AUTHORIZATION & INTAKE

OneSource Mobile Healthcare
7620 East McKellips Road, Suite 4-225
Scottsdale, Arizona 85257
phone: 888.495.4489 fax: 602.325.0169
info@onesourcemobilehc.com

I hereby request OneSource Senior HealthCare (OneSource) to assume responsibility for ☐**PODIATRY** ☐**OPTOMETRY** ☐**AUDIOLOGY** (select one/all) evaluation and treatment for: _____ until I cancel service in writing.
(please print patient name)

I understand that OneSource takes assignments. All bills shall be directed towards Medicare, Medigap, MMAI and insurance carriers when possible.
I authorize Medicare and my insurance to send payments directly to OneSource.
I also authorize the release of any information from any agency or carrier to OneSource for purposes of administering the Medicare program. I also authorize OneSource to release any required information to any agency, insurance carrier or Medicare as needed.
I acknowledge that OneSource Senior Health Care has offered or provided me with a copy of its Notice of Privacy Practices, which describes how medical information may be used and disclosed, and how I can request access to this information. I understand that if I have questions or complaints, I can contact the Privacy Officer at info@onesourcemobilehc,com.
I also understand that I will receive updates if OneSource Senior Healthcare, PLLC makes material changes to its Notice of Privacy Practices.

_____ DATE _____
(signature of patient, guardian, responsible party, or capacity signature)

IF FACESHEET IS NOT ATTACHED, PLEASE COMPLETE THE FOLLOWING:

PERSONAL INFORMATION

DATE OF BIRTH:
SOCIAL SECURTY NUMBER:
GENDER: ☐ FEMALE ☐ MALE
MEDICARE NUMBER
SECONDARY INSURANCE PROVIDER
MEMBER ID
PRIMARY CARE PROVIDER
FACILITY NAME
ADDRESS
CITY, STATE, ZIP CODE
FACILITY PHONE NUMBER
FACILITY CONTACT PERSON
FACILITY EMAIL
MEDICAL POA (If none then "Self")
POA PHONE NUMBER

DIAGNOSIS

☐ DIABETES	☐ NEUROPATHY
☐ CKD(STAGE3,4,5)	☐ EDEMA
☐ PVD	☐ ARTHRITIS
☐ DVT	☐ DEMENTIA
☐ VENOUS INSUFFICIENCY	☐ CVA
☐ ANEMIA	☐ HTN
☐ MACULAR DEGENERATION	☐ GLAUCOMA
☐ BLURRY VISION	☐ HEARING LOSS
☐	☐
☐	☐
☐	☐
☐	☐
☐	☐

CURRENT MEDICATIONS

☐ ASPIRIN	☐ APIXABAN(ELIQUIS)
☐ CLOPIDOGREL	☐ DABIGATRAN(PRADAXA)
☐ EDOXABAN(LIXIANA)	☐ GABAPENTIN
☐ GLIP1ZIDE	☐ GLIMEPIRIDE
☐ INSULIN	☐ INVOKANA
☐ JANUVIA	☐ JARDIANCE
☐ LASIX	☐ METFORMIN
☐ OXYGEN	☐ PIOGLITAZONE
☐ RIVAROXABAN(XARELTO)	☐ TRULICITY
☐ VICTOZA	☐ WARFARIN
☐	☐
☐	☐
☐	☐
☐	☐

FAX COMPLETED FORM TO 602-325-0169