Sumana Ketha M.D.
Board certified in Internal Medicine

DFW Medical Home PLLC
2925 Skyway Cir N Irving, TX 75038
PH#: (972) 675-7313, FAX#: (972) 675-7310
Email: admin@texashousecalls.com

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Texas Physician House Calls

PATIENT INFORMATION

*Patient Name: _____ *DOB: _____ Date: _____

*Address: _____ *City: _____

*Zip Code: _____ *State: _____

*Marital Status *(check one)*: ☐ Single ☐ Partner ☐ Married ☐ Divorced ☐ Widowed ☐ Other

*Home Phone: _____ *Mobile Phone: _____ Allow SMS: Yes ☐ No ☐

Email Address: _____ Allow Email: Yes ☐ No ☐

Allow Patient Portal: Yes ☐ No ☐

* Emergency Contact Person Name: _____ *Phone: _____

Occupation: _____

Employer: _____

Drivers/ID Number: _____ *Social Security Number: _____

Language: _____ Ethnicity: _____

Preferred Pharmacy Name: _____

Preferred Company Lab Name: _____

Current Home Health Agency: _____ Admission Date : _____

Current inpatient facility : _____ Admission Date : _____

INSURANCE INFORMATION

*Primary Insurance Provider: _____ Secondary Insurance Provider: _____

*Plan Name: _____ Plan Name: _____

*Policy Number: _____ Policy Number: _____

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PATIENT AGREEMENT

I_____(Name)_____dated, do hereby consent and acknowledgment my agreement to the terms set forth in the HIPAA and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward. In addition to the above, a condition of being admitted for treatment as a outpatient of the DFW Medical Home PLLC / Texas Physician Housecalls DBA, I acknowledge the following consent of treatment, authorization to release medical records, assignment of insurance

benefits, Medicare/ Medicaid assignment of benefits, frequency of Right/ Hotlink Procedure, and additional understandings. I understand by knowledgement of 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 her practice.

Condition of Admittance: As a condition of being admitted for treatment as an outpatient to the DFW Medical Home PLLC / Texas Physician Housecalls DBA, I agree to the following:

1. Consent of Treatment: I voluntarily request and consent to treatment by DFW Medical Home PLLC / Texas Physician Housecalls DBA I authorized the treating Physician and their Assistants and DFW Medical Home PLLC / Texas Physician Housecalls DBA 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 the services provided me by DFW Medical Home PLLC / Texas Physician Housecalls DBA are provided by doctors or physician assistants, podiatrist, psychologist, psychiatrist, physical therapist, and nurse practitioners. DFW Medical Home PLLC / Texas Physician Housecalls DBA will maintain records of the services you receive. His consent only covers your protected health information created why you are a patient at DFW Medical Home PLLC / Texas Physician Housecalls DBA. Your protected health information pertains to your diagnosis and a treatment by DFW Medical Home PLLC / Texas Physician Housecalls DBA 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 (HIV) 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 DFW Medical Home PLLC / Texas Physician Housecalls DBA use and/or disclosure of pre-existing health information about how DFW Medical Home PLLC / Texas Physician Housecalls DBA and physicians on its medical staff may use and or disclose protected health information about your treatment, payment, health care questions 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 with exception for those procedures administered necessary for extreme life-saving emergencies.

2. Authorization to Release Medical Information: I authorize DFW Medical Home PLLC / Texas Physician House calls DBA any treating physician to finish requested information from patient medical records to

   a. Any insurance company or third-party payer for the purpose of payment on the account of DFW Medical Home PLLC / Texas Physician Housecalls DBA or a treating Medical Practice.

   b. Any other persons or entities financially responsible for the patient's treatment
   c. Representatives of government agencies in accordance with law such information includes but is not limited to information about communicable diseases such as AIDS. I authorize release of information from or the review of the patient records for medical audit. Affiliation reviews or quality assistance reviews I authorize DFW Medical Home PLLC / Texas Physician Housecalls DBA to release information from our copies of the patient medical records to the referring physician or to any Skilled Nursing Facility or health-care facility which I may be transferred.

   d. Lastly only that designated person listed are authorization to read or have access to or be included to Patient Care conference or discuss on my behalf.

