Trident Lake Health Inc.
Trident Lake Home Health (TLHH)
3100 W Ray Rd, Suite 201, Chandler, AZ 85226
Phone (480) 256-9633 | Fax (480) 631-0526 | info@tridentlakehealth.com | www.tridentlakehealth.com

PATIENT INTAKE PACKET — HOME HEALTH

Skilled Nursing · Therapy · Medical Social Services · Home Health Aide

Please return this completed packet with a copy of your photo ID and the front and back of all insurance cards. All TLHH services are provided in your home.

PATIENT INFORMATION

Patient Name First _____ Middle _____ Last _____

Date of Birth _____ Sex ◯ Male ◯ Female ◯ Other Preferred Name _____

Address _____

City _____ State _____ ZIP _____

Gate code / directions / parking _____

Primary Phone _____ Alternate Phone _____ Email _____

May we leave a message? ◯ Yes ◯ No May we email you? ◯ Yes ◯ No May we text you? ◯ Yes ◯ No

Preferred Language _____ Interpreter needed? ◯ Yes ◯ No

Responsible Party / Legal Representative (if any)

Name _____ Relationship _____

Role ☐ Health care POA ☐ Legal guardian ☐ Financial POA ☐ Family/caregiver ☐ N/A

Phone _____ Email _____

Emergency Contacts

1. Name _____ Relationship _____ Phone _____

2. Name _____ Relationship _____ Phone _____

SERVICES REQUESTED & VISIT PREFERENCES

Services ☐ Skilled Nursing ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy
☐ Medical Social Services ☐ Home Health Aide (personal care)

Care setting In-home visits only — TLHH staff come to your home. Service address if different from above: _____

Preferred days ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat **Times** ☐ Morning ☐ Afternoon ☐ Evening

PHYSICIAN, PHARMACY & PAYMENT

Primary Care Physician _____ Phone _____ Fax _____

Physician Address _____

Referring Physician (if different) _____ Phone _____

Pharmacy _____ Phone _____ Delivers? ◯ Yes ◯ No

Payment source ☐ Private pay ☐ Commercial insurance ☐ Long-term care insurance ☐ AHCCCS / ALTCS
☐ Other: _____

Primary Insurance (if applicable)

Insurance Company _____

Member/Policy # _____ Group # _____

Policy Holder _____ Holder DOB _____

Relationship to Patient _____ Holder SSN (last 4) _____ Employer _____

My signature on a facsimile, scanned copy, PDF, or other reproduction of this document is as valid and binding as a signed original.

Secondary Insurance (if applicable)

Insurance Company

Member/Policy # Group #

Policy Holder Holder DOB

Relationship to Patient Holder SSN (last 4) Employer

HEALTH INFORMATION

Main reason for home health care / diagnosis

Hospital or rehab stay in the last 60 days? ◯ Yes ◯ No Facility Discharge date

Recent surgeries (type and date):

Current medications — name, dose, how often (or check here and attach a list):

☐ Medication list attached Do you use a pill organizer? ◯ Yes ◯ No Who manages your medications?

Allergies

Medications ◯ Yes ◯ No Food ◯ Yes ◯ No

Latex ◯ Yes ◯ No Other ◯ Yes ◯ No

Health conditions (check all that apply)

☐ Diabetes ☐ High blood pressure ☐ Heart disease / CHF ☐ COPD / breathing problems
☐ Stroke ☐ Dementia / memory loss ☐ Kidney disease / dialysis ☐ Cancer
☐ Wound / pressure injury ☐ Uses oxygen ☐ Seizures ☐ Depression / anxiety
☐ Arthritis / joint pain ☐ Fall in the last 6 months ☐ Incontinence ☐ Other:

Vision ☐ Glasses ☐ Impaired Hearing ☐ Hearing aids ☐ Impaired Dentures ☐ Upper ☐ Lower

Special diet ☐ None ☐ Diabetic ☐ Low salt ☐ Soft/pureed ☐ Thickened liquids ☐ Other:

DAILY ACTIVITIES

Activity	Independent	Needs some help	Needs full help
Bathing	◯	◯	◯
Dressing	◯	◯	◯
Toileting	◯	◯	◯
Getting in/out of bed or chair	◯	◯	◯
Walking	◯	◯	◯
Eating	◯	◯	◯
Taking medications	◯	◯	◯
Meals / housework	◯	◯	◯

Equipment in the home (check all that apply)

☐ Cane ☐ Walker ☐ Wheelchair ☐ Hospital bed
☐ Shower chair ☐ Grab bars ☐ Bedside commode ☐ Raised toilet seat
☐ Oxygen ☐ Lift chair ☐ Medical alert device ☐ Other:

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HOME & SAFETY

Lives ◯ Alone ◯ With spouse/partner ◯ With family ◯ Other Help available at home? ◯ Yes ◯ No

Pets in the home? ◯ Yes ◯ No Type _____ Smoking in the home? ◯ Yes ◯ No

Steps or stairs to enter? ◯ Yes ◯ No Working smoke detectors? ◯ Yes ◯ No Working air conditioning? ◯ Yes ◯ No

Anything our staff should know before visiting (safety, access, preferences)? _____

ADVANCE DIRECTIVES

Do you have an advance directive? ◯ Yes ◯ No

Type(s) ☐ Living will ☐ Health care POA ☐ Prehospital Medical Directive (DNR) ☐ Mental health POA

Copy provided to TLHH? ◯ Yes ◯ No Would you like information on advance directives? ◯ Yes ◯ No

Care is not conditioned on having an advance directive. You may complete one at any time and give us a copy.

