Royal Visiting Physicians LLC
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New Patient Intake Form

Patient Name *(Last):* _____ *(First):* _____ *(MI):* _ _____

Address: _____

City: _____ State: _____ Zip Code _____

Community Name: _____ Room #: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Social Security #: _____ Gender: Male / Female

In the event of emergency contact: _____

Relation to Patient: _____ Phone#: _____

Does Patient have a POA/Guardian: Yes/No *(skip this section)* Legal Status: POA/Guardian
(please include copies of any legal documents when submitting new patient forms)

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone#: _____ Notify before visits: Yes / No

Insurance Information

Please include copies affront and back of all insurance cards

Medicare #: _____ Effective Date: _____ Part B Eligible: Yes / No

Other Insurance Carrier *(if applicable):* _____

Member ID#: _____ Group#: _____

Type of Policy: HMO / PPO / Traditional Telephone#: _____

Currently receiving Home Health or Hospice Care? If yes, which agency: _____

How did you hear about our services? :_____

Consent for Services

By signing this form, I hereby consent to participate in the Chronic Care Management (CCM), Remote Patient Monitoring (RPM), Principal Care Management (PCM), and Remote Therapeutic Monitoring (RTM) services provided by Royal Visiting Physicians. **I understand that these services are voluntary and that I can withdraw my consent at any time.**

Nature of Services:

a) I understand that the services provided by Royal Visiting Physicians are **not a substitute** for direct in-person health care visits or health care emergencies. **Non-emergency** services will be provided during day time/weekdays from 8am-4 pm.

b) I am aware that Royal Visiting Physicians will collect, use, and disclose my health information as part of these services.

c) I understand that the data collected will be used to guide my treatment and care plan by the provider.

d) Benefits include improved access to care, continuous monitoring of health status, and personalized care management.

Data Privacy and Security:

a) I acknowledge that Royal Visiting Physicians will take appropriate measures to ensure confidentiality and security of my health information.

b) I understand my rights to access and control my health information under applicable privacy laws.

Patient Responsibilities:

a) I agree to provide accurate and complete health information.

b) I will inform Royal Visiting Physicians of any changes in my health status or contact information.

c) I agree to use the technology provided as instructed for the purpose of RPM and RTM services.

Billing and Costs:

a) I understand that there may be costs associated with these services, which may be billed to my insurance.

b) I agree to be responsible for any co-payments or deductibles as per my insurance plan.

Contact Information:

For any questions or concerns regarding these services, I can contact Royal Visiting

Physicians at: Phone: _____

Patient Consent:

I have read, or have had read to me, this consent form. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction. I consent to participate in the services provided by Royal Visiting Physicians as described above.

Patient Name Date of Birth

_____ _____

_____ _____

Patient Signature Date

Medical History

Name of Allergen (*include medications, foods*)	Reaction	Approximate onset date

Previous Hospitalizations

Reason for hospital stay	Date (approximate)	Name of Hospital

Surgeries (include all surgeries in your lifetime)

Type of Surgery	Date (approximate)	Name of Hospital

Check all that apply:

_ Allergies
_ Anemia
_ Anxiety
_ Asthma
_ Atrial Fibrillation
_ Blood clot
_ Congestive Heart Failure
_ Constipation
_ COPD
_ Dementia/Alzheimer's
_ Depression
_ Diabetes
_ Difficulty Swallowing
_ Edema
_ Heart Attack
_ High Cholesterol
_ Hypertension
_ Hypothyroidism
_ Kidney Disease
_ Parkinson's
_ Pneumonia
_ Seizures
_ Sleep Apnea
_ Stomach Ulcer
_ Stroke

_ Cancer (type) _____

_ Other *(please specify)* _____

Family History:

Is there a history in your family of?	Yes	No	Affected Relative *(s)*
Heart Attack			
Diabetes			
Cancer			
Alzheimer's/Dementia			
Other			

Tobacco and Alcohol History:

Are you an active smoker? Yes / No. Former Smoker? Yes / No How many packs daily? _____

Do you currently drink alcohol regularly? Yes / No If yes, approximately how many weekly?

Medication List

Name of Medication	Dosage (mg)	Frequency Given	Time Given

Pharmacy Information

Name of Pharmacy: _____

_ Address: _____

City: _____ State: _____ Zip Code: _____ _

Phone #: _____ Fax#: _____

Notice of Privacy Act's

I, (printed name) _____, Date _____ 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 remains in force from this time forward. In addition to the above, a condition of being admitted for treatment as an outpatient of the Royal Visiting Physicians. 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 Royal Visiting Physicians (RVP) I agree to the following:

I.

Consent of Treatment: I voluntarily consent and request to treatment by RVP, I authorize the treating physician(s) and their assistants and RVP 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 by RVP, are provided by doctors or physicians assistants, podiatrists, psychologists, psychiatrists, physical therapist nurse practitioners. RVP 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 RVP. Your protected health information pertains to your diagnosis and or treatment by RVP, 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 (UHIV"), 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 to RVP's 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 RVP, it's physicians, and it's 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 RVP 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 on the account of RVP 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 RVP 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) Lastly, only the designated person, listed here, are 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 records.

Please release the following information indicated by an "X"

( ) History and Physical	( ) Consultation	( ) Assessment
( ) Lab Results	( ) Radiology Results	( ) Treatment Plan ( ) Medications
( ) Billing Records	( ) Discharge Summary	
( ) Other	( ) All Records	

This information is necessary for the following purposes:

( ) Follow up Care	( ) Patient Requesting Disclosure
( ) Disability Benefits	( ) Attorney/Legal
( ) Insurance	( ) Transfer of Care

( ) Other (Please Explain): _____

( ) Please release my information via Fax #_____

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

INITIALS:

( ) HIV Medical Info _____ _

( ) Psychiatric Eval/Prot.. _____ _

( ) Substance Abuse _____ _

3. Assignment of Insurance Benefits: I assign to RVP all rights to file and interest in any payment due me for services described herein as provided in an insurance policy or employee benefit plan. I further assign all rights to payments due me for physician services under said policies to physicians, which provide treatment for me while I am a RVP patient. I understand I am responsible for providing to RVP all insurance information available at the time of this hospital visit to allow for verification. I agree to pay any amounts due the hospital or physicians that are not covered by insurance. I am responsible to inform the agency if I change to an HMO. Medicare Advantage HMO: I may be liable for payment of my Medicare/Medical Services.
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. I assign benefits payable for services to the physician or organization submitting a claim to Medicare for me.

   Medicaid: I understand that Medicaid recipients are responsible for payment for any medical services received that arc 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 the Practice Manager of the Practice Clinic to do the investigation of the complaint, which will be initiated within 10 calendar days and resolved within 30-calendar days receipt. I understand that it is my right and responsibility to be involved in my care and that I will he 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. I also acknowledge that I have read and received a copy of the PATIENTS BILL OF RIGHTS.
6. Additional Understandings:
   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 RVP to use its discretion to retain or dispose of any issue removed during any treatment or diagnostic procedure.

Medication Use Agreement

I, the above signee, understand that I have hindrances that have not been adequately controlled with other medications and that my function is limited by these hindrances. understand that the intent of the medication is to increase my ability to do more, though the medication is unlikely to eliminate any hindrances. I will take the medication only as prescribed; I will not take any sedatives, alcohol, or other pain medications without the preapproval of any doctor. Prescriptions will be provided only during regularly scheduled appointments. Refills will never be provided by telephone. [will not seek or accept any medications for pain other than those prescribed by my doctor. "Medications for pain" includes prescriptions from other doctors, medications borrowed or accepted from family or friends, and any illicit or street drugs. Medication refills will be provided as written prescriptions only. No refills will be given prior to the next schedule appointment date. If I do not keep my appointment, I will not receive a refill. Two (2) appointment cancellations with less than the workdays notice or two (2) no-show appointments may constitute grounds for immediate termination of this agreement. [understand that my doctor is under obligation to provide these medications to me, and that she or he reserves the right to discontinue these medications at any time. At my doctor's discretion, I agree to cooperate with random drug testing, which may be required from time to time. If I refuse, I understand the medication will be stopped. I understand the lost or stolen medication will not be refilled under any circumstances. It is my responsibility to protect and secure any medications. This includes keeping the medication out of reach of children. A copy of police report will be required for any lost or stolen narcotics prescriptions. I understand that my doctor may require specialist evaluation of my treatment, and I agree to keep appointments when my physician refers me. My doctor will send a report of care and a copy of this agreement when referral *is* made. In addition to the above agreements, I accept the right of my doctor's medical staff to terminate this agreement for any of the following reasons:

1. I seek to obtain any pain medication from a source other than my doctor.
2. I give, sell or in any way distribute prescribed medications to any other person(s).
3. I in any way attempt to forge or alter a prescription.
4. My medical condition declines to the point at which, in the judgment of my doctor, continued therapy with the medication presents a danger to my well-being or safety.
5. There is evidence that I am no longer receiving a reasonable therapeutic benefit from the medication, or my doctor determines that I am no longer a good candidate to continue the medication.

I agree to fill my prescriptions only at the pharmacy listed below. If I change pharmacies, I will contact my doctor's office and provide them with the name, address and. phone number of the new pharmacy. Under no circumstances will I obtain medications from more than one pharmacy at a time. In order to verify appropriate medication use, my doctor's office will provide my chosen pharmacy with a copy of this agreement. I understand that any alteration in my medication prescriptions will require a new written agreement.

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Telephone/Fax: _____

HIPAA Information

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy and implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about?: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange or information necessary to provide you with office services. HIPAA provides certain rights and protection to you as the patient. We balance these needs with our goal of providing you with quality professional services and care. Additional information is available from the U.S. Department of Health and Human Services: *www.hhs.gov*

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide service or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes sharing of information with other healthcare provider laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's conditions or information, which is not already a matter of public record. The normal purse of providing care means that such records may be left, at least temporarily, in an administrative area such as the front office, examination room, etc. These records will not be available to persons other than the office staff. You agree to the normal procedure utilized within the office for the handling of charts, patient's records, PHI and other documents or information.
2. It is the policy of this office to remind patients of the appointments. We may do this by telephone, email, US mail, or by any other means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. This practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents, which may include PHI by government agencies or insurance payer in normal performance of their duties.
5. You agree to bring any concern or complaints regarding privacy to the attention of the office manager or doctor.
6. Your confidential information will Dot be used for the purpose of marketing or advertising of products, goods or services.
7. We agree to provide patient with access to your records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the Practice and the Patient
9. You have the right to request restrictions in the use of your PHI and to request change in certain policies used within the office concerning your PHT. However, we are obligated to follow internal policies to confirm your request.

I, the undersigned, do hereby agree to the terms, conditions, and rules set forth in the Conditions of Admittance, Medication Use Agreement, and HIPAA information sections. Furthermore, I certify that all the information I provide is accurate and complete. I will inform the clinic should any information change in the future, therefore indemnifying the physicians and staff of my healthcare for information Dot provided or inaccurate for any and all future outcomes. I understand that I am an individual and treatment of me is on an individual basis. I recognize that I may revoke this consent at any time in writing, except at the extent that period has been taken in reliance on i.t and that in any event this consent shall expire in 6 months after the last date of service (Otherwise, specified date. I understand that the provision of my health care and the payment for my health care will not be affected if I do not sign this form. Upon which Royal Visiting Physicians (RVP) can no longer use or disclose my information for the above purpose without a new authorization. I understand that information used or disclosed pursuant to this authorization may be subject to oo-disclosure by the recipient and no longer protected by federal privacy regulations. I understand that the above information may include records/reports from other health care providers involved in any care or treatment. I have read this agreement and understand what information will be used or disclosed, who may use and disclose the information and the recipient(s) of that information.

Signature of Patient (or Authorized Party/Relationship) **Date** **Printed Patient Name**

Reason Patient is not signing: _____

Signature of Physician/NP/PA **Date** **Printed Name of Physician or NP/PA**

Signature of Witness/RVP Representative **Date** **Printed Name of Witness/Representative**

Medical Release of Information

Patient's Name: _____

Date of Birth: _____/_____/_____

Release Records from:

Provider's Name: _____

Provider's Tel Number: _____

Provider's Fax Number: _____

Address: _____

Send Records to:

Royal Visiting Physicians
224 W. Campbell Road Suite 222

Richardson, TX 75080

Office: 469-991-6010

Fax: 469-991-6030

Please release all progress notes, x-rays, laboratory test results, and diagnostic tests.

Authorization is hereby given for the release of my medical records as provided herein.

_____ _____

Patient or Responsible Party's Signature

Date

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until canceled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____ Security Code: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize _____to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date

INSURANCE RVP ACCEPTS

1. **Traditional Medicare**
2. **Blue Cross Blue Shield**
   - **Blue Choice PPO**
   - **Blue Essentials HMO**
   - **Blue Advantage HMO**
   - **Blue Cross Medicare Advantage PPO & HMO**
3. **United Healthcare**
   - **UHC Commercial**
   - **AARP Medicare Advantage [Welmed2]**
   - **United Healthcare Dual Complete [Medicare & Medicaid]**
   - **United Healthcare Group Medicare Advantage (UCard/TRS)**
4. **Aeta PPO "ONLY"**
5. **Humana PPO "ONLY"**
6. **Amerigroup Medicare Advantage/Now WellPointe**
7. **Molina Medicare Advantage**
8. **Care n Care Insurance**
9. **Superior Health Advantage**
10. **Baylor Scott & White Medicare Advantage**
11. **Railroad Medicare**