



Patient Name: _____ Date of Birth _____

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. We will send bills to the preferred billing address selected, however we request an alternate address be provided.

Once this form is completed and returned to our office, we will schedule an appointment to see the patient. We will call you --or you may call us at 803-699-9073 x102 or 843-757-1173 x 102.

Preferred Billing Address

Responsible Party Name

RP Address

RP City, State, Zip

RP Telephone

Preferred Billing Address

If patient is in a facility, please provide the name only:

Patient Address

Patient City, State, Zip

Patient Telephone

Primary Insurance Provider: Medicare Other: _____

ID Number: _____

If Medicare, please include any letters following the ID number

Secondary/Supplemental Insurance Provider: _____

ID Number: _____

Referred by: Home Health Hospice Physician Other Name: _____

Currently Receiving: Home Health Hospice

Who should we call to schedule your appointment (if not patient) _____

YOU MAY RETURN THIS FORM TO US BY FAX (866) 527-0937, E-MAIL SENIORHEALTH@SHAMD.COM, OR MAIL TO: 130 Camp St. Mary Road, Okatie, SC 29909

Responsible Party 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>.

Please sign below, indicating your awareness of the location of our Notice of Privacy Practices.

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) and all referring physicians that I have listed on the Designation of Care Providers form. 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 And/Or Not Medically Necessary Services

Your health insurance company may not pay for certain health care services that they consider non-covered or not medically necessary, based on their clinical guidelines. You may be financially responsible for any health care service that your insurance plan deems non-covered or not medically necessary and does not pay. You may be required to pay for any health care item or service provided to you that your insurance plan refuses to pay for because it deems the services or items not covered or not medically necessary under it's guidelines.

PLEASE SIGN BELOW INDICATING YOUR AGREEMENT TO ALL OF THE ABOVE, including awareness of our privacy practices and agreement for insurance assignment of service.

Patient or POA Signature

Date



SENIOR
Health Associates

Specializing in the Care of the Elderly

Authorization for Release of Protected Medical Records

Patient Name: _____

Date of Birth ___/___/___

SS#: _____ - _____ - _____

I, _____, hereby 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 below 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

Please fax records to 866-527-0937

130 Camp Saint Mary Road
Okatie, SC 29909
803-699-9073 or 843-757-1173
Fax 866-527-0937

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: _____