SENIOR HEALTH ASSOCIATES 01/2015

Mail to: 335 Pleasant Point Drive, Beaufort, SC 29907
Or Fax to 843-757-7173 OR 803-764-2361 for faster processing

Thank you for your assistance in filling out this form **COMPLETELY**.
Medicare requires that we collect this information **ON OUR FORMS** prior to providing services.
I apologize if this is a duplication of information provided to other companies, we still must collect it here. We will add new patients to our system only after the **required** sections are complete.

PATIENT INFORMATION – Required section

FIRST NAME	MIDDLE	LAST	DATE OF BIRTH	☐MALE ☐FEMALE
HOME ADDRESS				
MAILING ADDRESS FOR BILLS, IF DIFFERENT THAN ABOVE (OR DESIGNATE SOMEONE ELSE TO RECEIVE BILLS BELOW)				
HOME PHONE		MOBILE PHONE		
PRIMARY EMAIL ADDRESS		PHARMACY & TELEPHONE #		
DOES PATIENT LIVE IN A FACILITY? ☐Yes ☐No		IF YES, PROVIDE NAME OF FACILITY:		
HOSPICE OR HOME HEALTH UTILIZATION: ☐CURRENTLY ON SERVICE ☐PREVIOUSLY ON SERVICE NAME OF COMPANY:		☐ HAVE NEVER RECEIVED THESE SERVICES		

PATIENT INFORMATION – Optional section, Medicare requires us to collect this information but you may decline to provide it.

Race ☐Black ☐White ☐Asian ☐Hispanic ☐Other	Ethnicity ☐Hispanic ☐Non-Hispanic ☐Unknown
PREFERRED LANGUAGE ☐ English ☐ Other:	

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, PLEASE PROVIDE THIS INFORMATION BELOW:
(Due to the nature of our practice, SHA may be unable to accept patients without a designated contact for emergencies, however you may revoke this authorization at any time in writing through our office. We are unable to discuss your health information with anyone not listed below)

PRIMARY CONTACT -NAME		☐SPOUSE ☐ DAUGHTER ☐SON ☐OTHER: Is this person the ☐Healthcare POA ☐Legal POA PLEASE ATTACH COPY OF POA DOCUMENTS
ADDRESS:		
EMAIL ADDRESS:		
☐PLEASE SEND ALL BILLS TO THIS PERSON	HOME PHONE:	MOBILE PHONE:

NAME		☐SPOUSE ☐ DAUGHTER ☐SON ☐OTHER: Is this person the ☐Healthcare POA ☐Legal POA PLEASE ATTACH COPY OF POA DOCUMENTS
ADDRESS:		
EMAIL ADDRESS:		
☐PLEASE SEND ALL BILLS TO THIS PERSON	HOME PHONE:	MOBILE PHONE:

NAME		☐SPOUSE ☐ DAUGHTER ☐SON ☐OTHER: Is this person the ☐Healthcare POA ☐Legal POA PLEASE ATTACH COPY OF POA DOCUMENTS
ADDRESS:		
EMAIL ADDRESS:		
☐PLEASE SEND ALL BILLS TO THIS PERSON	HOME PHONE:	MOBILE PHONE:

INSURANCE – Required section

PRIMARY INSURANCE	ID NUMBER & LETTERS
MAILING ADDRESS:	
IS THIS A MEDICARE REPLACEMENT POLICY? □Yes □No	POLICY HOLDERS NAME, IF DIFFERENT THAN PATIENT
SECONDARY INSURANCE	ID NUMBERS & LETTERS
MAILING ADDRESS:	
POLICY HOLDERS NAME, IF DIFFERENT THAN PATIENT	

AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT – Required, please take a few minutes to ACTUALLY read this section. It has very important information that will help you work with our providers.

