INDIANA
HOME BASED
PRIMARY CARE

11550 N Meridian St, Suite 375-A
Carmel, IN 46032
Phone: (463) 223-5702
Fax: (855) 644-3036

New Patient Referral to Indiana Home Based Primary Care

Fax the following to 1-855-644-3036
Or email IntakePatients@IndianaHomeBasedPrimaryCare.com

- ☐ A copy of the patient's facesheet OR the attached Patient Referral Form
- ☐ The consent to treatment form signed by the patient or their power of attorney (Page 2)
- ☐ The records request form signed by the patient or their power of attorney (Page 3)
- ☐ The patient's medication list
- ☐ Any recent medical records, especially discharge summaries
- ☐ Any recent laboratory results

The remainder of this packet should be given to the patient or their power of attorney.

Thank you for helping us provide excellent medical care to our patients!

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Patient Referral Form

Patient Name: ____DOB: __________

Street Address: ____Apt #: ___________

City, State, Zip: ____

Phone number: ________________________________ Alternate phone number: ____________________

Email address: ___________________________________

Insurance Information:

Medicare ID #: _______________ Social Security Number: _______________
Primary Insurance: ________________________________ Policy #: _____________________
Secondary Insurance: ________________________________ Policy #: _____________________

Billable party (if other than patient)

Name: ____

Street Address: ____Apt #: ___________

City, State, Zip: ____

Phone number: ________________________________ Alternate phone number: ____________________

Email address: ___________________________________ Are you power of attorney? ☐ Yes ☐ No

Relationship to Patient: ____

Primary Contact for Scheduling Appointments (if different than patient):

Name: ____

Phone number: ________________________________ Alternate phone number: ____________________

Email address: ___________________________________ POA ☐ Yes ☐ No

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Consent for Treatment

Patient Name: ____DOB: ___________

I request and authorize Indiana Home Based Primary Care (INHBPC) to provide me with medical and other health services that it deems necessary or advisable. This care may include, but is not limited to, routine diagnostics, administration of pharmaceuticals, and routine medical and nursing care. I understand that my care may be provided by a physician and other practitioners. I am aware that the practice of medicine is not an exact science and that no guarantees have been made with respect to results of any diagnostic procedure or treatment.

I authorize INHBPC to bill my insurance for services received. I authorize INHBPC to obtain information necessary to process claims, including determining eligibility and seeking reimbursement for medical supplies and/or medications.

I understand that samples of body fluids and/or tissues may be withdrawn from me during routine diagnostic procedures. I authorize INHBPC to dispose of those bodily fluids. I understand that an HIV (human immunodeficiency virus) test may be performed on me without my further consent if a health professional is exposed to my blood or other body fluid.

Consent for Chronic Care Management (CCM) services.
Unless I opt out below, and if INHBPC determines I am eligible to receive CCM services, I hereby consent to receive CCM services. I understand that CCM services are to help me manage my ongoing chronic health conditions, which includes:

- Having access to my care team 24-hours-a-day, 7-days-a-week
- Occasional (about once per month) phone calls, text messages and/or email messages to help identify care needs,
- Care management of my chronic conditions, including scheduling of recommended preventive care services, medication reconciliation, and oversight of my medication management,
- Creation of a comprehensive plan of care for my health issues that is specific to me and in line with my values,
- Management of my care as I move between and among health care providers and settings,
- Coordination with home and community-based providers of clinical services,
- An annual wellness examination.

I will receive a copy of my comprehensive plan of care. I understand that I can stop receiving CCM services at any time by notifying INHBPC (effective at the end of a calendar month). Medicare will only pay one physician or health care professional to furnish me CCM services within a given calendar month.

I understand INHBPC will bill Medicare for performing the CCM services and that I am responsible for payment of the usual Medicare deductible and coinsurance applied to physician services. INHBPC may communicate my medical information to other treating providers as part of the care coordination. This designation is effective as of the date below and remains in effect until revoked by me.

I Do NOT wish to receive CCM services ____

By signing this, I agree to receive medical services from INHBPC.

I acknowledge that I have received a copy of the INHBPC Notice of Privacy Practices.

Signature of patient OR patient representative: ____ Date: _____________

If other than patient, printed name: __________________________________ Relationship to patient: _______________

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Request for Records

Patient Information - please fill out completely	
Patient Name:	
Address:	
City/State/Zip:	
Phone Number:	Date of Birth:
Name of Facility Releasing Information:	
Facility to which information will be released: Indiana Home Based Primary Care **11550 N Meridian St, Suite 375-A** **Carmel, IN 46032** **Phone: (463) 223-5702** **Fax: (855) 644-3036**	Purpose of request: Treatment, continuity of care
Information Requested	
Progress notes	Radiology/Imaging reports
Consultation reports	Radiology films
Most recent history and physical	Two-way verbal exchange of communication
Immunization record	Entire medical record
Laboratory reports	Other:
Date Range of Information Requested: Start Date / / End date / /	

By signing this authorization, I agree to the following:

- I understand if I authorize my information to be released to persons or organizations not subject to federal privacy laws, the information may be re-disclosed by the recipient and the information will no longer be protected.
- I understand that authorizing the use and disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to receive treatment.
- I understand that I may inspect a copy of the information to be used or disclosed.
- I understand that I can revoke this authorization at any time by contacting my provider, but any revocation will not apply to the extent that my provider has acted in reliance of this authorization.
- I authorize the use and disclosure of my health information as described above. This authorization expires one year from the date on which it was signed, unless otherwise specified. (Otherwise, specified date, event, or condition:___________)

Signature of Patient/Patient Representative: ____
Date: _____________
If Other Than Patient, Printed Name: ____
Relationship to Patient: ____________________

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Dear Prospective Patient,

Thank you for considering Indiana Home Based Primary Care (INHBPC) for your home-based medical care needs. We are a group of physicians, nurse practitioners, and physician assistants who provide primary care services to patients who find it difficult to leave their home. Below are some highlights:

Mission: The mission of INHBPC is to provide high-quality, goal-directed, friendly, compassionate medical care to seniors and others that find traveling to a medical office challenging.

Experience and Professionalism: Our group of board-certified physicians and licensed nurse practitioners, physician assistants, and nursing staff is one of the most experienced visiting medical groups in the U.S. We have done approximately 200,000 “house calls” to Ohio seniors in the last thirteen years – and we have presented our group’s successful care model and outcomes in many national meetings and publications. We are excited to expand into Kentucky and Indiana.

Integrated Care: Our approach is to listen to our patients, and their families and caregivers. Once we understand your goals, we work with our nurses, care managers, and administrative team to create a collaborative care plan that integrates medical, emotional, social, spiritual, and physical needs "in-between" medical visits.

24-Hour Service: We know that medical needs don't stop when office hours are over. We believe that providing local, timely answers to patient and caregiver concerns is paramount to quality senior care.

Senior Communities: Our medical team and local clinical support staff are experts at providing care that enables the "aging in place" philosophy best.

Quality Outcomes: Our group is a national leader in reducing hospitalization rates for people with multiple chronic illnesses. When hospitalization is needed, we help you transition back home as seamlessly as possible. Our group’s care management approach is associated with reductions in hospitalization rates, higher quality scores, and more holistic care planning.

I encourage all Medicare patients to list us as your primary care provider by using the MyMedicare.gov portal. Registering for the Medicare portal will enable you to keep an eye on your Medicare claims, find information about your eligibility, deductible information, and manage your prescription drug list.

I hope you will consider a care relationship with us. We would be honored to be your care provider.

Sincerely,
William Mills, M.D.
President and Founder

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Indiana Home Based Primary Care (INHBPC) Practice Polices

Our Services
We offer primary care services, including routine medical care, acute medical care, follow-up care after hospitalization, wound consultations, palliative care, hospice care, competency evaluations, fall assessments, and home safety evaluations.

Where We Go
We serve patients in their private homes, assisted living centers, senior apartments, group homes, and independent living centers in the Fort Wayne area. We also have practices serving Cleveland, Cincinnati (including Northern Kentucky), Columbus, and Dayton metro areas in Ohio; Bowling Green, Kentucky; and Nashville, Tennessee.

Insurance Accepted
We accept most insurance plans, including Medicare and many Medicare Advantage programs. It is the responsibility of the patient or their representative to ensure that the patient's insurance will cover services provided by INHBPC. In the event that your insurance does not cover our services, any balance owed will be the responsibility of the patient.

Contacting Us
Our office staff is available Monday through Friday, 8:30 a.m. to 5:00 p.m. for routine medical care, medication refills, and appointment requests. Most medical visits by your provider will take place during usual business hours. Call coverage is provided 24 hours a day, 7 days a week for urgent medical needs.

Our phone number is **(463) 223-5702**
You may also reach us toll-free at **(800) 807-6555**

Our fax number is **(855) 644-3036**

Preparing for Your Visit
Be advised that due to the nature of home-based primary care, exact appointment times are not possible. Please be prepared for your visit by wearing loose fitting, comfortable clothing. Be sure to have your medications and any medical records you have. You may have others present for the visit if you wish. If you have trouble getting to and from the door, please consider having a family or friend present or using a door side lockbox.

During Your Visit
The initial visit is comprehensive and includes all past and current medical conditions, your healthcare goals, and ordering of appropriate treatments. The typical initial visit length is about one hour. Follow-up visit length and frequency varies according to medical need. Assisted living patients must be seen at least four times a year due to state regulations.

After Your Visit
Our office processes any orders needed for home health agencies, hospice, durable medical equipment (DME), oxygen, and medications. We also assign an approximate follow-up date at the end of your visit.

Emergencies
In a life-threatening emergency, call 911 or go to the nearest emergency room. If an urgent medical problem arises during a time when the office is closed, simply call the office at **(463) 223-5702** and you will have access to the on-call provider.

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Medication Refills
At least 7 days prior to needing your medication, please have your pharmacy contact our office to request a refill. Controlled substance prescriptions cannot be called or faxed to pharmacies. If you require a controlled substance medication, it is your responsibility to call our office at least 7 days prior to the end of your prescription.

Claims Submission
We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Any remaining balance or denied service will be billed to the patient. Any changes to your insurance coverage must be reported to our office. Failure to do so may result your financial responsibility.

Chronic Care Management (CCM)
INHBPC provides chronic care management services (CCM) for our patients. CCM involves a combination of face-to-face and non-face-to-face services to ensure that each patient's healthcare needs are met. The non-face-to-face component of CCM involves the creation of a patient-centered plan of care, medication monitoring, management of care transitions, electronic care coordination, and exchange of health information with other health care providers as necessary, while providing you or your caregiver 24/7 access to your care team. INHBPC will bill my insurance for this service, and patients are responsible for any copayment or deductible. Any patient can revoke permission to bill CCM at any time by notifying INHBPC in writing.

Medical Records
Should the need arise, your medical records can be faxed directly to any other medical provider free of charge. Should you also need a hard copy of your records there will be a charge of **$35**. A release of information request may need to be completed prior to transfer of records.

Missed Appointments
A missed appointment fee of **$75** will be charged to private home patients not calling to cancel their appointment at least 24 hours in advance with the exception of the patient needing emergency medical care.

Hospitals
While we do not round at hospitals, we work closely with hospital doctors serving these facilities. We provide ongoing communication between these providers and our office to ensure coordination of care. This allows our patients to choose any hospital they wish.

Testing in the Home
We can arrange a variety of home testing including blood draws, x-ray, ultrasound, echocardiogram, circulation testing, and pulmonary function testing. Depending on the test and insurance there may be a fee that is not covered by insurance.

Home Health
We work with most home health and hospice agencies, ensuring ongoing communication and care of the home-bound patients. Home health services available include physical therapy, occupational therapy, skilled nursing, speech therapy, home health aide, and homemaker services. Insurance limitations apply.

Hospice
Due to the nature of our practice, some of our patients choose hospice care services. We continue to work closely with the hospice team and coordinate care as the patient's primary care provider.

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HIPAA Notice of Privacy Practices

This Notice describes how protected health information (PHI) about you may be used and disclosed and how you can get access to this information. This Notice provides you with information to protect the privacy of your PHI. The Notice also describes the policy rights you have and how you exercise those rights. Please review it carefully. This Notice is effective on January 1, 2019, replacing previous versions. If you have any questions about this Notice, please contact Indiana Home Based Primary Care at 800-807-6555.

Our Obligations:
We are required by law to:

- Maintain the privacy of PHI
- Give you this notice of our legal duties and privacy practices regarding your PHI
- Follow the terms of our notice

How We May Use and Disclose PHI:
The following describes the ways we may use and disclose PHI. Except for the purposes described below, we will use and disclose PHI only with your written permission. You may revoke such permission at any time by writing to our Privacy Officer: Jamie Roosa at Jamie.Roosa@westernreservemedicalgroup.com

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose PHI to specialists or therapists on your treatment team and who are involved in your care.
For Payment. We may use and disclose PHI so that we or others may bill and receive payment from you or a third party for the treatment and services you received.
For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our clients/patients receive quality care and to operate and manage our office.
Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We may also use this and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.
Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a third-party payment source.

Special Situations:

As Required by Law. We will disclose PHI when required to do so by international, federal, state or local law.
To Avert a Serious Threat to Health or Safety. We may use and disclose PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.
Business Associates. We may disclose PHI to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than information specified in our contract.
Public Health Risks. We may disclose PHI for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
Health Oversight Activities. We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with the civil right laws.
Data Breach Notification Purposes. We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your health information.
Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information released.
Law Enforcement. We may release PHI if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of a criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.
National Security and Intelligence Activities. We may release PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
For any non-routine request for disclosure of PHI, the Facility will review the request for disclosure on an individual basis.

Uses and Disclosures that Require Us to Give You an Opportunity to Object and Opt Out

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgement.
Disaster Relief. We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

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Health Information Exchange. We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We, and other healthcare providers, may allow access to your PHI through the Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. You may opt-out at any time by notifying the Health Information Management Services/Medical Records Department OR the Privacy Officer at 800-807-6555.

Your Written Authorization Is Required for Other Uses and Disclosures.
The following uses and disclosures of your PHI will be made only with your written authorization:

- Uses and disclosures of PHI for marketing purposes; and
- Disclosures that constitute a sale of your PHI

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. Disclosures that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

You have the following rights regarding PHI we have about you:
Rights to Inspect and Copy. You have a right to inspect and copy PHI that may be used to make decisions about your care or payment for your care, including medical and billing records. To inspect and copy this PHI, you must make your request, in writing, to our Privacy Officer. We have 30 days to make your PHI available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.
Right to an Electronic Copy of Electronic Medical Records. If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your PHI in the form or format you request, if it is readily producible in such form or format. If the PHI is not readily producible in the form or format you request your record will be provided in either our standard electronic form or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.
Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured PHI.
Right to Amend. If you feel that the PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.
Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of PHI for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, make a request, in writing, to our Privacy Officer.
Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the PHI we disclose to someone involved in your care or the payment for your care, like a family member or friend. To request a restriction, you must make your request, in writing, to our Privacy Officer. We are not required to agree with your request unless you are asking us to restrict the use and disclosure of your PHI to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out of pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
Out-of-Pocket-Payments. If you paid out-of-pocket, in full, for your health care provided by Indiana Home Based Primary Care, your PHI with respect to that health care service will not be disclosed to a health plan (i.e. your health insurance provider) for purposes of payment or health care operations; you must request a Superbill be provided to you with respect to that health care service, and your health insurance provider may also request that you provide supporting documentation (i.e. treatment notes, evaluation report).
Destruction of PHI. PHI stored in paper, electronic or other format will be destroyed utilizing an acceptable method of destruction after the appropriate retention period has been met (i.e. 7-year rule as required by law). Access to PHI stored on computer equipment and media will be limited by taking the appropriate measures to destroy electronically stored PHI.
Electronic Protected Health Information ("e-PHI").
It is the policy of INHBPC to protect the use, storage, and transmission of e-PHI (for example, email, text, voice-messaging, and/or web-based data storage) as well as to fulfill our duty to protect the confidentiality and integrity of each client's e- PHI as required by law, professional ethics, and accreditation requirements. The information released will be limited to the ***minimum necessary*** to meet the requestor's needs. Whenever possible, de-identified information will be used.

For example:
Text/SMS Text/SMS messaging will not be used to send sensitive information, including information about current or past conditions, or treatment, as well as identifying information such as social security numbers or insurance identification information.
Voice Messaging Clients are responsible for providing updated contact information to Indiana Home Based Primary Care, when applicable; voicemail messaging will not be used to send sensitive information, including information about current or past conditions, or treatment, as well as identifying information such as social security numbers or insurance identification information.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please see our business office.

Changes to this Notice. We reserve the right to change this notice and make the new notice apply to PHI we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer: All complaints must be in writing. You will not be penalized for filing a complaint.

You may contact our office at:
26110 Emery Road, Suite 300
Warrensville Heights, OH 44128
800.807.6555
Privacy Officer: Jamie Roosa at Jamie.Roosa@westernreservemedicalgroup.com