ACCESS HEALTHCARE ASSOCIATES | MODERN HOUSE CALLS ™ IN THE GREATER LOS ANGELES AREA

Patient Name:_____

AUTHORIZATION FOR TREATMENT AND ASSIGNMENT OF BENEFITS

I/ We request to secure the professional services of Access Healthcare Associates, including Dr. Lefferman and any nurse practitioner and/or physician associate practicing under his license, for medical treatment. I authorize Access Healthcare Associates to furnish the necessary medical treatment and/ or procedures, including laboratory services (i.e. blood draws, EKG's). I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as the result of treatment/ diagnostic procedures.

I understand that Access Healthcare Associates and Dr. Lefferman does from time to time rely upon third-party providers to assist with patient care such as specialist physicians, home health agencies, hospice agencies, and diagnostic laboratory and radiology companies; these providers operate and bill independently and are not under the direct supervision of any of the providers at Access Healthcare Associates.

I/ We hereby authorize and consent to the use of psychotropic, narcotic, and antidepressant medications (e.g. Ativan, Xanax, Haldol, Percocet, Morphine, Lexapro) where appropriate. Where indicated, the risks and benefits of their use have been explained to me and I/we am aware of their addictive potential. Alternative therapies have been discussed and reviewed.

I/ We hereby authorize and direct my insurance carrier to pay directly to this provider of medical services any benefits due under my insurance plan. I agree to pay the balance of expenses not paid under this plan. I/ We understand I am responsible for any deductible and coinsurance. Should the account be referred to an attorney for collection, the undersigned shall pay actual attorney fees and collecting expenses. If I am uninsured, I understand that I am fully responsible for all charges.

I/ We authorize Access Healthcare Associates to use and disclose any of my personal health information, treatment, payment and health care operations purposes requested by this insurance company necessary to collect benefits under the policies in effect at the time of treatment or any policies which I subsequently make claim against for hospital services including related physicians' services on this or related date of services. Unless indicated, this authorization includes but is not limited to the release of information related to drug, alcohol, HIV antibody and/ or psychiatric treatment. I/ We further authorize any physician and/ or institution that attended this patient previously to furnish medical records or information which maybe requested by Access Healthcare Associates.

I/We understand that I/ we have the right to refuse treatment and to revoke consent for treatment. I/ We also have the right to be informed of the medical consequences of such refusal or revocation and to be informed of available alternate treatment. When the patient/ resident is determined by the physician or a court of law not to be mentally competent to make a decision regarding treatment, the decision may be made by the legal representative or other surrogate decision maker in accordance with applicable state and federal law. **My signature on this form indicates (1) I/We have read and understood the information provided, (2) have had a chance to ask questions, (3) I/We agree to and have authorized and consented to the above.** NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California, (800) 633-2322, www.mbc.ca.gov.

Matthew Lefferman, D.O., Medical Director
9233 West Pico Boulevard Suite #230, Los Angeles CA 90035
Tel: 310-356-8146 Fax: 310-356-8142 Web: www.accesshealthca.com

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_____Signature _____Name _____Date
Patient/Resident

_____Signature _____Name _____Date
Legal Representative/Relationship

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As a medical practice, our goal is to provide you and your loved one with the best medical care available. As a small business, we strive to regulate our expenses and cost of doing business. What a patient owes their doctor once their insurance company has paid its portion is individual to each patient's insurance plan. In an effort to streamline patient payments, we are asking our patients to provide us with their credit or debit card number which we will keep in our secure file. Nothing will be charged to you until after your insurance has been billed and we receive an *"Explanation of Benefits"* (EOB) from Medicare. What would be charged to your card would be the *Patient Responsibility* portion as defined by your EOB.

The maximum that we would automatically charge your card would be $100.00. However, this amount is generally less and may be covered by your secondary or supplemental insurance. You will receive an e-mail confirmation with the amount charged. If your *Patient Responsibility* is greater than $100.00, you will receive a statement from Access Healthcare Associates reflecting a payment up to the maximum and any remaining balance owed.

Thank you for your cooperation and understanding.

AUTHORIZATION TO CHARGE MY CREDIT/DEBIT CARD FOR MY YEARLY DEDUCTIBLE

I AUTHORIZE Access Healthcare Associates to charge my credit or debit card with the balance due *(Patient Responsibility)* portion of my insurance company's EOB (not to exceed $100.00). If I feel that the *Patient Responsibility* on my EOB is inaccurate, I must resolve this issue directly with my insurance company. Any correction or change in the EOB will be reflected as a credit or additional charge on my credit or debit card.

