MemoryCare

100 Far Horizons Lane, Asheville, North Carolina 28803
Phone: (828) 771-2219 www.memorycare.org

PATIENT CONSENT FORM

1. **CONSENT TO MEDICAL CARE**. I hereby authorize MemoryCare to perform examinations and administer treatments that are necessary and in my best interest.
2. **AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION**. I authorize MemoryCare to furnish medical information, including identity, diagnosis, prognosis or treatment of any kind to any insurance company that is providing benefits to me or to the physician's office and to any professional review organizations with whom I may have insurance coverage or who may be assisting in payment of my medical care expenses. MemoryCare will follow terms of our Notice of Privacy Practices.
3. **TRANSMISSION OF MEDICAL INFORMATION**. I understand that physicians, health care agencies, clinicians, medical and nursing facilities involved in my medical care may need medical information quickly for purposes of continuity of care and follow-up. I hereby authorize MemoryCare to transmit needed medical information to such entities via the most efficient method available in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and our Notice of Privacy Practices .
4. **ASSIGNMENT OF INSURANCE BENEFITS**. In the event I am entitled to benefits arising out of any insurance policy, said benefits are hereby assigned to MemoryCare for application to my bill for services rendered. I authorize and direct any insurance company from which payment may be received for my care to furnish MemoryCare information regarding my benefits, status of claim, reasons for non-payment, and other information deemed necessary by MemoryCare.
5. **MEDICARE BENEFITS**. If the patient is covered by Medicare, the undersigned certifies that the information given in applying for payment under Title XVIII of the Social Security Act is correct. The undersigned authorizes any holder of medical or other information about the patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. The undersigned assigns the benefits payable for the physician services to the physician or organization furnishing the services.
6. **FINANCIAL AGREEMENT**. The undersigned agrees, whether he or she signs as patient, as patient's guardian or as patient's agent or representative, that in consideration of the services to be rendered to the patient he or she obligates himself or herself to pay the account owed by the patient to MemoryCare.
7. **PHOTO**. A photograph of the patient and the individuals who accompany the patient will be taken and placed in the chart. This is to help staff members communicate more efficiently. You have the right to refuse this.
8. **RETIREMENT COMMUNITIES**. The undersigned agrees that MemoryCare has permission to release information to the clinical and social work staff of the retirement community in which he or she lives.

I understand that I retain the right to revoke this consent by notifying MemoryCare in writing at any time. MemoryCare retains the right to seek payment of services obtained prior to any decision to revoke this consent.

THE UNDERSIGNED CERTIFIES THAT HE OR SHE HAS READ AND UNDERSTANDS THE FOREGOING. THE UNDERSIGNED FURTHER CERTIFIES THAT HE OR SHE IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT AS THE PATIENT'S GENERAL AGENT OR REPRESENTATIVE TO EXECUTE THE FOREGOING AND ACCEPT ITS TERMS.

_______________________	_______________	
(Patient)	(Date)	
(Designated Surrogate)	(Relationship to patient)	(Date)