



Return Completed Forms to:
 FAX 866-461-1388
 or mail to: Po Box 84068
 Lexington, SC 29073

Please call us with any questions:
 803-699-9073
 843-757-1173

Patient Name:		Date of Birth:	
<p>We have received a request to provide medical care to the above named patient. We are requesting your written authorization to do so. We will bill any associated charges to your insurance company provided to us, however, you will be responsible for any non-covered charges. Currently, our office does not accept credit cards.</p> <p>Once this form is completed and returned to our office, we will verify your insurance, check to see if you are in our geographical area, and check to see if our providers are able to add new patients to their case load. We will then contact you to schedule an appointment. This may take up to a week, but is usually done faster. Please call us with any questions.</p>			
Patient Information	Facility Name (if applicable) and Room Number:		
	Address:		
	City, St, Zip		Telephone:
Financial Responsibility		<input type="checkbox"/> Self <input type="checkbox"/> Other - provide information below	
Financially Responsible Party Billing Address	Name:		
	Address:		
	City, St, Zip	Telephone	
Primary Insurance Provider:		ID Number & Letters:	
<input type="checkbox"/> Medicare <input type="checkbox"/> Other:			
Secondary/Supplemental Insurance Provider:		ID Number & Letters:	
Previous or Current Physician:		Telephone:	
Referred by: <input type="checkbox"/> Home Health <input type="checkbox"/> Hospice <input type="checkbox"/> Physician <input type="checkbox"/> Other			
Please Provide Name:			
Currently Receiving: <input type="checkbox"/> Home Health <input type="checkbox"/> Hospice			
Please Provide Name:			
Who should we call to schedule your appointment (if not self):			
Responsible Party or Patient Signature:		Date:	



Patient Name:

Privacy Practices Agreement

In accordance with federal law, Senior Health Associates has developed Privacy Practices designed to increase your awareness of how your medical information may be used and disclosed to others. Our Privacy Practices can be found on our web site with the following address: <http://www.seniorhealthassociates.com/Privacy.htm>. If you do not have web access, please contact our office for a paper copy. Please sign below, indicating your awareness of the location of our Notice of Privacy Practices and your right to access them.

Insurance Authorization and Assignment

I hereby authorize Senior Health Associates to furnish information concerning my medical care to insurance carriers (including Medicare, Medicaid, and Worker’s Compensation). I hereby assign to Senior Health Associates all payment for services rendered to me or the patient. If my account is sent to a collection agency I understand and acknowledge that a collection fee will be added and I will be responsible for this additional amount as well. I certify that all information provided here is true and correct to the best of my knowledge. I agree to notify Senior Health Associates within 10 days of any change in my insurance coverage.

Financial Notice for Non Covered Services

Your health insurance company may not pay for certain health care services. You are financially responsible for any and all co-pays, deductibles, and health care services that your insurance plan deems non-covered.

Prescription Refill Policy

Prescription refills should primarily be requested during scheduled visits with your provider. If necessary, you may call our office and request refills during normal business hours (Monday - Friday 8:00am - 5:00pm). Non urgent refill requests may be left on our refill line at any time. Our office staff will call your prescription to your pharmacy within **2** business days. If your prescription requires mailing (such as Duragesic, Fentanyl, Morphine, Percocet, etc.) you will need to give **at least 5** days notice or you may not receive your prescription before you run out. **Urgent refill requests made to our staff or by paging our providers will incur a \$25.00 fee.**

PLEASE SIGN BELOW INDICATING YOUR AGREEMENT TO ALL OF THE ABOVE,

Patient or POA Signature

Date



Return Records to:

FAX 866-461-1388

or mail to:

Po Box 84068

Lexington, SC 29073

Please call us with any questions:

803-699-9073 ext. 103

Authorization for Release of Protected Medical Records

PROVIDER:

Please provide us with any and all medical records for the preceding 12 months for the following patient, unless other time period is provided here: _____.

Please FAX Records to 1-866-461-1388

Patient Name: _____

Date of Birth: _____

Social Security: _____

I authorize: _____

to disclose my complete medical records to Senior Health Associates, PA.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Senior Health Associates, PA at the above address. I understand that a revocation is not effective to the extent that Senior Health Associates, PA has relied on the use of disclosure of the protected health information.