AUTHORIZATION	Your signature below indicates agreement that you have requested services through our medical providers. You agree that we will perform procedures and treatments as required to provide reasonable and appropriate medical care. You are also assigning insurance benefits to SHA, however you understand that that insurance may not cover all services and you will be responsible for those charges.
LATE FEES	Payment is expected upon receipt of invoice. SHA will charge a $25.00 per month late fee for any balance greater than 30 days. Balances greater than 60 days old may be sent to collections which may result in additional charges.
INSURANCE	We will verify your insurance before providing services. You agree to notify us immediately of any change in your insurance provider or assume financial responsibility for any charges incurred.
HIPAA	Our privacy policies are posted on our web site: www.SeniorHealthAssociates.com/Forms.htm. If you are unable to access these policies on the internet, please contact our office for a paper copy. Your signature below indicates your awareness of the existence and location of our privacy policies and your right to access them.
PRESCRIPTIONS	**HOME PATIENTS –** Please request ALL refills during regularly scheduled visits. We will happily provide you with enough refills to last until your next appointment and can call them to your pharmacy during our visit. **FACILITY PATIENTS –** Please request refills by writing this request in our physician notification book located in EVERY facility. The facility staff will usually write this for you if you ask them. **EMERGENCY REFIILLS –** You may call our refill line in our office during the following times (M-TH 8:30 – 3:00, F 8:30 – 12:00) to request refills up to 4 times per year for routine medications without additional charges. Refills will be processed within 48 hours. Additional calls will result in a **$25.00** charge. **AFTER HOURS EMERGENCIES – If you call our office after business hours, the answering service will page the provider on call. There will be a $25.00 charge for each call.** This fee is not covered by insurance and will be your responsibility to pay. The on-call physician may not be able to prescribe after hours, but the fee will still be charged. **PAIN MEDICATIONS –** Due to unfortunate recent changes in Federal and State laws related to pain medications, we are no longer allowed to fax, call-in, e-prescribe, or refill pain medications. These prescriptions must be processed in our office and mailed directly to the pharmacy or patient each month for every patient. We charge $7.50 per month to offset our expense and time of this process. WE ARE ATTEMPTING TO WORK WITH STATE AGENCIES IN PROTEST OF THIS REDICULOUS SC STATE LAW. IF YOU WOULD LIKE TO HELP, PLEASE SEE OUR WEB SITE FOR MORE INFORMATION.
APPOINTMENTS	**HOME PATIENTS –** Please call our office to make appointments. **FACILITY PATIENTS –** Please write all non-emergency requests in our physician notification book located in every facility. We will see you on our next visit to the facility. Upon receipt of completed Patient Information Forms, we will verify your insurance, assess our capacity to add new patients, and review your health information to determine our ability to meet your medical needs. This may require requesting additional medical records from previous providers. This process could take 2 – 21 days.
TRIP CHARGES	**HOME PATIENT VISITS will be subject to a $45 trip charge not covered by insurance.**
Chronic Care Management	By signing below, you are consenting to participation in Chronic Care Management. This Medicare program is only for our patients with 2 or more chronic conditions that place the patient at higher risk of complications. This allows us to coordinate your care with multiple agencies (such as home health) and spend more time talking to you and your family. You may access this information from our patient portal. Only one provider at a time may offer you CCM. We will share your medical records with other agencies for care coordination (such as ordering x-rays or labs). You may revoke CCM at any time in writing to our office – services will end at the end of the current month. We will bill you for any copays or deductible associated with your account.
CANCELLATIONS	Any visit not cancelled through our main office number within 12 hours of the appointment time, will be subject to a $45 charge.

Signature of Patient or Power of Attorney as listed above _______________ **Date** _______________

SIGNATURES CAN BE ACCEPTED FROM THE PATIENT (UNLESS INCAPACITATED), THE SPOUSE (IF PT. INCAPACITATED), FROM A POA (MUST ATTACH), OR FROM AN ONLY CHILD (IF PT. INCAPACITATED). If there are multiple siblings and no POA, we will need a letter signed by each sibling agreeing to a single decision maker before accepting patient.

SENIOR HEALTH ASSOCIATES

PATIENT NAME: ______________________

Health Information Form

Please indicate if the patient or a blood relative has or has had the following problems:

Patient	Blood Relative		Patient	Blood Relative		Patient	Blood Relative	
		Alcoholism			Glaucoma			Thyroid
		Anemia			Heart Attack / Disease	Allergies:		
		Asthma			High Blood Pressure			
		Bleeding Disorder			High Cholesterol			
		Cancer			Kidney Disease			
		Dementia			Mental Illness			
		Diabetes			Osteoporosis			
		Emphysema/Lung Disease			Stroke			

Please list additional medical problems and previous hospitalizations or surgeries:

Please list all medications that you are now taking. Include…..DRUG NAME, STRENGTH, DIRECTIONS
Or attach a current med list

Please mark current symptoms:

GENERAL		FEVER		OVERALL DECLINE		WEIGHT CHANGE		CHRONIC PAIN		NIGHT SWEATS		FATIGUE
SKIN		ITCHING		RASH		CANCERS		DRYNESS		PSORIASIS		
EYES		PAIN		GLASSES		CHANGING VISION		DISCHARGE		DRYNESS		GLAUCOMA
ENT		EAR PAIN		SORE THROAT		SINUS DIFFICULTY		↓ HEARING		LOSS OF SMELL OR TASTE		
HEART		DIZZINESS		CHEST PAIN		ANKLE SWELLING		PALPITATIONS		BLACKOUTS		HBP
LUNGS		COUGH		WHEEZE		CHEST PAIN		SHORTNESS OF BREATH				
GI		NAUSEA		HEARTBURN		CONSTIPATION		ULCERS		DIARRHEA		
		IRRITABLE BOWEL		ABDOMINAL PAIN		BLOOD IN STOOL		CHANGE IN BOWEL HABITS		BOWEL INCONTINENCE		
URINARY		PAINFUL URINATION		FREQUENT URINATION		HESITANT URINATION		INCONTINENCE		VOIDING DIFFICULTY		BLOOD IN URINE
		DISCHARGE		TESTICULAR PAIN		SEXUAL DISFUNCTION						
ORTHOPEDIC		PAINFUL JOINTS		MUSCLE WEAKNESS		SWOLLEN JOINTS		OSTEOPOROSIS		LIMITED RANGE OF MOTION		BACK PAIN
NEURO		SEIZURES		HEADACHES		DIZZINESS		FALLING		TINGLING		TREMOR
CIRCULATION		BLOOD CLOTS		LEG SWELLING								
MEMORY/MOOD		MEMORY DISTURBANCE		DIFFICULTY UNDERSTANDING		STRANGE OR SUSPICIOUS IDEAS		BEHAVIORAL DISTURBANCES		DECREASED ATTENTION		
REPRODUCTIVE		ABNORMAL BLEEDING				ABNORMAL DISCHARGE						
ENDOCRINE		INCREASED THIRST				INCREASED URINATION				LETHARGY		
SLEEP		DIFFICULTY FALLING ASLEEP				DIFFICULTY STAYING ASLEEP		EARLY AWAKENING		DAYTIME DROWSINESS		

SOCIAL HISTORY

ALCOHOL	TOBACCO	STREET DRUGS	EXERCISE	CAFFEINE					
DRINKS PER WEEK:	PPD: #YEARS: WANT TO STOP:	TYPE:	TIMES PER WEEK: TYPE:	CUPS PER DAY:	ARE YOU MARRIED?		YES		NO
					LIVING WILL?		YES		NO
					SALT INTAKE?		HIGH		LOW
					FAT INTAKE?		HIGH		LOW

Additional Comments:

SENIOR HEALTH ASSOCIATES
335 Pleasant Point Drive
Beaufort, SC 29907
803-699-9073
843-757-1173

Fax Completed Forms or Medical Records to:
803.764.2361

REQUEST FOR MEDICAL RECORDS

____
Patient Name

____
Date of Birth

____
Social Security Number

____
Name of Previous Medical Provider or Company

I hereby authorize the above named medical provider or company to disclose my complete medical records to Senior Health Associates. I understand that this authorization may be revoked at any time in writing by sending notification to Senior Health Associates at the address above. I understand that a revocation is not effective to the extent that Senior Health Associates has relied on the use of disclosure of the protected health information.