What are your goals for home health care?

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CONSENTS & AUTHORIZATIONS

CONSENT FOR HOME HEALTH SERVICES

I consent to Trident Lake Home Health (TLHH) providing the home health services ordered by my physician and described in my plan of care, including assessment, treatment, and personal care in my home. I understand I may refuse any service or withdraw consent at any time.

Patient/Guardian Signature _____ **Date** _____

RELEASE OF MEDICAL INFORMATION

I authorize Trident Lake Home Health (TLHH) to obtain and release information from my medical records, including diagnoses and treatment, to and from my physicians and other health care providers, hospitals, pharmacies, and my insurance company or other payers, as needed for my care and for payment.

Patient/Guardian Signature _____ **Date** _____

FINANCIAL RESPONSIBILITY & ASSIGNMENT OF BENEFITS

I request that insurance or other benefits for services provided by Trident Lake Home Health (TLHH) be paid directly to Trident Lake Health Inc. I understand I am responsible for charges not covered by insurance, including deductibles, co-payments, and private-pay services, as explained in my Service Agreement and the TLHH fee schedule.

Patient/Guardian Signature _____ **Date** _____

PATIENT RIGHTS, COMPLAINTS & EMERGENCY PLAN — RECEIPT

I received a copy of the TLHH Patient Bill of Rights and Responsibilities and the complaint procedure. I can voice a complaint without fear of reprisal to the Administrator at (480) 256-9633, or to the Arizona Department of Health Services complaint line at (602) 364-2536. TLHH reviewed with me my individual emergency plan and how to reach TLHH 24 hours a day at (480) 256-9633.

☐ Bill of Rights received ☐ Complaint procedure received ☐ Emergency plan reviewed ☐ 24-hour contact number given

Patient/Guardian Signature _____ **Date** _____

MISSED VISITS & CANCELLATIONS

- Please call (480) 256-9633 at least 24 hours before a scheduled visit if you need to cancel or will not be home.
- If staff arrive and cannot reach you, we will call you and your emergency contact to make sure you are safe.
- For staff safety, pets should be secured and no one should smoke during visits. TLHH may pause visits if the home is unsafe for staff, and will work with you on a plan.

Patient/Guardian Signature _____ **Date** _____

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name _____ DOB _____

I voluntarily authorize Trident Lake Home Health (TLHH) to disclose or exchange the patient's health information, in writing or verbally, with the person(s) or organization(s) listed below, in addition to the parties named in the Release of Information in this packet.

#	Name / Organization	Relationship	Phone	Fax or Email
1				
2				
3				

Information to release: ☐ All records ☐ Evaluations / plans of care ☐ Progress notes ☐ Billing ☐ Other: _____

This authorization expires on _____ (if blank, one year from the date signed)

Redisclosure: once information is disclosed to the recipient above, it may no longer be protected by federal privacy law and could be redisclosed. Right to refuse or revoke: I may refuse to sign or revoke this authorization at any time by written notice; this will not affect the patient's treatment, payment, or eligibility for services. Revocation takes effect when received, except for actions already taken in reliance on this authorization.

Printed Name _____ Relationship to Patient _____

Patient/Guardian Signature _____ **Date** _____

NOTICE OF PRIVACY PRACTICES — ACKNOWLEDGEMENT

Trident Lake Home Health (TLHH) protects the patient's health information as required by HIPAA. A full Notice of Privacy Practices is available on request at any time and at www.tridentlakehealth.com. In summary, we may use and disclose health information:

- Treatment — to coordinate care with your physicians and other providers.
- Payment — to bill and collect payment from you, your insurance, or other payers.
- Health care operations — quality review, training, licensing, and accreditation activities.
- As required by law — including reports of suspected abuse, neglect, or exploitation and to avert a serious threat to health or safety.
- Appointment reminders — by phone, voicemail, text, or email, based on the preferences you gave above.
- We will not use your information for marketing without your written authorization.

You have the right to request a copy of your records, request corrections, request limits on certain disclosures, request confidential communications, and receive an accounting of disclosures. Questions or privacy complaints: (480) 256-9633 or info@tridentlakehealth.com.

By signing below, I acknowledge that I received or was offered the Notice of Privacy Practices.

Patient/Guardian Signature _____ **Date** _____

PRE-SERVICE ORIENTATION ACKNOWLEDGEMENT

By signing below, I confirm that the information in this packet is complete and accurate to the best of my knowledge, that it serves as my pre-service orientation, and that it will be reviewed by Trident Lake Home Health (TLHH) provider(s) before services begin. I will tell Trident Lake Home Health (TLHH) about any changes.

Patient/Guardian Signature _____ **Date** _____

OFFICE USE ONLY

Received by _____ Date _____ Chart / MR # _____

☐ Photo ID copied ☐ Insurance cards (front/back) copied ☐ Eligibility verified ☐ Entered in EMR

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