PATIENT NAME (printed): _____
DATE:_____

RESPONSIBLE PARTY (printed)
(if different than patient): _____

CREDIT CARD HOLDER SIGNATURE
(either patient or responsible party): _____

VISA/MASTERCARD/AMERICAN EXPRESS CARD
#_____

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EXP. DATE: _____ 3 DIGIT SECURITY CODE (on back of card): _____

E-MAIL ADDRESS:
_____

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ACCESS HEALTHCARE ASSOCIATES

MODERN HOUSE CALLS ™
IN THE GREATER LOS ANGELES AREA

Thank you for entrusting us with the care of your loved one. The following items summarize what you can expect as a patient and family member of a patient at Access Healthcare Associates (AHA):

1. **Doctor's Visits:** Most of our patients can expect a house call visit from Dr. Lefferman, or one of our highly trained Nurse Practitioners or Physician Assistants every 4 - 6 weeks. Every effort is made to schedule visits in advance. To schedule a visit, please call the below number Monday – Friday, between 9am-5pm.

2. **Urgent Visits:** Though many times we are able to accommodate a medical visit within 24 - 48 hours, **we are not a substitute for the ER or Urgent Care. For emergencies, please dial 911 immediately. Do not wait for instructions from your physician.**

3. **After Hours:** One of our Doctors, Nurse Practitioners, or Physician Assistants can be reached after hours via the below phone number and pressing Option 9. Please inform our office if your loved one will be going to the emergency room. We will notify our hospital associates to receive them in case they are admitted.

4. **Hospitals:** Our team of associate physicians follows our patients at local hospitals. Our office is in contact with hospitals on a regular basis, allowing for optimal continuity of care.

5. **Ancillaries:** Our mobile ancillary team is equipped to perform EKG, B-12 shots, blood work, ear lavage, and other services. Please call our office to inform us if there are specific requests or if there are questions regarding tests performed.

6. **Home Health & Referrals:** We can order skilled nurses to visit for acute needs like blood pressure or glucose monitoring, wound dressing, and physical, occupational, or speech therapies. We also work with specialists such as podiatrists, dentists, orthopedists, cardiologists, psychiatrists, and many others. *Not all do house calls.

7. **Diagnostic Studies:** We are equipped to perform house call X-Rays and Ultrasounds.

8. **Reports & Letters:** Physician's Reports & TB clearance needed to move into Assisted Living or Board & Cares can be prepared by our office within 48 hours. There is a standard fee of $50 for completion of letters, medical documents, RCFE's, etc. There is a greater fee for completion of extensive medical documents. Please call our office for more information.

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9. **Insurance:** Medicare and secondary insurance covers house call visits. Most PPO/POS insurances also have out of network benefits. HMO insurance such as SCAN or Secure Horizons, already have a doctor assigned to them. Please call our office for new patient insurance verification. We are happy to help with the enrollment process.

10. **Office Hours:** Our staff is available to answer your calls Monday – Friday, 9am - 5pm. Refills and other requests can be faxed to the number below.

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HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 1/1/2016)*

First follow these orders, then contact Physician / NP / PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document**.

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A — CARDIOPULMONARY RESUSCITATION (CPR): *If patient has no pulse and is not breathing.*

If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.

Check One

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B — MEDICAL INTERVENTIONS: *If patient is found with a pulse and/or is breathing.*

Check One

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

☐ ***Trial Period of Full Treatment.***

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Request transfer to hospital only if comfort needs cannot be met in current location.***

☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Additional Orders: _____

C — ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible and desired.*

Check One

☐ Long-term artificial nutrition, including feeding tubes. Additional Orders: _____

☐ Trial period of artificial nutrition, including feeding tubes. _____

☐ No artificial means of nutrition, including feeding tubes. _____

D — INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____, available and reviewed →
☐ Advance Directive not available
☐ No Advance Directive

Health Care Agent if named in Advance Directive:
Name: _____
Phone: _____

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name:	Physician/NP/PA Phone #:	Physician/PA License #, NP Cert. #:
Physician/NP/PA Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*	Date:	**FOR REGISTRY USE ONLY**
Mailing Address (street/city/state/zip):	Phone Number:	

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011 or 10/1/2014 are also valid

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient Information

Name (last, first, middle):	Date of Birth:	Gender: M F

NP/PA's Supervising Physician	**Preparer Name** (if other than signing Physician/NP/PA)	
Name:	Name/Title:	Phone #:

Additional Contact ☐ None

Name:	Relationship to Patient:	Phone #:

Directions for Health Care Provider

Completing POLST

- **Completing a POLST form is voluntary**. California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician, or a nurse practitioner (NP) or a physician assistant (PA) acting under the supervision of the physician, who will issue appropriate orders that are consistent with the patient's preferences.
- **POLST does not replace the Advance Directive**. When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician/NP/PA believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician/NP/PA, based on the known desires of the patient or, if unknown, the patient's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.
For more information or a copy of the form, visit **www.caPOLST.org**.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED