MyHome Healthcare

We treat you like family

WELCOME TO OUR PRACTICE!

Thank you for choosing MyHome Healthcare to be your primary care provider (PCP). Our dedicated providers work closely with you, your family, and any healthcare team members involved in your care to ensure the best possible outcomes. Our comprehensive and collaborative model of primary care ensures access to everything you need right in the comfort of your own home.

Please complete the attached documents to officially register as a patient of MyHome Healthcare. We are committed to seeing our new patients within a week of registration to ensure a seamless transition into our practice and to ensure all of your needs are met.

We will reach out to you or your designated health care proxy to coordinate the date and time of your first visit. We look forward to meeting you and showing you the MyHome Healthcare difference!

CONTACT INFORMATION: Phone – (978) 494-0441

Fax – (978) 288-0198

Email – office@myhomehc.com

AFTER 5PM & WEEKENDS: Phone – (978) 494-0441 to reach the on-call provider

OFFICE HOURS: Monday-Friday 9am-5pm

Saturday-Sunday Closed

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NEW PATIENT REGISTRATION CHECKLIST

- ☐ Signed consent forms
- ☐ Medication list
- ☐ Copy(s) of insurance card(s)
- ☐ Health Care Proxy document
- ☐ Power of Attorney document (if available)
- ☐ Health care directives and/or living will
- ☐ MOLST/POLST form (can also be completed with provider at initial visit)
- ☐ Phone call with MyHome Healthcare Clinical Coordinator to review health history in preparation for initial visit

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GENERAL CONSENT FOR CARE AND TREATMENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment by MyHome Healthcare providers in your home. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss your treatment plan with your provider about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a health care provider, or other designees as deemed necessary, to perform reasonable and necessary medical examinations, testing and treatment for the condition which has brought me to seek care at MyHome Healthcare. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Print Patient Name	**Signature**	**Date**
Print Representative /Guardian Name	**Signature**	**Date**

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AGREEMENT TO RECEIVE CHRONIC CARE MANAGEMENT SERVICES

As a patient with two or more chronic conditions, you may benefit from a new program providing chronic care management services to Medicare patients. Chronic care management services include:

- Care management for chronic conditions, including systematic assessment of your health care needs, timely scheduling of preventive care services, and medication review and oversight;
- Access to your care team 24-hours-a-day, 7-days-a-week, including non-face-to-face access such as telephone, email, and secure messages;
- Successive routine appointments with a designated member of your care team;
- Creation of a comprehensive plan of care for your health issues;
- Management of care transitions among health care providers and settings, including referrals to other clinicians, follow-up after emergency department visits, and follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities;
- Coordination with home and community based clinical service providers.

Your Rights

- As part of the chronic care management service, you will receive a copy of your comprehensive plan of care.
- You have the right to stop these chronic care management services at any time, effective at the end of the calendar month. Please contact our practice at 978-494-0441 to revoke your consent.

You agree and consent to the following by signing this agreement:

- You consent to MyHome Healthcare providing chronic care management services to you and billing for them.
- You acknowledge that only one provider can furnish and bill for chronic care management services for you during a calendar month. Please let us know if you have entered into a similar agreement with another practice.
- You consent to electronic communication of your health information with others involved in your care.
- **You understand that standard coinsurance, copays, and deductibles apply to chronic care management services, so you may be billed for these services up to once a month, whether or not you had a face-to-face meeting with your provider.**

Patient / Guardian / Caregiver: _____

Signature: _____ Date: _____

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MEDICAL RECORD RELEASE FORM

****Authorization for Use or Disclosure of Medical Record Information****

Patient Full Name:	Date of Birth:
Address:	City:
State:	Zip:
Phone:	

I hereby authorize Name/Physician's Office:
Address: City:
State: Zip:
Fax
To release my medical record information to:
MyHome Healthcare 800 Turnpike Street, Suite 300 North Andover, MA 01845 Phone: (978) 494-0441 Fax: (833) 974-2132

The information release pursuant to this authorization may be re-disclosed by the receiving institution or individuals or other individuals or organizations that are not subject to privacy protected laws.

I DO	I DO NOT	DESCRIPTION	INITIAL
		Want mental health or psychotherapy notes / information released	
		Want information about HIV test & related information released	
		Want information about alcohol and/or substance abuse released	
		Want information about genetic testing released	
		Want information about Social Worker communication released	
		Want information about rape / sexual abuse released	
		Want information about developmental disability released	
		Want information about sexually transmitted disease (STD) released	
		Want information about _____ released	

****PLEASE FAX 1 YEAR OF PROGRESS NOTES, VACCINES, LABS, TESTING, AND MEDICATION LIST****

Print Patient Name **Signature** **Date**

Print Representative /Guardian Name **Signature** **Date**

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PATIENT FINANCIAL RESPONSIBILITY

FINANCIAL AGREEMENT:

- I acknowledge, that as a courtesy, MyHome Healthcare may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

THIRD PARTY COLLECTION:

- I acknowledge that MyHome Healthcare may utilize the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

ASSIGNMENT OF BENEFITS:

- I hereby assign to MyHome Healthcare any insurance or other third-party benefits available for health care services provided to me. I understand MyHome Healthcare has the right to refuse or accept such assignment of such benefits. If these benefits are not assigned to MyHome Healthcare, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

MEDICARE PATIENT CERTIFICATION AND ASSIGNMENT OF BENEFIT:

- I certify that any information I provide in applying for payment under Title XVII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to MyHome Healthcare by the Medicare or Medicaid program.

CONSENT TO TELEPHONE CALLS FOR FINANCIAL COMMUNICATIONS:

- In order for MyHome Healthcare, Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I agree and consent that MyHome Healthcare or EBO Servicer and collection agents may contact me by telephone at any telephone number I have provided or which MyHome Healthcare, EBO Servicer and collection agents have obtained or at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and / or use of an automatic dialing device, as applicable.

A PHOTOCOPY OF THIS CONSENT SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.

Print Patient Name **Sign Name** **Date**

Print Representative /Guardian Name **Sign Name** **Date**

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CONSENT TO RECEIVE ELECTRONIC COMMUNICATION

I, _____, hereby consent and state my preference to have my provider, _____, and other staff at MyHome Healthcare communicate with me, facility staff, and other health care providers involved in my care via email or standard SMS messaging regarding various aspects of my medical care, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing.

I understand that email and standard SMS messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS messaging regarding my medical care might be intercepted and read by a third party.

Email address for communication: _____

Mobile phone number for SMS communication: _____

By signing below, you are acknowledging your consent to electronic communication with MyHome Healthcare.

_____

Print Patient Name **Sign Name** **Date**

_____

Print Representative /Guardian Name **Sign Name** **Date**

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HIPAA PRIVACY AND RELEASE OF INFORMATION AUTHORIZATION

Patient Name:_____ DOB:_____

I, _____, hereby authorize MyHome Healthcare PLLC, and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice. However, this authorization may not be revoked if it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

_____

Patient Printed Name Patient Signature Date

_____

Legal Representative Printed Name Legal Representative Signature Date

Legal Representative – By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

MASSACHUSETTS MEDICAL ORDERS for LIFE-SUSTAINING TREATMENT

(MOLST) www.molst-ma.org

Patient's Name _____

Date of Birth _____

Medical Record Number if applicable: _____

INSTRUCTIONS: *Every patient should receive full attention to comfort.*

→ This form should be signed based on goals of care discussions between the patient (or patient's representative signing below) and the signing clinician.
→ Sections A–C are valid orders only if Sections D and E are complete. Section F is valid only if Sections G and H are complete.
→ If any section is not completed, there is no limitation on the treatment indicated in that section.
→ The form is effective immediately upon signature. Photocopy, fax or electronic copies of properly signed MOLST forms are valid.

A
Mark one circle ➔

CARDIOPULMONARY RESUSCITATION: for a patient in cardiac or respiratory arrest

O Do Not Resuscitate O Attempt Resuscitation

B
Mark one circle ➔

VENTILATION: for a patient in respiratory distress

O Do Not Intubate and Ventilate O Intubate and Ventilate

Mark one circle ➔

O Do Not Use Non-invasive Ventilation (e.g. CPAP) O Use Non-invasive Ventilation (e.g. CPAP)

C
Mark one circle ➔

TRANSFER TO HOSPITAL

O Do Not Transfer to Hospital (*unless needed for comfort*) O Transfer to Hospital

PATIENT or patient's representative signature

D
Required

Mark one circle and fill in every line for valid Page 1.

Mark one circle below to indicate who is signing Section D:
o Patient o Health Care Agent o Guardian* o Parent/Guardian* of minor

Signature of patient confirms this form was signed of patient's own free will and reflects his/her wishes and goals of care as expressed to the Section E signer. Signature by the patient's representative (indicated above) confirms that this form reflects his/her assessment of the patient's wishes and goals of care, or if those wishes are unknown, his/her assessment of the patient's best interests. **A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.*

X _____ _____
Signature of Patient (or Person Representing the Patient) Date of Signature

_____ _____
Legible Printed Name of Signer Telephone Number of Signer

CLINICIAN signature

E
Required
Fill in every line for valid Page 1.

Signature of physician, nurse practitioner or physician assistant confirms that this form accurately reflects his/her discussion(s) with the signer in Section D.

X _____ _____
Signature of Physician, Nurse Practitioner, or Physician Assistant Date and Time of Signature

_____ _____
Legible Printed Name of Signer Telephone Number of Signer

Optional
Expiration date (if any) and other information

This form does not expire unless expressly stated. *Expiration date (if any) of this form:* _____

Health Care Agent Printed Name _____ Telephone Number _____

Primary Care Provider Printed Name _____ Telephone Number _____

SEND THIS FORM WITH THE PATIENT AT ALL TIMES.
HIPAA permits disclosure of MOLST to health care providers as necessary for treatment.

Patient's Name: _____ Patient's DOB _____ Medical Record # if applicable_____

F — Statement of Patient Preferences for Other Medically-Indicated Treatments

INTUBATION AND VENTILATION			
Mark one circle ➔	O Refer to Section B on Page 1	O Use intubation and ventilation as marked in Section B, but short term only	O Undecided O Did not discuss
NON-INVASIVE VENTILATION (e.g. Continuous Positive Airway Pressure - CPAP)			
Mark one circle ➔	O Refer to Section B on Page 1	O Use non-invasive ventilation as marked in Section B, but short term only	O Undecided O Did not discuss
DIALYSIS			
Mark one circle ➔	O No dialysis	O Use dialysis O Use dialysis, but short term only	O Undecided O Did not discuss
ARTIFICIAL NUTRITION			
Mark one circle ➔	O No artificial nutrition	O Use artificial nutrition O Use artificial nutrition, but short term only	O Undecided O Did not discuss
ARTIFICIAL HYDRATION			
Mark one circle ➔	O No artificial hydration	O Use artificial hydration O Use artificial hydration, but short term only	O Undecided O Did not discuss

Other treatment preferences specific to the patient's medical condition and care _____

_____

_____

G — PATIENT or patient's representative signature

Required

Mark one circle and fill in every line for valid Page 2.

Mark one circle below to indicate who is signing Section G:

o Patient o Health Care Agent o Guardian* o Parent/Guardian* of minor

Signature of patient confirms this form was signed of patient's own free will and reflects his/her wishes and goals of care as expressed to the Section H signer. Signature by the patient's representative (indicated above) confirms that this form reflects his/her assessment of the patient's wishes and goals of care, or if those wishes are unknown, his/her assessment of the patient's best interests. **A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.*

X _____ _____

Signature of Patient (or Person Representing the Patient) | Date of Signature

_____ _____

Legible Printed Name of Signer | Telephone Number of Signer

H — CLINICIAN signature

Required

Fill in every line for valid Page 2.

Signature of physician, nurse practitioner or physician assistant confirms that this form accurately reflects his/her discussion(s) with the signer in Section G.

X _____ _____

Signature of Physician, Nurse Practitioner, or Physician Assistant | Date and Time of Signature

_____ _____

Legible Printed Name of Signer | Telephone Number of Signer

Additional Instructions For Health Care Professionals

→ Follow orders listed in A, B and C and honor preferences listed in F until there is an opportunity for a clinician to review as described below.

→ Any change to this form requires the form to be voided and a new form to be signed. To void the form, write VOID in large letters across both sides of the form. *If no new form is completed, no limitations on treatment are documented and full treatment may be provided.*

→ Re-discuss the patient's goals for care and treatment preferences as clinically appropriate to disease progression, at transfer to a new care setting or level of care, or if preferences change. Revise the form when needed to accurately reflect treatment preferences.

→ The patient or health care agent (if the patient lacks capacity), guardian*, or parent/guardian* of a minor can revoke the MOLST form at any time and/or request and receive previously refused medically-indicated treatment. **A guardian can sign only to the extent permitted by MA law. Consult legal counsel with questions about a guardian's authority.*

Massachusetts Medical Orders for Life-Sustaining Treatment

IMPORTANT INFORMATION ABOUT MASSACHUSETTS MOLST

The Massachusetts MOLST form is a MA DPH-approved standardized medical order form for use by licensed Massachusetts physicians, nurse practitioners and physician assistants.

While MOLST use expands in Massachusetts, health care providers are encouraged to inform patients that EMTs honor MOLST statewide, but that systems to honor MOLST may still be in development in some Massachusetts health care institutions.

PRINTING THE MASSACHUSETTS MOLST FORM

- Do not alter the MOLST form. EMTs have been trained to recognize and honor the standardized MOLST form. The best way to assure that MOLST orders are followed by emergency medical personnel is to download and reproduce the standardized form found on the MOLST web site.

- Print original Massachusetts MOLST forms on bright or fluorescent pink paper for maximum visibility. Astrobrights® Pulsar Pink* is the color highly recommended for original MOLST forms. EMTs are trained to look for the bright pink MOLST form before initiating life-sustaining treatment with patients.

- Print the MOLST form (pages 1 and 2) as a double-sided form on a single sheet of paper.

- Provide an electronic version of the downloaded MOLST form to your institution's forms department or to personnel responsible for copying/providing forms in your institution.

FOR CLINICIANS: BEFORE USING MOLST

MOLST requires a physician, nurse practitioner, or physician assistant signature to be valid. This signature confirms that the MOLST accurately reflects *the signing clinician's discussion(s) with the patient*. The MOLST form should be filled out and signed only after in-depth conversation between the patient and the clinician signer.

Before using MOLST:

- Access the *Clinician Checklist for Using MOLST with Patients* at: http://www.molst-ma.org/health-care-professionals/guidance-for-using-molst-forms-with-patients.

- Listen to *MOLST Overview for Health Professionals* at: http://www.molst-ma.org/molst-training-line.

- Access the MOLST website at: http://www.molst-ma.org periodically for MOLST form updates.

- For more information about Massachusetts MOLST or the Massachusetts MOLST form, visit http://www.molst-ma.org.

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* Astrobrights® Pulsar Pink paper can be purchased from office suppliers, including:

Staples - Item #491620 Wausau™ Astrobrights® Colored Paper, 8 1/2" x 11", 24 Lb, Pulsar Pink, in stores or at http://www.staples.com, and

Office Depot – Item #420919 Astrobrights® Bright Color Paper, 8 1/2 x 11, 24 Lb, FSC Certified Pulsar Pink, in stores or at http://www.officedepot.com.