph 682-321-7036 fax

I, (printed name), do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent remain in force from this time forward. In addition to the above, a condition of being admitted for treatment as a patient of **Doctors At Home**, I acknowledge the following **Consent of Treatment, Authorization to Release Medical Information, Assignment of Insurance Benefits, Medicare/Medicaid.**

Assignment of Benefit, Frequency Rights/Hotline Procedure, and Additional Understandings.

I understand by acknowledging this agreement, I must abide by the rules reviewed above and that failure to abide by these agreements will result in termination of medication prescriptions and possibly termination of services from my doctor and his or her practice.

Conditions of Admittance

As a condition of being admitted for treatment as an outpatient of the **Doctors At Home**, I agree to the following:

1. Consent of Treatment: I voluntarily consent and request to treatment, I authorize the treating physician(s) and their assistants to perform medical treatment and technical procedures, to administer drugs, and to render care as their judgment may indicate to be necessary or advisable. I understand that the services provided to me, are provided by doctors or physicians assistants or nurse practitioners. **Doctors At Home** will maintain a record of the care and services you receive. This consent only covers your protected health information created while you are a patient of **Doctors At Home**. Your protected health information pertains to your diagnosis and or treatment, including but not limited to information concerning medical illness (except for psychotherapy notes), use of alcohol or drugs or *communicable diseases such as Human Immunodeficiency Virus ("HIV"), and Acquired Immune Deficiency Syndrome ("AIDS")*, laboratory test results, medical history, treatment history, treatment progress or any other such related information. By signing this form, you consent that **Doctors At Home** may use and/or disclosure of pre-existing health information about you for treatment, payment, healthcare operations and as otherwise allowed by law, our *Notice of Health Information Practice* provides information about how **Doctors At Home**, its physicians, and its medical staff may use and/or disclose protected health information about you for treatment, payment, healthcare operations and as otherwise allowed by law. Consent for any major surgical procedures or other procedures by physicians/surgeons requiring additional consent will be requested by the physician performing such, and shall be obtained preceding the procedure with exception for those procedures considered necessary for extreme, life-saving emergencies.

2. Authorization to Release Medical Information: I authorize **Doctors At Home** and any treating physician to furnish requested information from patient medical and other records to:

- a) Any insurance company or third party payer for the purpose of payment to **Doctors At Home** or a treating medical provider.
- b) Any other persons or entities financially responsible for the patient's treatment.
- c) Representative of governmental agencies in accordance with law. Such information may include, but not be limited to, information about communicable diseases such as AIDS, or HIV. I authorize release of information from or the review of the patient records for medical audit, utilization reviews, or quality assurance reviews. I authorize **Doctors At Home** to release information from our copies of the patient medical records to the referring physician or to a skilled nursing facility or health care facility which I may be transferred.
- d) Only the designated person, (name/number) authorized to read or have access to or be included in patient care conference or discussers on my behalf. I understand that this document does not supersede traditional power of attorney, yet it is my intent that only the person(s) listed are hereby granted access to my records.

I authorize the release of the following information (check all that apply)

- | | |
|-------------------|-------------------------|
| All Records | Consultation Assessment |
| Treatment plan | Medications |
| Lab Results | History and Physical |
| Billing Records | Radiology Results |
| Discharge Summary | |

This information is necessary for the following purposes (check all that apply)

- | | |
|------------------|--|
| Follow up Care | Disability Benefits |
| Insurance | Attorney/Legal |
| Transfer of Care | Other (Please Explain): <input type="text"/> |

I give my special permission to release my information regarding items listed below:

INITIALS:

HIV Medical Info Psychiatric Information Substance Abuse

3. Assignment of Insurance Benefits: I assign to **Doctors At Home** all rights to file claims and collect payment for services provided. I further assign all rights to payments for physician services under said policies to Doctors At Home physicians and/or other providers, which provide treatment for me while I am a patient. I understand I am responsible for providing all insurance information available at the time of admission and periodically for verification. I agree to pay any amounts due to **Doctors At Home** that is not covered by insurance including co-pays and/or annual deductibles as required by my insurance. **I understand I'm required to submit payment upon receipt, to Doctors At Home for any co-pays, deductibles or other required out of pocket expenses.**

*******I am responsible to inform **Doctors At Home** if I change my payer source/insurance to a HMO, Medicare Advantage Plan or other health plan: Without proper notification, I understand I may be liable for payment of the Medical Services rendered by Doctors At Home.

