Esenga Health

Bringing Care Closer to You

Worcester County: (774) 548-4004
Hampden County: (413) 602-8022
Fax: (774) 366-0770
info@esengahealth.com · esengahealth.com

New Patient Information

PATIENT INFORMATION

Last Name: **First Name:** **MI:** ☐ Male ☐ Female

Date of Birth: **Preferred Name:** **Preferred Language:**

Home Address: **Apt/Rm #:** **City:**

State: **ZIP:** **Phone:** **Email:**

Best way to reach me: ☐ Phone call ☐ Text ☐ Email ☐ Through my caregiver/facility

LIVING SETTING

I live: ☐ At home (alone) ☐ At home (with family/caregiver) ☐ Group home ☐ Assisted living ☐ Other:

Group Home/Facility Name: **Room #:**

Facility Contact: **Phone:** **Fax:**

EMERGENCY CONTACT & DECISION-MAKER

Emergency Contact Name: **Relationship:** **Phone:**

Legal decision-maker (if any): ☐ None ☐ Health Care Proxy ☐ Guardian ☐ Power of Attorney

Name: **Relationship:** **Phone:**

Email:

A copy of the Health Care Proxy, guardianship decree, or POA document is required before we can discuss your care with that person. Please email or fax it to our office.

INSURANCE (PLEASE PROVIDE A COPY OF THE FRONT AND BACK OF ALL INSURANCE CARDS)

Medicare #: **MassHealth ID #:**

Primary Insurance: **Member ID #:**

Secondary Insurance: **Member ID #:**

CURRENT CARE TEAM

Primary Care Provider: **Phone:** **Fax:**

Specialist / Type: **Phone:** **Fax:**

Specialist / Type: **Phone:** **Fax:**

Home Health / VNA Agency: **Phone:**

Hospice Agency (if any): **Phone:**

Behavioral Health Provider: **Phone:**

Please have ready for your first visit: ☐ Photo ID ☐ Insurance cards ☐ Medication list or bottles ☐ MOLST / Proxy copies

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Health History

Patient Name: _____ **DOB:** _____

MEDICAL HISTORY (CHECK ALL THAT APPLY)

- ☐ Atrial Fibrillation
- ☐ Anxiety
- ☐ Arrhythmia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bipolar Disorder
- ☐ BPH
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chronic Pain
- ☐ Chronic Kidney Disease
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Dysphagia
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Failure
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Hypothyroidism
- ☐ Intellectual/Developmental Disability
- ☐ Liver Disease
- ☐ Multiple Sclerosis
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Schizophrenia
- ☐ Seizure Disorder
- ☐ Stroke / TIA
- ☐ Other: _____

Cancer type/location: _____ **Other conditions:** _____

SURGICAL & HOSPITAL HISTORY

Surgery / Hospitalization: _____ **Date:** _____ **Complications:** _____

Surgery / Hospitalization: _____ **Date:** _____ **Complications:** _____

Surgery / Hospitalization: _____ **Date:** _____ **Complications:** _____

DAILY LIVING & FUNCTION

Activity	Independent	Needs Help
Bathing	☐	☐
Dressing	☐	☐
Toileting	☐	☐
Transferring	☐	☐
Walking	☐	☐
Continence	☐	☐
Eating	☐	☐

Height: _____ **Weight:** _____

Glasses: ☐ Yes ☐ No

Hearing aids: ☐ Yes ☐ No

Dentures: ☐ Yes ☐ No

Mobility aid: ☐ None ☐ Cane ☐ Walker ☐ Wheelchair

Fall in the past year? ☐ Yes ☐ No

Special diet: _____

Oxygen / medical equipment: _____

ADVANCE DIRECTIVES

Do you have a MOLST form? ☐ Yes ☐ No ☐ Not sure

Do you have a Health Care Proxy? ☐ Yes ☐ No ☐ Not sure

Do you have a Living will? ☐ Yes ☐ No ☐ Not sure

If yes, please have a copy ready so we can take a copy at your first visit. Blank MOLST and Health Care Proxy forms can be printed from **esengahealth.com**, and we are happy to talk through them with you.

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Medications & Allergies

Patient Name: _____ **DOB:** _____

PHARMACY & ALLERGIES

Preferred Pharmacy: _____ **Location:** _____ **Phone:** _____

Medication Allergies (and reaction): _____

Food / Other Allergies: _____

CURRENT MEDICATIONS (INCLUDE VITAMINS & SUPPLEMENTS, OR ATTACH A MEDICATION LIST)

Medication	Dose	How Often	What It Is For

REASON FOR VISIT

Referred by (name / agency): _____ **Phone:** _____

What would you like help with?

HOME VISIT INFORMATION

Pets in the home? ☐ Yes ☐ No **Type / how many:** _____

Parking instructions: _____

Entry instructions (door, buzzer, code): _____ **Who will usually be present:** _____

For everyone's safety, please secure pets in a separate room during home visits.

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How We Work & Patient Consent

Patient Name: _____ **DOB:** _____

ABOUT OUR PRACTICE

Esenga Health, PLLC is a home-based primary care practice led by nurse practitioners. We care for **adults 18 years and older** who have difficulty leaving home. This includes older adults as well as younger adults living with disabilities, such as intellectual and developmental disabilities, autism, or other conditions that make office visits hard. We see patients wherever they live: their own home, with family, in a group home, or in assisted living. Visits are scheduled in advance, and some may be offered by secure telehealth.

