SENIOR HEALTH ASSOCIATES
www.SeniorHealthAssociates.com
803-699-9073
866-527-0937 FAX

Urgent Care Program

SHA will notify your Primary Care Physician of visits made and send copies of our notes to their office as directly below:

Primary Care Physician:_____

Fax Number to send notes:_____

PATIENT INFORMATION

First Name	Middle/Maiden	Last Name	Date of Birth	Social Security Number:

Mailing Address	Unit #	City	State/Zip	Preferred Language	Sex (Circle)
				□ English □ Other:	M - F

Home Phone	Mobile Phone	E-Mail Adddress of Patient or Responsible Party:

Medicare requires us to collect this information, you may decline to provide it.	Race ☐Black ☐White ☐Asian ☐Hispanic ☐Other Ethnicity ☐Hispanic ☐Non-Hispanic ☐Unknown	Name of Facility, If Applicable – EVEN in Independent Living

Responsible Party Name, required alternate caregiver to assume financial liability if needed	Relationship ____ Check if Legal Power of Attorney and include copy

Address, if different than above	Home Phone	Mobile Phone

Additional Contacts

Mail All Bills to: ☐Patient Address ☐ Responsible Party Address	**Do you feel that you would benefit from the following services?** ☐Home Health ☐ Hospice ☐Physical Therapy
How would you rate your overall health? ☐Excellent ☐ Fair ☐Poor ☐Declining	**Do you feel that you take too many medications**? ☐Yes ☐No

Are you ____ currently receiving services from or have you ___ previously received services from home health or hospice?
Provide Name of Agency:

INSURANCE INFORMATION

Primary Insurance Provider _____CHECK IF THIS IS A MEDICARE REPLACEMENT POLICY	ID Number, including Letters:

Secondary Insurance Provider	ID Number, including Letters:

AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT

I request and authorize Senior Health Associates (SHA) to perform procedures and treatment as required to provide reasonable and appropriate medical care for the above named patient. I authorize the release of any medical information necessary to provide such care and to process insurance claims and I hereby assign benefits payable to SHA from any and all of my health insurance carriers. Furthermore, I understand that my insurance may not pay for certain health care services and I agree to pay in full for any services not covered by my insurance carrier upon receipt of invoice. I understand that SHA will charge $25.00 per month late fee for any balance greater than 30 days and balances greater than 60 days may be sent to a collection agency and I will assume responsibility for additional charges that may be added as a result. I agree to notify SHA within 10 days of any change in my insurance coverage.

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.

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.

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