4. Medicare/Medicaid Assignment of Benefit: I certify that the information given by me in applying for payment under the Social Security Act is correct. I authorize the release of information concerning me to the Social Security Administration or its intermediaries or carriers as well as any information needed for filing a Medicare claim. I request that the payment of authorized benefit be made on my behalf to **Doctors At Home**. I assign benefits payable for services to the organization submitting a claim on my behalf.

Medicaid: I understand that Medicaid recipients are responsible for payment for any medical services received that are beyond the scope of the Texas Medical Program, as determined by the Texas Department of Health and Human Services. All such payments are due and payable at the time of discharge.

5. Frequency Rights/Hotline Procedure: I have received an explanation of my Patient Bill of Rights of the Elderly, as appropriate. I have been notified of my rights to voice a complaint and may direct that complaint with the Secretary of the Health and Human Service. (US Department of Health and Human Services at 200 Independence Ave, SW. Washington D.C. 20201) I may also direct a complaint to **Doctors At Home** to do the investigation of the complaint, which will be initiated within 10 calendar days and resolved within 30-calendar day's receipt. I understand that it is my right and responsibility to be involved in my care and that I will be informed as to the nature and purpose of any abuse, neglect and exploitation agency testing policy and hazardous waste disposal in home. I have been advised verbally and in writing the purpose and my right pertaining to the collection of information and the Privacy Act. HIPPA—I have received the Notice of Privacy Practices and consent to the agency's use and/or disclosure of protected health information for the patient.

6. Attestation:

A) I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me with respect to the result of any examination or treatment to be performed.

B) I authorize Doctors At Home to use its discretion to retain or dispose of any tissue removed during treatment.

C) **My signature below attests that I choose Dr. Mary Snellings as my PCP (Primary Care Physician).**

Complete all areas below: (please provide copies of Medicare and Secondary Insurance cards)

Patient Name (printed)

Patient Signature

Date

Name of POA

Phone Number

Guarantor (Person responsible for co-payments/deductible)

Mailing Address

Guarantor Phone Number

Guarantor Email Address

DOCTORS AT HOME

P.O. Box 172696
Arlington, TX 76003
682-321-7007 ph 682-321-7036
Mary Snellings MD

Credit Card Authorization Form

Doctor's at Home requires a credit card on file for co-pays and/or deductibles required by Medicare and/or Insurance companies.

You may mail the information to the office address above, email it to info@docsathome.com or provide it via phone to the Billing Manager at the office.

Please complete all fields

Card Type: <input type="checkbox"/> MASTER CARD <input type="checkbox"/> VISA <input type="checkbox"/> DISCOVER <input type="checkbox"/> DEBIT CARD
Cardholder Name (as shown on card) _____
Card Number: _____
Expiration Date (mm/yy) _____
CVV Code (3 digit code on back of card) _____
Cardholder ZIP Code (from credit card billing address) _____

I, _____ authorize **Doctors At Home** to charge my credit/debit card listed above for deductibles and/or co-pays required by Medicare and/or my insurance carrier for _____ (patient name). I understand that my information will be stored and encrypted in my medical chart for future transactions. I understand if my card is cancelled, expired or authorization revoked, I will be responsible for payment of any outstanding invoice(s) plus related fees for late payments.

If you would like a receipt for payment, please provide an email address:
