BlueSky HOUSE CALLS

1601 17th Ave S, Nashville, TN 37212
Phone: 615-340-6840 Fax: 615-600-4804

Hello!

Thank you for allowing BlueSky HouseCalls to assist you with your health care needs. We sincerely appreciate the opportunity to serve you. Our services allow you to enjoy the comfort and safety of your home as your personal health care setting. We can serve as either your Primary Care Provider or can be used on an "as needed" basis.

Please provide the following information to our office ***prior*** to your first at-home visit:

- Patient Information Packet (please complete the entire form); BlueSky will not be liable for incomplete or inaccurate medical information
- Consent to Receive Medical Care
- Copies of your insurance cards (including primary and secondary insurance)
- Complete a Release of Information form to obtain information from previous providers
- Legal Documentation of Power of Attorney or Conservatorship
- Include a copy of any recent labs, hospital notes and/or current medication list if available.

If you have questions or concerns, please feel free to contact our office and we will be pleased to assist you. Our business hours are 8AM – 4:30pm, Monday through Friday. We are available after business hours for emergencies only.

Sincerely,

Bruce A. Wallstedt, MD

Charges for Services and Billing Processes

Insurances Accepted

- **Traditional Medicare and all Medicare Supplement (Medigap) Plans**
- **Humana PPO and HMO Plans**
- **Cigna HealthSpring PPO and HMO plans**
- **United Healthcare PPO and HMO plans**
- **BlueCross BlueShield PPO and HMO plans**
- **Amerigroup HMO (non-Medicaid Policy)**
- **Aetna PPO** (Out-of-Network Benefits will apply)
- **Commercial Insurances** (To be determined prior to service)

Private Homes

Private homes will be charged a Home Visit Fee of $200, payable at the time of visit. Home Visit Fee is subject to change without prior notice. Fee is waived for residents of Senior Living Communities.

Additional Charges for Administrative Services are as follows:

- Document Preparation (Writing Letters) - $50.00
- Filling out forms
    - 1 to 2 pages - $25.00
    - 3 to 5 pages - $50.00
    - 6+ pages - $100.00
- Completion of Legal Documents (Conservatorship Affadavits, etc.) - $100
- Copying of Medical Records – 1 to 10 pages free, then $1.00 per page after that
- Faxing Medical Records:
    - No charge when faxed to another physician, hospital, patient, patient's caregiver, or Power of Attorney for the first time.
    - Market rates apply for all other faxes

Patient Balances

After all insurance payments are made, any remaining balance will be passed on to the patient. Patient balances are expected to be paid within (1) month of issuance and delinquent accounts will be assessed a 18% annual interest charge.

BlueSky HouseCall's professional fees for medical services are based on Medicare allowable charges. The actual amount you will have to pay will be determined after all insurance payments and applicable adjustments have been made. BlueSky HouseCalls will submit all claims to the patient's insurance companies. **However, all known deductibles and copays are expected to be paid by the patient.**

Patients are responsible for their bills and providing all necessary information needed to execute insurance claims. Patients or responsible parties must notify BlueSky HouseCalls if there are any changes in insurance information. In the event that the patient or responsible party does not notify BlueSky HouseCalls to a change in the patient's insurance, patient will be fully liable for the service charge.

OFFICIAL USE

Patient Name: Reviewed and approved by:

BlueSky HOUSE CALLS
507 E Iris Dr, Nashville, TN 37204
Phone: 615-340-6840 Fax: 615-600-4804

Patient Information

The following information will be kept in the strictest confidence, released only with your authorization.

Date: ____ / ____ / _____

Patient Name: *First*: _____ *Middle*: _____ *Last*: _____

Date of Birth: ____ / ____ / _____ **SSN**: _____-_____-_____ **Gender**: Male ☐ Female ☐

Home Address: _____ **Apartment#**: _____

City: _____ **State**: _____ **ZIP**: _____ **Facility**: _____

Facility Type: Independent ☐ Assisted ☐ Memory Care ☐

Community Phone#: (_____) _____-_____ **Personal Phone#**: (_____) _____-_____

Email: _____ **Marital Status**: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Race: Native American ☐ Asian ☐ African American ☐ Pacific Islander ☐ White ☐

Preferred Pharmacy: _____ **Phone**: _____

Pharmacy Address: _____

Referred By: _____

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Patient Name: Reviewed and approved by:

Main Point of Contact: *please provide the primary contact with which we may discuss your medical care.*

☐ **Self – See Patient Information**

Name: _____ **Relationship:** _____ **POA:** ☐ If yes, please provide documentation

Street Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Phone#: (_____) _____-_____ **Work Phone#:** (_____) _____-_____

Email: _____

Second Point of Contact: *please provide the secondary contact with which we may discuss your medical care.*

Name: _____ **Relationship:** _____ **POA:** ☐ If yes, please provide documentation

Street Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Phone#: (_____) _____-_____ **Work Phone#:** (_____) _____-_____

Email: _____

Please attach separate sheet with additional points of contact if you have more than two.

Emergency Contact #1:

☐ **Same as Main Point of Contact** ☐ **Same as Second Point of Contact**

Name: _____ **Relationship:** _____

Street Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Phone#: (_____) _____-_____ **Work Phone#:** (_____) _____-_____

Emergency Contact #2:

☐ **Same as Main Point of Contact** ☐ **Same as Second Point of Contact**

Name: _____ **Relationship:** _____

Street Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Phone#: (_____) _____-_____ **Work Phone#:** (_____) _____-_____

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Patient Name: Reviewed and approved by:

Billing Information

Responsible Party: Please list who will be responsible for paying bills and receiving invoices.

Same as patient: ☐

Name: _____ **Relationship**: _____ **Conservator**: ☐

Street Address: _____ **Apartment#**: _____ **P.O. Box#**: _____

City: _____ **State**: _____ **ZIP**: _____

Home Phone#: (_____) _____-_____ **Cell Phone#**: (_____) _____-_____

Email: _____ **Date of Birth**: ____ / ____ / _____

Health Insurance

Primary Insurance Company Name: _____

Policy Holder's Name: _____ **Date of Birth**: ____ / ____ / _____

Policy Holder's ID: _____ **Group ID**: _____

_____

Secondary Insurance Company Name: _____

Policy Holder's Name: _____ **Date of Birth**: ____ / ____ / _____

Policy Holder's ID: _____ **Group ID**: _____

_____

Prescription Insurance Company Name: _____

Policy Holder's Name: _____ **Date of Birth**: ____ / ____ / _____

Policy Holder's ID: _____ **Group ID**: _____

Must attach a copy of insurance cards with the above information

New Medicare ID Cards have been issued, please provide updated copy

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Patient Name: Reviewed and approved by:

Medical Information

Medications – must be completed*

Please list the medication, with dosages and instructions that you currently use (a copy of current list is fine). Please include over-the-counter and herbal medications. Attach additional pages if needed.

If not taking any medications, check here ☐

Medication	Dosage	Instructions

Allergies

Please list any drug allergies you have. Attach additional pages if needed. **N.K.A** ☐

Drugs	

Preventive Medicine

Have you fallen recently?	☐ Yes ☐ No	Tetanus Shot	**Date:**
Have you had a colonoscopy?	☐ Yes ☐ No	Pneumonia Shot	**Date:**
Have you had a mammogram?	☐ Yes ☐ No	Shingles Shot	**Date:**
Have you had a pap smear?	☐ Yes ☐ No	Influenza Shot	**Date:**
	☐ Yes ☐ No	Other:	**Date:**

Height / Weight

Height:	**Weight**:

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Patient Name: Reviewed and approved by:

Past Medical History – must be completed*

Check all that apply - Attach additional pages if needed. **None/Healthy** ☐ **Unknown** ☐

☐ CVA / Stroke	☐ Circulatory Issues
☐ Hearing Loss	☐ High Cholesterol
☐ Cataracts	☐ Diverticulitis
☐ Asthma	☐ Arthritis _____
☐ C.O.P.D / Emphysema	☐ Skin Disorders _____
☐ C.A.D (Heart Disease)	☐ Endocrine _____
☐ MI (Heart Attack)	☐ Diabetes Type 1, Type 2
☐ Atrial Fibrillation	☐ Cancer _____
☐ CHF	☐ Anemia
☐ HTN (High Blood Pressure)	☐ Other: _____
☐ Reflux / Heartburn	_____
☐ Dementia / Memory Loss	

Past Surgical History/Hospitalizations – must be completed*

Check all that apply. Attach additional pages if needed. **None** ☐ **Unknown** ☐

Operation:	**Date:**
☐ Appendectomy	**Date:**
☐ Cataracts	**Date:**
☐ Gallbladder Removal	**Date:**
☐ Hysterectomy – Total / Partial	**Date:**
☐ Tonsillectomy	**Date:**
☐ Heart Bypass / C.A.B.G	**Date:**
Other:	**Date:**
Other:	**Date:**
Other:	**Date:**
Other:	**Date:**

OFFICIAL USE

Patient Name: Reviewed and approved by:

Family History of Medical Problems – must be completed*

Check all that apply. Attach additional pages if needed. **None** ☐ **Unknown** ☐

CVA / Stroke	☐ Mother	☐ Father	☐ Grandparent	Hypertension	☐ Mother	☐ Father	☐ Grandparent
Hearing Loss	☐ Mother	☐ Father	☐ Grandparent	Hyperlipidemia	☐ Mother	☐ Father	☐ Grandparent
Cataracts	☐ Mother	☐ Father	☐ Grandparent	Diverticulitis	☐ Mother	☐ Father	☐ Grandparent
Chronic Obstructive Pulmonary Disease	☐ Mother	☐ Father	☐ Grandparent	Arthritis	☐ Mother	☐ Father	☐ Grandparent
Coronary Artery Disease	☐ Mother	☐ Father	☐ Grandparent	Diabetes Type I ☐ II ☐	☐ Mother	☐ Father	☐ Grandparent
Heart Attack	☐ Mother	☐ Father	☐ Grandparent	Anemia	☐ Mother	☐ Father	☐ Grandparent
Atrial Fibrillation	☐ Mother	☐ Father	☐ Grandparent	Cancer: (specify)			
Heart Failure	☐ Mother	☐ Father	☐ Grandparent	Other:			

Social History – must be completed*

Unknown ☐

Do you use Tobacco? Yes ☐ No ☐	How many pack a day? How many years?
Do you use Alcohol? Yes ☐ No ☐	How many drink per week?
Do you use any Street Drugs? Yes ☐ No ☐	Which ones?
Living Will Yes ☐ No ☐	☐ Full Code ☐ DNR ☐ POA (please provide a copy)
What is your living situation?	☐ Alone ☐ With Spouse ☐ With other family ☐ Senior Living Facility ☐ Other:_____

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Patient Name: Reviewed and approved by:

BlueSky HOUSE CALLS
507 E Iris Dr, Nashville, TN 37204
Phone: 615-340-6840 Fax: 615-600-4804

Consent to Receive Medical Care

I am aware that BLUESKY HOUSECALLS ("BSHC") provides medical services based on information provided to BSHC by the patient, their family or any trained medical staff working or residing in the patient's place of residence. I understand that accurate and complete medical information is essential to the medical services provided by BSHC. I understand BSHC will not accept liability for inaccurate and incomplete information. I give my consent to receive medical care by professionals associated with BSHC as a result of such information.

Guarantee of Payment and Assignment of Insurance Benefits

I understand that I am financially responsible for the services provided to me by BSHC regardless of insurance coverage. I request that payment of authorized Medicare or other insurance benefits be made on my behalf to BSHC for any services provided to me by BSHC. I authorize and direct any holder of medical information or documentation about me to release to the Centers for Medicare and Medicaid Services and its carriers and agents, as well as to BSHC and its billing agents and any other payers or insurer any information or documentation needed to determine these benefits or benefits payable for any services provided to me by BSHC, now or in the future. I agree to immediately remit to BSHC any payments that I receive from any source for the services provided to me and I assign all rights to such payments to BSHC. The undersigned hereby guarantees payment to BSHC of all charges incurred, and if account is turned over for collection, he/she agrees to pay all cost of collection. The undersigned here agrees to pay interest at a rate of 18% annual percentage rate on all outstanding balances. Interest accrues starting 30 days after all expected insurance payments have been received and balance owed statements have been sent.

Acknowledgement of Receipt of Notice of Privacy Practices and Assignment of Insurance Benefits

I, _____, give my consent to receive medical care by professionals associated with BLUESKY HOUSECALLS and also acknowledge BLUESKY HOUSECALLS has provided me access to a copy of the Notices of Privacy Practices. For additional information I am aware that I may contact BLUESKY HOUSECALLS.

_____ _____
Patient Signature Date

_____ _____
Patient Representative's Signature* Relationship to Patient

(Must provide documentation of healthcare proxy, consent considered invalid without documentation)

OFFICIAL USE

Patient Name: Reviewed and approved by:

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, BlueSky HouseCalls, 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 or member of my care team,
- 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 (ie: 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: _____

OFFICIAL USE

Patient Name: Reviewed and approved by:

HIPAA Notice of Privacy Practices

THIS NOTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law. Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose our protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations

We may use or disclose, as-needed, your protected health care information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training medical students, licensing, and conduction or arranging for other business activities. For example, we may disclose your protected health care information to medical school students that see patients at our practice. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Use and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.
Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

OFFICIAL USE

Patient Name: Reviewed and approved by:

Authorization for Release of Patient Information

I hereby authorize

_____ _____-_____-_____ _____-_____-_____
Doctor Name **Telephone** **Fax**

to release the following health information from the records of:

_____ _____ _____-_____-_____
(Patient Name) (DOB) (SSN)

Information to be released:

- ☐ Copy of complete health record
- ☐ H&P
- ☐ Recent lab-work results
- ☐ Diagnostics (x-rays, MRI results, etc.)
- ☐ Immunization record
- ☐ Discharge summary
- ☐ Preventive care records (colonoscopy, mammogram, pap smear, PSA, smoking cessation counseling, etc.)
- ☐ Operative report
- ☐ Other: _____

Information is to be released to:

BlueSky HouseCalls, LLC
6323 Canterbury Close
Brentwood, TN 37027
FAX #: (615) 600-4804

Purpose for disclosure is for continuation of medical care.

Signed: _____ _____
(Patient or Representative) (Date)

_____ _____
(Relationship to Patient) (Witness)

OFFICIAL USE

Patient Name: Reviewed and approved by: