Doctor Jeannie
Senior Care

Consent Form

Authorization for Treatment

I request and have given consent to the following: Medical Services, Chronic Care Management, Remote Patient Monitoring, Behavioral Health Integration, Televisits, SureScripts medication management. I also have received the *Doctor Jeannie Senior Care Handbook* explaining these programs as well as the *Notice of Patient Privacy*. I give authorization to Doctor Jeannie Senior Care, a division of Creative Healthcare, PLLC, to treat with Dr. Jean Lessly as the physician and her supervised nurse practitioners/physician assistants. I understand that I am allowed to keep all of my current medical providers if I so desire, and Doctor Jeannie Senior Care will coordinate care with them to ensure a comprehensive healthcare plan.
New Doctor Jeannie Senior Care Member:

(your name printed) **Member Name** : _____

Date of Birth : _____

Assignment of Benefits

I hereby authorize and direct my insurance carrier(s), including but not limited to Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Creative Healthcare, PLLC dba Doctor Jeannie Senior Care for any medical services rendered to myself regardless of the extent of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance, including co-pays (Medicare REQUIRES Doctor Jeannie Senior Care to send bills for co-pays). If I am unable to meet these financial obligations, I will reach out to Doctor Jeannie Senior Care staff to discuss my options for financial hardship. I understand that Doctor Jeannie Senior Care NEVER refers anyone to a collections agency. We want to work with you to ensure desired health outcomes.

Authorization Release Information

I hereby authorize Creative Healthcare, PLLC to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for an indefinite period. This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. PLEASE PROVIDE DOCTOR JEANNIE SENIOR CARE WITH A COPY OF YOUR INSURANCE CARDS OR ALLOW US TO TAKE PICTURES FOR OUR RECORDS.

_____ _____

DrJ Senior Care Member/Responsible Party Signature Today's Date

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Records to Be Released FROM: _____

Address:_____

City, State, Zip Code: _____

Telephone:_____Fax:_____

☐ **I hereby request and authorize you to furnish records for the purpose of continuity of care or at my request. Please include Notes, Labs, Radiology, Immunizations.**

Records to Be SENT To: DrJ Senior Care Medical Records Coordinator

Address: P.O. Box 683038, Franklin, TN 37068_____

Telephone: 615-562-1411_____ **Fax: 833-992-2132 (preferred)**

DrJ Senior Care Member Name:_____ DOB:_____

Home Address:_____

Phone Number: _____

I understand that:

1. I may revoke this authorization at any time in writing, except to the extent that action has been taken already based upon it.
2. The recipient of these records may further disclose this information and it may then no longer be protected by federal privacy regulations.
3. I am entitled to a copy of this document.
4. I may refuse to sign this authorization and my refusal to sign will not affect treatment, payment, enrollment or eligibility for benefits.
5. There may be a charge for the release of these records pursuant to 45 CFR 164.524 © (4) (HIPAA) but you will be informed prior to any action taken requiring extra payment.
6. This authorization shall expire upon written request to revoke or according to state law.
7. A copy of this authorization is as valid as the original.

Signature of DrJ Member/Responsible Party:

_____ Date: _____

Doctor Jeannie Senior Care

General Information Form

Doctor Jeannie Senior Care Member Name: _____

Home Address: _____

Member Cell Phone Number:_____ Date Of Birth: _____

SSN:_____ Email Address: _____

Primary Insurance (Name and Numbers): _____

Secondary:_____

Emergency Contact: _____ Relationship: _____

Cell Phone: _____ OK to leave voice message ☐ Yes ☐No

Email Address: _____ Portal access ☐ Yes ☐No

Primary Care Provider: _____ Phone: _____

Pharmacy Name and Address: _____

Allergies: _____

☐Have you ever used **tobacco**? If so, how long did you smoke and how many packs per day?

_____

☐ **I acknowledge, if I get a new prescription from an outside medical provider, I will be responsible for letting DrJSenior Care's office know by calling 615-562-1411 and sending a copy of the new prescription either through the patient portal or via fax 833-992-2132.**

Resident / Responsible Party Signature: _____ **Date:**_____

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Medical Conditions

(Please select all that apply)

- ☐ **Attention Deficit Disorder**
- ☐ **AIDS/HIV**
- ☐ **Abdominal Pain**
- ☐ **Abnormal Bleeding**
- ☐ **Acid Reflux (GERD)**
- ☐ **Allergies/Hay fever**
- ☐ **Anemia**
- ☐ **Anesthesia Complications**
- ☐ **Anxiety**
- ☐ **Arthritis/Osteoarthritis**
- ☐ **Asthma**
- ☐ **Atrial Fibrillation**
- ☐ **Back Problems**
- ☐ **Blood Transfusion**
- ☐ **COPD/Chronic Bronchitis/Emphysema**
- ☐ **Cancer (type): _____**
- ☐ **Chronic Cough**
- ☐ **Chronic Diarrhea**
- ☐ **Chronic Ear Infections**
- ☐ **Congestive Heart Failure**
- ☐ **Constipation**
- ☐ **Coronary Artery Disease**
- ☐ **Cystitis/Painful Bladder**
- ☐ **Deep Vein Thrombosis**
- ☐ **Dementia/Memory Issues**
- ☐ **Dentures**
- ☐ **Depression**
- ☐ **Diabetes**
- ☐ **Difficulty swallowing**
- ☐ **Diverticulitis/Diverticulosis**
- ☐ **Eczema**
- ☐ **Edema/Swelling**
- ☐ **Fainting Spells**
- ☐ **Falls**
- ☐ **Fecal/Bowel Incontinence**
- ☐ **Fibromyalgia**
- ☐ **Frequent Urination**
- ☐ **GI/Stomach Problems**
- ☐ **Glasses**
- ☐ **Gout**
- ☐ **Hallucinations**
- ☐ **Headaches**
- ☐ **Hearing Loss**
- ☐ **Heart Attack**
- ☐ **Heart Disease**
- ☐ **Heart Arrhythmia**
- ☐ **Hepatitis B or C**
- ☐ **High Blood Pressure**
- ☐ **High Cholesterol**
- ☐ **Hyperthyroidism**
- ☐ **Hypothyroidism**
- ☐ **Insomnia**
- ☐ **Kidney Disease**
- ☐ **Low Vitamin B12**
- ☐ **Low Vitamin D**
- ☐ **Liver Disease**
- ☐ **Lupus**
- ☐ **Mental Disorder**
- ☐ **Neuropathy**
- ☐ **Obesity**
- ☐ **Osteoporosis/Thin Bones**
- ☐ **Pain (where): _____**

_____

_____

_____

- ☐ **Parkinson's Disease**
- ☐ **Peripheral Vascular Disease**
- ☐ **Polyps in the Colon**
- ☐ **Poor appetite**
- ☐ **Prostate Problems/Trouble with Urination**
- ☐ **Pulmonary Embolism**
- ☐ **Recurrent Urinary Tract**
- ☐ **Rheumatoid Arthritis**
- ☐ **Infections**
- ☐ **Seizures**
- ☐ **Skin Problems/Wounds**
- ☐ **Stroke**
- ☐ **Thyroid Disease**
- ☐ **Tremors**
- ☐ **Unsteady Gait**
- ☐ **Urinary Incontinence**
- ☐ **Urinary Tract Infections**
- ☐ **Vertigo/Dizziness**
- ☐ **Vision or Eye Problems**
- ☐ **Weight Loss**
- ☐ **Other _____**

_____

_____

_____

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Medications

(Please list name, dose, and how often you take including any supplements or over the counter medications)

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

9._____

10._____

11._____

12._____

13._____

14._____

15._____

16._____

17._____

18._____

19._____

20._____

More:_____

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Hospitalizations (Please list why admitted, where, and approximate date if known)

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____
11._____
12._____
13._____
14._____
15._____
More:_____

Surgeries

(Please list name of surgery, where performed, and approximate date if known)

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____
11._____
12._____
13._____

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Your Medical Providers

Medical Provider: ____________________________________Phone: ________________
Address: ____
Type of Medical Provider/Specialty: ____
Treats Which of Your Medical Conditions: _______________________________________
☐Yes, I give permission for DrJ Senior Care to contact to coordinate my healthcare.
☐Yes ☐No I want this Medical Provider to receive copies of DrJ Senior Care notes.

Medical Provider: ____________________________________Phone: ________________
Address: ____
Type of Medical Provider/Specialty: ____
Treats Which of Your Medical Conditions: _______________________________________
☐Yes, I give permission for DrJ Senior Care to contact to coordinate my healthcare.
☐Yes ☐No I want this Medical Provider to receive copies of DrJ Senior Care notes.

Medical Provider: ____________________________________Phone: ________________
Address: ____
Type of Medical Provider/Specialty: ____
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Medical Provider: ____________________________________Phone: ________________
Address: ____
Type of Medical Provider/Specialty: ____
Treats Which of Your Medical Conditions: _______________________________________
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☐Yes ☐No I want this Medical Provider to receive copies of DrJ Senior Care notes.

Medical Provider: ____________________________________Phone: ________________
Address: ____
Type of Medical Provider/Specialty: ____
Treats Which of Your Medical Conditions: _______________________________________
☐Yes, I give permission for DrJ Senior Care to contact to coordinate my healthcare.
☐Yes ☐No I want this Medical Provider to receive copies of DrJ Senior Care notes.

Medical Provider: ____________________________________Phone: ________________
Address: ____
Type of Medical Provider/Specialty: ____
Treats Which of Your Medical Conditions: _______________________________________
☐Yes, I give permission for DrJ Senior Care to contact to coordinate my healthcare.
☐Yes ☐No I want this Medical Provider to receive copies of DrJ Senior Care notes.

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Your Support Group

(These are family members, friends, neighbors, etc. who are involved in your care)

Name: ____________________________________Phone: _________________________

Address: ____

Relationship to You: ____

☐Yes ☐No I give permission for DrJ Senior Care to contact to coordinate my healthcare

Name: ____________________________________Phone: _________________________

Address: ____

Relationship to You: ____

☐Yes ☐No I give permission for DrJ Senior Care to contact to coordinate my healthcare

Name: ____________________________________Phone: _________________________

Address: ____

Relationship to You: ____

☐Yes ☐No I give permission for DrJ Senior Care to contact to coordinate my healthcare

Name: ____________________________________Phone: _________________________

Address: ____

Relationship to You: ____

☐Yes ☐No I give permission for DrJ Senior Care to contact to coordinate my healthcare

Name: ____________________________________Phone: _________________________

Address: ____

Relationship to You: ____

☐Yes ☐No I give permission for DrJ Senior Care to contact to coordinate my healthcare

Do you have a Living Will? ☐Yes ☐No (If yes, please have available for 1st visit)

Do you have a Durable Power of Attorney for Healthcare? ☐Yes ☐No

If yes, who?___________________________________ (please have available for 1st visit)

AGREEMENT FOR LONG TERM CONTROLLED SUBSTANCE PRESCRIPTIONS

The following is an agreement for use of controlled substance which may or may not apply to you at this time but is part of the requirements of prescribing these medications so we do ask that you go ahead and read over the information and sign in case you should require such medications in the future. Thank you!

The long term use of controlled substance prescriptions may cause addiction and, if used incorrectly, can lead to harmful side effects including death. Medications are only one part of the treatment for such conditions such as pain, anxiety, ADHD/ADD, and other conditions which will be discussed in progress notes. I understand that the goals of my medications are to improve my ability to function by my helping my underlying condition(s) as much as possible while understanding the risk of dangerous side effects.

I have been told that:
1. If I drink alcohol or use street drugs, I may not be able to think clearly and I could become sleepy and risk personal injury including respiratory depression leading to death (especially if alcohol, benzodiazepines, and opioids are combined) if I am also taking controlled substances.
2. I may get addicted or physically dependent to controlled substance medications.
3. If I or anyone in my family has a history of drug or alcohol problems, there is a higher chance of addiction.
4. If I ever need to stop any controlled medications, I must do so slowly and under medical direction or I may get very sick.

I agree to the following:
1. I am responsible for my medicines. I will not share, sell, or trade my medicine. I understand that if I do, my treatment will be stopped. I will not take anyone else's medicine. I will keep my medicine safe, secure, and out of the reach of children.
2. I will take my medication as instructed and not change the way I take it without first talking to my medical provider. This includes taking more medicine than is prescribed.
3. I understand that my medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed. A police report is required for any stolen medication before any refills will even be considered. Refills will not be made during after-hours calls but only during a scheduled appointment with my primary DrJSeniorCare medical provider. I will keep track of my medications understanding that no early or emergency refills may be made.
4. I will keep all appointments set up my medical provider. I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a DrJSeniorCare staff member immediately.
5. I may be asked for a pill count where I will need to present to my pharmacy within 24 hours for a counting of my remaining drugs to ensure that medications have not been sold or used improperly. If I do not present within 24 hours for a pill count, my treatment may stop.
6. I agree to give a blood or urine sample, if asked, to test for drug use.

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7. I will treat the DrJSeniorCare staff respectfully at all times. I understand that if I am disrespectful to staff or behave in a threatening manner, my treatment will be stopped.
8. I will tell my DrJSeniorCare Team all other medicines that I take, and let them know right away if I have a prescription for a new medicine.
9. I will only use one pharmacy to get any controlled substance prescriptions as outlined in my chart. My DrJSeniorCare Team may speak to the pharmacist regarding my prescriptions.
10. I will not get any opioid pain medications (Lortab, Norco, Percocet, morphine, oxycodone, Dilaudid, hydrocodone, etc.) or other controlled substance prescriptions that can be addictive such as gabapentin, muscle relaxants, appetite suppressants, benzodiazepines (Klonopin, Xanax, Valium, Ativan) or stimulants (Ritalin, amphetamine) without telling a DrJSeniorCare Team Member BEFORE I FILL THAT PRESCRIPTION. I understand that I can call 615-562-1411 at anytime to discuss any new prescriptions.
11. I will not use illegal drugs or street drugs. I understand that if I do, my treatment may be stopped.
12. I understand that I may lose my right to treatment under DrJSeniorCare if I break any part of this agreement and/or my medical provider decides that the medication is hurting me more than helping me, and that this medication will be stopped by my medical provider in a safe way.
13. I understand the rules above. I understand that my medical provider will monitor me carefully and may stop medications if the risk is considered to outweigh the benefit. I understand that controlled substances have risks, but with the intention of improving my quality of life as well as function, I agree with my medical provider that the benefits outweigh the risks.

_____ _____

DrJSeniorCare Member/Responsible Party Signature

Date