Signature of Patient or Power of Attorney

Date of Authorization

Admission Questionnaire

Patient Name	Other Family Members with whom we can share medical information (and their phone numbers):
Address	
City, State Zip	
Home Telephone	
Date of Birth	Who has Power of Attorney?
Insurance Primary:	Pharmacy & Telephone
Secondary:	Patient Social Security Number

Medical Information

Medications:	Drug Allergies
	Year of Last Vaccine: Tetanus Flu Pneumonia Other
	Previous Hospitalizations or Surgeries:
	Date: Reason:
	Date: Reason:
	Date: Reason:
	Date: Reason:
	Date: Reason:

Family History

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents		Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
Alcoholism							High Blood Pressure						
Asthma							Kidney Disease						
Bleeding Disorder							Mental Illness						
Cancer							Migraine						
Diabetes							Osteoporosis						
Epilepsy/ Convulsions							Stroke						
Glaucoma							Thyroid Disease						
Hair Loss							Other						
Heart Disease							Other						

Habits

O Alcohol Type: _____ Amount: _____	O Coffee Cups Per Day: _____ Other Caffeine: _____	O Diet Salt Intake: _____ Fat Intake: _____	Exercise Routine: _____	O Smoking PPD _____ How Long _____ Want to Stop? _____	O Sleep Problems Difficulty Falling Asleep _____ Continuity Disturbances _____ Early Morning Awakening _____ Daytime Drowsiness _____ Other _____
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Review of Systems	
General	<input type="checkbox"/> Chronic Pain <input type="checkbox"/> Recent Weight Loss <input type="checkbox"/> Overall Decline in Condition <input type="checkbox"/> Night Sweats <input type="checkbox"/> Able to Live Independently Comments:
Skin	<input type="checkbox"/> Itching <input type="checkbox"/> Excessive Dryness <input type="checkbox"/> Rash <input type="checkbox"/> Skin Cancer <input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema Comments:
Eyes, Ears, Nose & Throat	<input type="checkbox"/> Decreased Vision <input type="checkbox"/> Decreased Hearing <input type="checkbox"/> Loss of Smell <input type="checkbox"/> Loss of Taste <input type="checkbox"/> Difficulty Chewing/Swallowing <input type="checkbox"/> History of Eye Surgery <input type="checkbox"/> Glaucoma Comments:
Respiratory	<input type="checkbox"/> Cough <input type="checkbox"/> Chest Pain on Breathing <input type="checkbox"/> Shortness of Breath (<input type="checkbox"/> at rest – <input type="checkbox"/> on exertion) Comments:
Heart	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Chest Pain on Exertion <input type="checkbox"/> Skipped Beats <input type="checkbox"/> Awareness of Heartbeat <input type="checkbox"/> Dizziness <input type="checkbox"/> Blackouts <input type="checkbox"/> Unable to Sleep Lying Flat <input type="checkbox"/> Swelling of ankles or feet <input type="checkbox"/> Leg Pain with Activity <input type="checkbox"/> History of Heart Attack <input type="checkbox"/> History of Heart Surgery Comments:
Gastro-Intestinal	<input type="checkbox"/> Bowel Incontinence <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Heartburn <input type="checkbox"/> Change in Bowel Habit <input type="checkbox"/> Bloody or Tarry Stools <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Irritable Bowel Comments:
Reproductive	<input type="checkbox"/> Abnormal Bleeding <input type="checkbox"/> Abnormal Discharge Comments:
Urinary	<input type="checkbox"/> Increased frequency of urination (<input type="checkbox"/> especially at night) <input type="checkbox"/> Urgency <input type="checkbox"/> Leakage <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Voiding Difficulty <input type="checkbox"/> Hesitancy <input type="checkbox"/> Straining <input type="checkbox"/> Intermittent Stream) Comments:
Musculoskeletal	<input type="checkbox"/> Joint Pain <input type="checkbox"/> Swollen Joints <input type="checkbox"/> Recent Fracture/Dislocation <input type="checkbox"/> Limited Range of Movement <input type="checkbox"/> Back Pain <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Gout Comments:
Neurological	<input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> Falling <input type="checkbox"/> Balance Problem <input type="checkbox"/> Problem Walking <input type="checkbox"/> Localized Pain <input type="checkbox"/> Numbness or Tingling of Hands or Feet <input type="checkbox"/> Tremor Comments:
Memory and Mood	<input type="checkbox"/> Memory Disturbance <input type="checkbox"/> Unable to Understand Information <input type="checkbox"/> Strange Ideas or Suspicions <input type="checkbox"/> Behavioral Disturbances <input type="checkbox"/> Unable to Pay Attention Comments:
Endocrine	<input type="checkbox"/> Increased Urination <input type="checkbox"/> Increased Thirst <input type="checkbox"/> Lethargy Comments:

This Document Prepared By:

Name: _____
Relationship to Patient: _____
Phone: _____

This Document Reviewed By:

Signature: _____
Date: _____