____
Signature of Patient or Legal Power of Attorney

____
Date of Authorization

PROVIDERS:

Please provide SHA will any and all medical records for the **preceding 12 months** for the patient listed left, unless other time period is specified here:

____

PLEASE FAX RECORDS TO:
803-764-2361

SENIOR HEALTH ASSOCIATES Fax Completed Forms to 803.764.2361

CREDIT CARD PAYMENT AUTHORIZATION

☐ AMEX ☐MASTERCARD ☐VISA ☐DISCOVER

CARD NUMBER

EXPIRATION DATE (MM/YY)

CVC CODE (3 NUMBERS FROM BACK OF CARD)

PATIENT NAME DATE OF BIRTH

CARDHOLDER NAME

CARDHOLDER ADDRESS

CITY, STATE, ZIP

CARDHOLDER EMAIL

CARDHOLDER CELLPHONE

SENIOR HEALTH ASSOCIATES IS REQUESTING THAT PATIENTS VOLUNTARILY PROVIDE A VALID CREDIT CARD FOR PATIENT RESPONSIBLE CHARGES. AT THIS TIME, WE DO NOT REQUIRE THAT YOU DO SO UNLESS YOU ARE APPLYING AS A SELF-PAY PATIENT.

SHOULD YOU CHOSE TO PROVIDE US WITH A CREDIT CARD, WE WILL PROVIDE YOU WITH A SAME DAY RECEIPT FOR ALL CHARGES TO YOUR CARD. WILL APPLY CHARGES TO YOUR CARD ONLY AFTER YOUR INSURANCE CARRIER ADVISES OF THE REMAINING BALANCE IN PATIENT RESPONSIBILITY.

PROVIDING THIS INFORMATION WILL REDUCE LATE FEES THAT MAY OCCUR FROM LATE PAYMENTS TO YOUR ACCOUNT.

CARDHOLDER SIGNATURE

Bringing today's doctor's office to you...

Welcome to Senior Health Associates!

Senior Health Associates is a large group multi-specialty medical practice with physicians and nurse practitioners board-certified in the fields of Internal Medicine, Family Medicine, Geriatrics, Hospice and Palliative Medicine.

Our focus is providing Geriatric specialized medical care to patients in Assisted Living Facilities, Skilled Nursing Facilities, Independent Living and at home.

Our Geriatricians are experts on end of life care and are active in legislation and education at the state and national level.

Who will be my medical provider?

Senior Health Associates currently has 12 medical providers that care for patients in over 55 facilities. Each facility that we visit is assigned to one physician and / or nurse practitioner who provides care for each of our patients. That provider will visit the facility on a regular schedule up to five times per week, based upon the facility need.

If your facility is assigned to a nurse practitioner, you can still request a physician consult by contacting our office to schedule a visit.

How often will I see the provider?

In general, our **assisted living facility** and **home patients** are seen for routine follow up **every 3 months** and our **nursing facility** patients are seen for routine follow up **monthly**.

However, our patients are seen more often if sick or otherwise medically justified, if we are notified of illness, change of condition, or upon request of the patient/family.

The appropriate way to notify us of non-urgent conditions is to either write the information in our physician notification book (located in every facility) or to ask the facility staff to do this. We will see every patient listed in this book on each visit. For urgent issues, either the patient, family member, or facility should call our office immediately.

Our providers are available to discuss your health concerns at any time. If you feel that you or your family member needs medical attention or may require a higher level of care, you may call our office at **803-699-9073** (Midlands) or **843-757-1173** (LowCountry).

For more information, please visit our web site at **www.SeniorHealthAssociates.com**.

Patient Portal Information

Please provide us with an email address on the first page of your paperwork so that we can send you login information to our patient portal. This will allow you to access your medical records online.

Please login to the portal as soon as you receive the login information so that you can notify us of any login issues.