WHO QUALIFIES FOR HOME-BASED PRIMARY CARE

Patients must be homebound, following Medicare's definition. **Both** of the following must apply: **(1)** because of illness, injury, or disability, the patient needs the help of another person, a supportive device, or special transportation to leave home, *or* leaving home is medically not recommended; **and (2)** the patient is normally unable to leave home, and leaving home takes a considerable and taxing effort. Short, infrequent absences, such as medical appointments, religious services, or adult day programs, do not change homebound status.

HOURS AND HOW TO REACH US

Office line: Monday–Friday 10 AM–9 PM; Saturday 10 AM–2 PM. Home visits: Monday–Friday 10 AM–7 PM; Saturday by appointment only. Closed Sundays and holidays. Messages and email are answered during office hours. Same-day visits are often not possible, but we will do our best to see you as soon as we can. **Esenga Health is not an emergency service. For a medical emergency, call 911 or go to the nearest emergency department. For a mental health crisis, call or text 988.**

OUR SERVICES

We provide evaluation, treatment, medication management, care coordination, and behavioral health services within our scope of practice. When needed, we can arrange in-home lab draws and mobile X-rays. We will share information with your other providers as needed to coordinate your care.

PRESCRIPTION MONITORING (MASSPAT)

Massachusetts law requires prescribers to check the Massachusetts Prescription Awareness Tool (MassPAT) before prescribing certain controlled substances. I understand and agree that Esenga Health may review my prescription history in MassPAT as part of my care.

TELEHEALTH CONSENT

I understand that some visits may take place by secure video or phone. Telehealth has limits, including that a physical exam cannot be performed, and I may request an in-person visit instead. Telehealth visits are billed to insurance in the same way as in-person visits when covered.

COMMUNICATION CONSENT

I agree that Esenga Health may contact me, my caregiver, or my facility by phone, text message, voicemail, fax, or email about appointments and my care. I will let Esenga Health know the best ways to reach me.

FINANCIAL RESPONSIBILITY

Esenga Health will bill my insurance for covered services. I agree to provide accurate and current insurance information and to notify the office of any changes. I understand I am responsible for co-pays, co-insurance, deductibles, and services my insurance does not cover, as allowed by my plan and by law. Patients who are enrolled in MassHealth or in the Medicare Qualified Medicare Beneficiary (QMB) program will not be billed for amounts that federal or state rules do not allow. Self-pay rates are available upon request.

HOSPICE

If you enroll in hospice, Esenga Health will coordinate with your hospice team about your ongoing care.

ENDING CARE

You may end care with Esenga Health at any time. Esenga Health may also end the care relationship with written notice, for example if you no longer meet homebound criteria or move outside our service area. We will help transfer your records to your next provider.

PRIVACY

I acknowledge that I have been offered a copy of Esenga Health's Notice of Privacy Practices, which explains how my health information may be used and shared for treatment, payment, and health care operations.

Please check one:

☐ I will use my insurance coverage for services.

☐ I choose to be a self-pay patient and will pay at the time of service.

By signing below, I confirm that I have read (or had read to me) and agree to the information above.

Patient or Legal Representative – Printed Name*	Signature*	Date*

If signed by a representative, relationship to patient: _____

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Authorization to Obtain Medical Records

I authorize the provider or facility named below to release my health information to **Esenga Health, PLLC**, 16 Ekman St, Worcester, MA 01607, Fax (774) 366-0770, for the purpose of continuing my medical care.

Last Name: _____ **First Name:** _____ **DOB:** _____

Address: _____

RELEASE INFORMATION FROM

Provider / Facility Name: _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Fax: _____

INFORMATION TO BE RELEASED

Dates of service: ☐ Past 2 years ☐ All records ☐ From: _____ to _____

☐ Office / visit notes ☐ Hospital discharge summaries ☐ Medication list ☐ Lab results
☐ Imaging reports ☐ Consultation reports ☐ Immunization records ☐ Other: _____

Specially protected information — Massachusetts and federal law require your specific permission.
Initial each type you agree to release:

_____ HIV/AIDS testing or treatment
_____ Mental / behavioral health records
_____ Alcohol or substance use disorder treatment
_____ Genetic testing
_____ Sexually transmitted infections
_____ Domestic violence or sexual assault counseling

YOUR RIGHTS

This authorization is voluntary. My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign it. I may revoke this authorization at any time by sending a written request to Esenga Health, except to the extent that action has already been taken based on it. Information released under this authorization may be re-disclosed by the recipient and may no longer be protected by federal privacy rules, except that substance use disorder records remain protected under 42 CFR Part 2. A copy or electronic version of this authorization is as valid as the original.

This authorization expires: ☐ One year from the date signed ☐ On this date: _____

_____ _____ _____
Patient or Legal Representative – Printed Name* **Signature*** **Date***

If signed by a representative, relationship to patient / authority: _____

Please fax records to (774) 366-0770

Mail: Esenga Health, PLLC, 16 Ekman St, Worcester, MA 01607 · Questions: (774) 548-4004 · info@esengahealth.com