3. Assignment of Insurance Benefits: I assign to DFW Medical Home PLLC / Texas Physician Housecalls DBA 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 payment due to use The Physician Services Under said policies to positions which provide treatment for me while I'm a DFW Medical Home PLLC / Texas Physician Housecalls DBA patient. I understand I am responsible for providing to DFW Medical Home PLLC / Texas Physician Housecalls DBA all insurance information available

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at the time of outpatient visit to allow for verification. I agree to pay any amount due to physician that are not covered by insurance. I'm responsible to inform the agency of any changes to my insurance plan

4. Medicare/ Medicaid assignment of benefits: I certify that the information given to me by applying for payment under the Social Security Act information required for filing a Medicare claim I request that payment of authorized benefit to be made out on my behalf, I assign benefits payable for services to The Physician organization submitting a claim to Medicare for me. Medicaid: I understand that Medicaid recipients are responsible for payment of any medical services receive that are beyond the services of the Medicaid Program as determined by the Texas Department of Health and Human Services all such payments are due and payable at the time of services rendered.
5. Frequency Rights/Hotline Procedure: I understand that Dr. Sumana Ketha or her Designee Physician or Assigned Physician Assistants / Nurse Practitioners will be my visiting doctor. I understand my patient Bill of Rights. I have been notified of my rights to voice complaint and may direct that complaint with the Secretary of the Health and Human Services (Dept. Of Health and Human Services at 200 Independence Ave, SW. Washington D.C. 20201).

I may also direct complaint to the Management of the Practice to do the investigation of the complaint which week 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 case and I will be informed as to the nature and purpose of any abuse, neglect or exploitation of agency testing policy and hazardous disposal. I have been advised verbally and in writing my right to the collection of information and the Privacy Act HIPPA. I have received the Notice of Privacy Practices and the consent of 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 results of any examination or treatment to be performed by DFW Medical Home PLLC / Texas Physician Housecalls DBA.
   b. I authorize DFW Medical Home PLLC / Texas Physician Housecalls DBA to use its discretion to retain or dispose of any issue removed during any treatment or diagnosis procedure.
   c. All accounts over 60 days old will be considered delinquent and payable immediately. If payment is not received by 30 days, the account will be referred to an outside collection agency or attorney's office and will be reported to the credit bureau. The patient or responsible party will be responsible for all attorney and/ or collection agency fees and cost.

Medication Use Agreement

I, the above signed, understand that I have hindrances that have not been adequately controlled with other medications and my function is limited by these hindrances. I understand that the intent of the medication is to increase my ability to do more, through the medication is unlikely to eliminate the hindrances. I will take the medication only as prescribed; I will not take any sedatives such as alcohol or other pain medications without the authorization of doctor. I understand that the medication will be prescribed only by Dr. Ketha/ DFW Medical Home PLLC / Texas Physician Housecalls DBA / NP/PA's and only by the agreed upon schedule. Prescriptions will only be provided during regularly scheduled appointments. Refills will never be given over the telephone. I will not seek or accept medications from family or friends, and any licit street drugs. Medication refills will be provided as written prescription only.
No refills will be given prior to the next appointment date. If I do not keep my appointment, I will not receive refills. Two (2) appointment cancellations with less that a workday notice or two (2) no-show appointments may constitute grounds for immediate termination of this agreement. I understand that my doctor under no obligation to provide these medications to me, and that he/she reserves the right to discontinue these medications at any time at Dr. Ketha's discretion. I agree to cooperate with random drug testing, which may be requested at any time. If I refuse, I understand the medications will be stopped. I understand that lost or stolen medication will not be refilled under any circumstances. It is my responsibility and duty to secure and protect my medications and keep out of the reach of children. A copy of the police report will be required for any lost or stolen narcotic prescriptions. My doctor will send a report of my care and copy of this agreement when a 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 or obtain medication from another source other than my doctor.
2. I give, sale, or an 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 confirms therapy with the medication presents a larger threat to my wellbeing 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 medication(s).

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

NOTICE OF PRIVACY PRACTICES [DFW Medical Home PLLC / Texas Physician Housecalls DBA 2925 Skyway Circle N Irving, Tx. 75038][Sumana Ketha, M.D. Phone 972-675-7313]

Effective Date (April 14, 2003) THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice property. We are required by law to maintain the privacy of protected health Information, to provide Individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health Information. This notice describes how we may use and disclose your medical Information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

1. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.]
2. Sign in Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
3. Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative, or another person responsible for your care about your location, your general condition or, unless you had Instructed us otherwise, In the event of your death.
4. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you.
5. Changes to this Notice of Privacy Practices We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received.
6. Complaints about this Notice of Privacy Practices or how this medical practice handles your health Information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.
7. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us.

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 all the information I provide is accurate and complete. I shall notify the clinic should any Information change in the future. I understand that I am an Individual and treatment for me is on an Individual basis. I recognize I may revoke this consent at any time in writing except of the extent that period has been taken in reliance on It. 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.

INFORMED CONSENT

Effective July 1 2016 There Will be a fee of 25.00 For Any Missed Appointments. If You need To Reschedule/Cancel Appointment Notify The Office 24 Hours Before Visit. Signing This document is stating that you agree to the terms. Thank you for your cooperation.

