First Choice Community Medical Services, P.C.

575 Turnpike Street, Suite 25
North Andover, MA 01845
Phone: 978-290-4646 Fax: 978-290-4822

First Choice Community Medical Services, P.C. is a house-call program comprised of experienced Certified Nurse Practitioners. Our program is dedicated to delivering high-quality primary care to qualifying elders who experience difficulty getting to a traditional Primary Care office.

Certified Nurse Practitioners from First Choice are highly trained and experienced in caring for the older adult. Our Nurse Practitioners visit patients to assess, diagnose, prescribe, and monitor plans of care for acute and chronic medical conditions. Paramount is making sure our patients enjoy the best possible quality of life — in their own homes.

Communication and relationships with Visiting Nurses Associations and the facilities are utilized to bolster care. We coordinate laboratory and radiology services, which are available to be done in-home. All this keeps the patient where they are most comfortable.

At First Choice Community Medical Services, P.C. (FCCMS) we recognize the value of every person. We are guided by our commitment to excellence and leadership in providing domiciliary skilled medical care for older adults. The commitment of our Certified Nurse Practitioners and staff to our patients permits us to maintain a quality of presence and a tradition of caring, which are the hallmarks of First Choice.

For more information,

please visit our website:
www.firstchoicecommunity.com
or contact us at: **contact_us@firstchoicecommunity.com**
or call our office at: **978-290-4646**

First Choice Community Medical Services, P.C.

575 Turnpike Street, Suite 25
North Andover, MA 01845
Phone: 978-290-4646 Fax: 978-290-4822

GENERAL CONSENT FOR CARE & TREATMENT CONSENT

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 at this office or any other satellite office under common ownership. 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 the treatment plan with your health care provider about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist, and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. 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.

_____ _____

Signature of Patient or Health Care Proxy Date

_____ _____

Printed Name of Patient or Health Care Proxy Relationship to Patient

First Choice Community Medical Services, P.C.

575 Turnpike Street, Suite 25
North Andover, MA 01845
Phone: 978-290-4646 Fax: 978-290-4822

HIPAA ACKNOWLEDGEMENT

Our medical practice is committed to maintaining the privacy of your protected health information (PHI), while providing high quality medical care. We understand that information about you and your health is personal. We create a record of the care and services you receive at our medical practice, as well as records regarding payment for those services. We need those records to provide you with quality care and to comply with certain legal requirements. This notice of privacy practices applies to all of the records of your care generated by our practice Physicians, Nurse Practitioners, and/or our staff.

We may use and disclose your PHI for treatment, payment and healthcare operations.

You have the right to review a copy of your medical record and request that your doctor change your record if it is not accurate, relevant, or complete.

You have the right to file a complaint to both the Office Manager of this practice, and the U.S. Department of Health and Human Services, regarding any alleged violations.

We may call you with appointment reminders and cancellations, and may leave voice mail messages at your home, cell phone, or place of employment.

First Choice Community Medical Services, P.C.

575 Turnpike Street, Suite 25
North Andover, MA 01845
Phone: 978-290-4646 Fax: 978-290-4822

HIPAA CONSENT

ACKNOWLEDGEMENT OF RECEIPT

Date:_____

I,_____acknowledge receipt of the document titled "HIPAA ACKNOWLEDGMENT" and am aware that First Choice Community Medical Services makes every effort to protect my patient information and privacy.

_____ _____
Patient Name (Print) Patient Signature

If completed by the patient's Health Care Proxy, please print and sign your name in the space below

_____ _____
Health Care Proxy Name (Print) Health Care Proxy Signature

_____
Relationship to Patient

First Choice Community Medical Services, P.C.

575 Turnpike Street, Suite 25
North Andover, MA 01845
Phone: 978-290-4646 Fax: 978-290-4822

PATIENT INFORMATION SHEET (PLEASE PRINT)

Patient Name:_____Gender:____Birthdate:_____SSN:_____
Address:_____City:_____State:_____Zip: _____
Apartment #_____ALF Facility Name: _____
Patient Home Phone:_____Patient Cell (if appl):_____
Pharmacy Name:_____Pharmacy Phone: _____

Health Care Proxy Name:_____Health Care Proxy Relationship:_____
HCP Home Phone:_____HCP Cell:_____HCP E-Mail:_____
HCP Address:_____City:_____State:_____Zip:_____
Advanced Directives: ☐ HCP/POA ☐ Living Will ☐ DNR ☐ Full code ☐ MOLST/POLST

INSURANCE INFORMATION

Primary Insurance Company: _____
Insurance Phone #_____Policy Insurance ID #: _____
Secondary Insurance Company: _____
Insurance Phone #_____Policy Insurance ID #: _____

In order to process insurance claims, I authorize the release of any medical or other information necessary.

BILLING INFORMATION

Name:_____Relationship to Patient: _____
Billing Address:_____City:_____State:_____Zip: _____

Patient/Representative Signature:_____Date: _____

Please include copies of insurance cards and Health Care Proxy (if applicable) when submitting the completed forms

First Choice Community Medical Services, P.C.

575 Turnpike Street, Suite 25
North Andover, MA 01845
Phone: 978-290-4646 Fax: 978-290-4822

PATIENT FINANCIAL POLICY & PROCEDURE

Thank you for choosing First Choice Community Medical Services as your primary care providers.

We are committed to providing you with high-quality health care. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. It is your responsibility to notify our office if any patient information changes (i.e., name, address, telephone, insurance information, etc.)

Insurance. We participate in most insurance plans, including Medicare. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Proof of insurance. All patients must complete our new patient registration forms before seeing a clinician. We must obtain a copy of your current insurance card to verify proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Nonpayment. It is our office policy that all past due accounts be sent two statements. If payment is not made on the account an email and a phone call will be made to try to make payment arrangements. If no resolution can be made, the patient will be discharged from the practice. If this is to occur, you will be notified by regular mail that you have 30 days to find alternative medical care. During that 30-day period, our clinicians will only be able to treat you on an emergency basis.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I,_____ acknowledge and understand the above office policies and procedures.

Signature of Responsible Party:_____ Date: _____

First Choice Community Medical Services, P.C.

575 Turnpike Street, Suite 25
North Andover, MA 01845
Phone: 978-290-4646 Fax: 978-290-4822

PATIENT CONSENT FORM

FOR SEASONAL INFLUENZA VACCINE

I have read, or have had explained to me, the CDC Vaccine Information Statement about influenza and the influenza vaccine. I understand that this vaccine may cause flu-like symptoms in some people and in rare incidents Guillain-Barre Syndrome. I have had an opportunity to ask questions which were answered to my satisfaction. I understand the benefits and risks of influenza vaccine and request that the vaccine be given to me (or person named below for whom I am authorized to make this request).

Please Print

Name: _____ **Date of Birth:** ____/____/_____
(First) (MI) (Last)

Patient or Patient Representative: _____Date:_____

Has the person receiving the vaccine ever had a severe allergic (hypersensitivity) reaction to eggs, chickens, or chicken feathers? ____Yes ____No

Does the person receiving the vaccine have a history of Guillain-Barre Syndrome or a persistent neurological illness? ____Yes ____No

Is the person receiving the vaccine allergic to Thimerosal (Preservative found in contact lens solution) any vaccine ingredient, or latex? ____Yes ____No

_____ _____
Signature of patient or patient representative Date

Please check one of the following:

_____ I agree, I would like to receive yearly influenza vaccines. By agreeing to receive the yearly influenza vaccines, I will no longer need to give yearly permission to First Choice Community Medical Services.
_____ I do not agree, to receive yearly influenza vaccines.

_____ _____
Signature of patient or patient representative **Date**

First Choice Community Medical Services, P.C.

575 Turnpike Street, Suite 25
North Andover, MA 01845
Phone: 978-290-4646 Fax: 978-290-4822

Patient Name: _____

PATIENT HEALTH HISTORY

Drug Reactions/Allergies: _____

Immunizations: COVID-19_____Pneumococcal(13/23)_____Influenza____Shingles_____

Major Illnesses:

☐ Alzheimer's Disease	☐ Diabetes	☐ Mental Illness
☐ Anemia	☐ DVT	Type:_____
☐ Anxiety	☐ Heart Attack	☐ Parkinson's
☐ Arthritis	☐ Heart Disease	□ Respiratory Illness
☐ Cancer	Type:_____	Type: _____
Type: _____	☐ High Blood Pressure	☐ Stroke
☐ COPD	☐ High Cholesterol	☐ Thyroid issues
☐ Chronic Pain	☐ Kidney Disease	Type:_____
☐ Dementia	☐ Lung Disease	☐ Other – Please Explain:
☐ Depression	☐ Memory Impaired	_____

Surgeries/Injuries: _____

Family History:
Mother: Age at Death: _____Cause of Death/Illnesses: _____
Father: Age at Death: _____Cause of Death/Illnesses: _____

Social History: (Please complete the below information)
Marital Status:_____Spouse Name (if applicable)_____
Children #:____Name:_____Name: _____Name:_____
Tobacco Use: (Circle) Never Current Former: Year Quit: _____
If Current: (Circle) Some Days Every Day Packs per day:_____Years Smoked: _____
Alcohol Use: (Circle) Never Occasionally Moderate Heavy
Substance Abuse: _____

First Choice Community Medical Services, P.C.

575 Turnpike Street, Suite 25
North Andover, MA 01845
Phone: 978-290-4646 Fax: 978-290-4822

AUTHORIZATTION TO RELEASE MEDICAL INFORMATION

I,_____authorize First Choice Community Medical Services to release and discuss any medical information regarding patient:_____.

with the following individuals:

1._____

2._____

3._____

4._____

_____ _____
Patient Name (Print) Patient Signature

If completed by the patient's Health Care Proxy, please print and sign your name in the space below

_____ _____
Health Care Proxy Name (Print) Health Care Proxy Signature

_____
Relationship to Patient

First Choice Community Medical Services, P.C.

575 Turnpike Street, Suite 25
North Andover, MA 01845
Phone: 978-290-4646 Fax: 978-290-4822

AUTHORIZATION FOR RELEASE OF

MEDICAL/PSYCHIATRIC/ALCOHOL/DRUG INFORMATION

Patient Name:_____ Date of Birth: _____

I hereby authorize the below named facility and its physicians to release my medical records including any psychiatric, alcohol, or drug abuse information. This authorization is good for a period of **90 days** from the date signed below.

From the following office:

Name:_____

Address: _____

_____

Phone:_____

Fax: _____

To the following office:

First Choice Community Medical Services, P.C.
575 Turnpike Street Suite 25
North Andover, MA 01845
Phone: 978-290-4646
Fax: 978-290-4822

Requesting:

__x__Laboratory Reports
__x__Pathology Reports
__x__Progress Notes
__x__Psychiatric Notes
__x__History/Physical
__x__Operative Reports
__x__Radiology Reports
__x__Special Diagnostic Reports (EKG, EEG etc.)
__x__Discharge Summaries
__x__Immunization Record

_____Other _____

Records Should Include:

__x__Last 1-2 Years
_____Other: _____

This facility, its employees, and physicians are released from legal responsibility or liability for the release of the above medical records to the extent indicated and authorized herein.

_____ _____
Patient/Patient Representative Signature Date

_____ _____
Patient/Patient Representative Name (please print) Phone Number

First Choice Community Medical Services, P.C.

575 Turnpike Street, Suite 25
North Andover, MA 01845
Phone: 978-290-4646 Fax: 978-290-4822

PATIENT'S CURRENT MEDICATION LIST

Patient's Name: _____ **Date: _____**

Please list prescription and over the counter medications

Name of Medication	Route	Dosage	Frequency	Prescribed by

Allergies: _____

_____

Pharmacy/ Prescription Drug Plan:

Name of Pharmacy: _____ Name of Pharmacy: _____

Address of Pharmacy: _____ Address of Pharmacy: _____

_____ _____

Phone # of Pharmacy: _____ Phone # of Pharmacy: _____