

SENIOR HEALTH ASSOCIATES

Mail to: 2858 Sunset Blvd, West Columbia, SC 29169 or
 Fax to: 866-527-0937 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	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
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HOME ADDRESS

MAILING ADDRESS FOR BILLS, IF DIFFERENT THAN ABOVE (OR DESIGNATE SOMEONE ELSE TO RECEIVE BILLS BELOW)

HOME PHONE	MOBILE PHONE
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PRIMARY EMAIL ADDRESS	PHARMACY & TELEPHONE #
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DOES PATIENT LIVE IN A FACILITY? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, PROVIDE NAME OF FACILITY:
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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 <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Other	Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown
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PREFERRED LANGUAGE <input type="checkbox"/> English <input type="checkbox"/> Other:	
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IF YOU WOULD LIKE TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION, 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	<input type="checkbox"/> SPOUSE <input type="checkbox"/> DAUGHTER <input type="checkbox"/> SON <input type="checkbox"/> OTHER: Is this person the <input type="checkbox"/> Healthcare POA <input type="checkbox"/> Legal POA PLEASE ATTACH COPY OF POA DOCUMENTS
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ADDRESS:

EMAIL ADDRESS:

<input type="checkbox"/> PLEASE SEND ALL BILLS TO THIS PERSON	HOME PHONE:	MOBILE PHONE:
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NAME	<input type="checkbox"/> SPOUSE <input type="checkbox"/> DAUGHTER <input type="checkbox"/> SON <input type="checkbox"/> OTHER: Is this person the <input type="checkbox"/> Healthcare POA <input type="checkbox"/> Legal POA PLEASE ATTACH COPY OF POA DOCUMENTS
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ADDRESS:

EMAIL ADDRESS:

<input type="checkbox"/> PLEASE SEND ALL BILLS TO THIS PERSON	HOME PHONE:	MOBILE PHONE:
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NAME	<input type="checkbox"/> SPOUSE <input type="checkbox"/> DAUGHTER <input type="checkbox"/> SON <input type="checkbox"/> OTHER: Is this person the <input type="checkbox"/> Healthcare POA <input type="checkbox"/> Legal POA PLEASE ATTACH COPY OF POA DOCUMENTS
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ADDRESS:

EMAIL ADDRESS:

<input type="checkbox"/> PLEASE SEND ALL BILLS TO THIS PERSON	HOME PHONE:	MOBILE PHONE:
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INSURANCE – Required section	
PRIMARY INSURANCE	ID NUMBER & LETTERS
MAILING ADDRESS:	
IS THIS A MEDICARE REPLACEMENT POLICY? <input type="checkbox"/> Yes <input type="checkbox"/> 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	<p>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 send them to your pharmacy during our visit.</p> <p>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.</p> <p>EMERGENCY REFILLS – 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.</p> <p>AFTER HOURS EMERGENCIES – If you call our office after business hours for refills, our 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.</p>
APPOINTMENTS	<p>HOME PATIENTS – Please call our office to make appointments.</p> <p>FACILITY PATIENTS – Please ask facility staff to 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.</p> <p>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.</p>

TRIP CHARGES	HOME PATIENT VISITS will be subject to a \$45 trip charge not covered by Insurance.
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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.
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CANCELLATIONS	Any visit not cancelled through our main office number within 12 hours of the appointment time, will be subject to a \$45 charge.
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Signature of Patient or Power of Attorney as listed above	Date
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SIGNATURES CAN ONLY BE ACCEPTED FROM THE PATIENT OR POWER OR ATTORNEY

Health Information Form

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

Blood Patient		Blood Relative		Blood Patient		Blood Relative		
<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack / Disease	Allergies:		
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure			
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol			
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease			
<input type="checkbox"/>	<input type="checkbox"/>	Dementia	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness			
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis			
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema/Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	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 DYSFUNCTION			
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 DRINKS PER WEEK:	TOBACCO PPD: #YEARS: WANT TO STOP:	STREET DRUGS TYPE:	EXERCISE TIMES PER WEEK: TYPE:	CAFFEINE CUPS PER DAY:	ARE YOU MARRIED?	YES	NO
					LIVING WILL?	YES	NO
					SALT INTAKE?	HIGH	LOW
					FAT INTAKE?	HIGH	LOW

Additional Comments:



2858 Sunset Blvd
West Columbia, SC 29169
803-699-9073 office

Please Fax Medical Records to:
866-527-0937

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

Please provide SHA with 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:
866-527-0937

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 ask the facility staff to write the request/issue in our physician notification. 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**.

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



Patient Portal

Patients may access their medical records through our patient portal. We will send you a registration link to the email provided.

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