

At Your Door: Visiting Healthcare Services
P.O. Box 175
New Albany, OH 43054
T: 614-284-4114 F: 614-245-4389
www.atyourdoorhealthcare.com



NEW PATIENT REFERRAL

Please complete the following and return along with any records.

Thanks for your referral.

Patient Name: _____ Facility: _____

DOB: _____ Social Security #: _____

Address: _____

Home #: _____ Cell #: _____

Email Address: _____

POA Name: _____ Contact #: _____

POA Address: _____

Email address: _____

Primary Insurance: _____ ID #: _____

Secondary Insurance: _____ ID #: _____

Medicaid #: _____ Medicare #: _____

Please check box that applies:

- Came from hospital (please provide name of hospital): _____
- Came from Home
- Transfer from another facility (please provide name): _____
- Transfer within facility



At Your Door

Visiting Healthcare Services

102 W. Main Street, #175
New Albany, Ohio 43054
614/284-4114 Fax 614/245-4389

CONSENT TO TREATMENT

_____ [name of resident] (the "Resident"), is hereby aware that a provider of At Your Door: Visiting Healthcare Services, will be providing care in collaboration with Dr. Stephen Canowitz or _____ (the "Physician").

The Practitioner will provide services within the Practitioner's scope of practice. The Practitioner will also provide services in collaboration with the Physician pursuant to the standard care arrangement between the Practitioner and the Physician required under Ohio law. The appropriate payer(s) will be billed for care the Practitioner provides.

The Resident hereby consents and agrees to the Practitioner rendering care. The Resident acknowledges that he/she has the right to refuse any treatment by any health care provider and to be informed of the consequences of refusing the treatment.

The Resident hereby consents to payment to the Practitioner not covered by their insurance.

Resident Signature _____ Date _____

Responsible Party/POA _____ Date _____

Address for billing purposes: _____

Legal Status of Responsible Party: (check one)

- Guardian: _____
- Power of Attorney: _____
- Family Member: _____

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 health information 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 your Nurse Practitioner.



CONSENT FOR RELEASE OF MEDICAL RECORDS

I do hereby consent and authorize you to release copies of my medical records, including current and previous medical records from other practices and practitioners, hospitals, and/or clinics, which are a part of my medical records. PLEASE NOTE: This authorization includes consent for the release of alcohol, drug, psychiatric and psychological information and any information relating to pregnancy, sexually transmitted diseases, HIV testing, AIDS, and any AIDS-related syndromes. It also includes any information concerning cancer, cancer testing, and cancer results. I agree that a copy of this release or a fax of this release shall be as valid as this original release. Please send copies of all requested information as soon as possible to the address listed below:

Patient's Name _____

Patient's Address _____

Patient's Date of Birth _____

Patient's Social Security Number _____

Please release my medical records from (Name, Address, Phone Number, Fax Number):

Please send my medical records to:

At Your Door Healthcare Services
102 W. Main St. #175
New Albany, Ohio 43054

Or fax to 614-245-4389

Patient's Signature: _____ Date: _____

Parent/Guardian (If a minor) _____ Date: _____

Witness: _____ Date: _____