*Patient Signature: _____ *Date: _____

Note: open in adobe acrobat to place electronic signature

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PFSH (Past Medical, Family and Social History)

MEDICAL PROBLEMS	

SURGERIES / HOSPITALIZATION / INJURIES / TRANSFUSION		

ALLERGIES ☐ NO ALLERGIES

ALLERGY	ALLERGIC REACTION

DENTAL ISSUES

DME

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IMMUNIZATION	

FAMILY HISTORY

Father : _____

Mother : _____

Siblings : _____

Spouse : _____

Offspring: _____

Other Family Relative: _____

SOCIAL HISTORY

Current employment: ◯ Employed ◯ Unemployed ◯ Retired ◯ Disabled

Current Occupation: _____

Use of Tobacco, Alcohol and Recreational Drugs *(check)*:

☐ Tobacco Current Status: ◯ Current ◯ Quit (date)_____ ◯ Never

☐ Alcohol Current Status: ◯ Current ◯ Quit (date)_____ ◯ Never

☐ Recreational Drugs Current Status: ◯ Current ◯ Quit (date)_____ ◯ Never

Education Level: _____

Sexual history: _____

Other History : _____

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MEDICATION LIST

MEDICATIONS *(Please list ALL)*	DOSE *(Mg., pill, etc.)*

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REVIEW OF SYSTEMS

GENERAL

- ☐ Weight change
- ☐ Anorexia
- ☐ Night sweats
- ☐ Heat or Cold
- ☐ Weakness
- ☐ Fever
- ☐ Insomnia
- ☐ Fatigue
- ☐ Irritability

SKIN

- ☐ Rashes
- ☐ Lumps
- ☐ Itching or Dryness
- ☐ Color changes
- ☐ Hair and nail changes
- ☐ Psoriasis

HEAD & NECK

- ☐ Stiffness
- ☐ Lumps
- ☐ Pain
- ☐ Masses
- ☐ Head injury

EARS

- ☐ Hearing changes
- ☐ Earache
- ☐ Drainage
- ☐ Ringing in ears

EYES

- ☐ Vision changes
- ☐ Pain/redness
- ☐ Blurry/double vision
- ☐ Flashing lights
- ☐ glaucoma

THROAT

- ☐ Bleeding
- ☐ Soreness/pain
- ☐ Dry mouth
- ☐ Hoarseness
- ☐ Thrush
- ☐ Non-healing sores

BREASTS

- ☐ Lumps/masses
- ☐ Pain
- ☐ Discharge
- ☐ Breast-feeding

RESPIRATORY

- ☐ Coughing/sneezing
- ☐ Sputum Coughing
- ☐ blood Shortness of
- ☐ breath Wheezing
- ☐ Painful breathing
- ☐ Asthma

CARDIOVASCULAR

- ☐ Chest pain/discomfort
- ☐ Tightness
- ☐ Palpitations
- ☐ Difficulty Breathing while laying down (Orthopnea)
- ☐ Swelling
- ☐ Syncope (temporary loss of consciousness)
- ☐ Shortness of breath with activity

GASTROINTESTINAL

- ☐ Swallowing difficulties
- ☐ Heartburn
- ☐ Appetite changes
- ☐ Nausea
- ☐ Change in bowel nature
- ☐ Rectal bleeding

MUSCULOSKELETAL

- ☐ Music or joint pain
- ☐ Stiffness
- ☐ Back pain
- ☐ Swelling of joint
- ☐ Trauma
- ☐ Aches/cramping
- ☐ Gout
- ☐ Arthritis
- ☐ Limitations in range of motion/calf pain

NEUROLOGIC

- ☐ Dizziness/Fainting
- ☐ Seizures
- ☐ Weakness and/or numbers Tingling
- ☐ Tremors
- ☐ Paralysis
- ☐ Changes in mentation

PSYCHIATRIC

- ☐ Anxiety
- ☐ Suicidal thoughts
- ☐ Substance dependence
- ☐ Depression
- ☐ Memory loss

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0 ☐	1 ☐	2 ☐	3 ☐
2. Feeling down, depressed, or hopeless	0 ☐	1 ☐	2 ☐	3 ☐
3. Trouble falling or staying asleep, or sleeping too much	0 ☐	1 ☐	2 ☐	3 ☐
4. Feeling tired or having little energy	0 ☐	1 ☐	2 ☐	3 ☐
5. Poor appetite or overeating	0 ☐	1 ☐	2 ☐	3 ☐
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0 ☐	1 ☐	2 ☐	3 ☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 ☐	1 ☐	2 ☐	3 ☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0 ☐	1 ☐	2 ☐	3 ☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	0 ☐	1 ☐	2 ☐	3 ☐

_____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