



Pre-Visit Packet

If you have spoken with our scheduler and prefer to expedite your paperwork instead of waiting for your packet to arrive in the mail, please complete the attached Pre-Visit Packet and return it to MemoryCare along with your deposit check for \$50. We look forward to seeing you and hope that our program will be of assistance to you and your family. If you have any questions please call the office at 828-771-2219.

Return the Packet and your Deposit check to:

The SECU Center for MemoryCare
100 Far Horizons Lane
Asheville, NC 28803



The SECU Center for MemoryCare
 100 Far Horizons Ln
 Asheville NC 28803-2046
 Ph: 828-771-2219 Fax: 828-771-2634

IMPORTANT

Please return the deposit check and all completed papers in the enclosed envelope by _____. If not received by this date, we will assume you are not interested. Thank you.

PRE-VISIT QUESTIONNAIRE

A family member/caregiver of the person referred is requested to participate in completion of this form using patient data.

Date Completed: _____

Name of person filling out form: _____ Relationship to patient: _____

Patient Name: _____ Last 4 digits of SS#: _____

Address: _____

Phone: (____) _____ Date of Birth: _____ Age: _____ Gender: Male Female

Marital Status: _____ How many years married? ____ Spouse Name: _____

Emergency contact for patient: Name: _____ Phone: _____
 Address: _____
 Email: _____

Primary Insurance: _____ Member ID: _____ Group#: _____

Secondary Insurance: _____ Member ID: _____ Group#: _____

Medicare ID: _____

REVIEW OF BODY/ORGAN SYSTEMS: Please check any symptoms you have had in the past year.

General: Fever Sweats Fatigue Weight gain or weight loss (____ lbs. in ____ months) Insomnia
 Poor Appetite

Skin: Rashes Jaundice Sores or boils Easy bruising Blistering Itching Insect bites Animal bites

HEENT: Sore throat Cough Sinus Trouble Ear pain or pressure Eye pain Vision changes Trouble hearing
 Headaches Toothaches Difficulty chewing or swallowing

Cardiac: Chest pain Chest pressure Shortness of breath with exertion Irregular heart rate
 Difficulty breathing when lying down Swelling in lower legs or ankles

Lungs: Cough Sputum production Blood in sputum Difficulty breathing Wheezing

Gastrointestinal: Abdominal pain Bloating Heartburn Difficulty swallowing Nausea Vomiting Diarrhea
 Constipation Blood in stool Hemorrhoid pain Rectal bleeding

Musculoskeletal: Joint pain Joint Stiffness Joint swelling Joint redness
 Bone fractures - If YES, where? _____

Genitourinary: Pain with urination Difficulty emptying the bladder Bladder urgency Incontinence Frequent urination

Neurological: Tremors Seizures Dizziness Fainting Leg or arm weakness Memory problems Hallucinations
 Depression Involuntary muscle movements

MEDICAL CONDITIONS YOU HAVE NOW, OR HAVE HAD IN THE PAST (please check):

VISION AND HEARING

- Cataracts - If YES, did you have surgery to remove them? No Yes
- Glaucoma
- Macular Degeneration
- Hearing Loss - If YES, do you currently wear a hearing aid? Right ear Left ear

HEART CONDITIONS

Do you have a pacemaker or defibrillator? No Yes - If YES, please explain: _____

- Angina High Blood Pressure
- Heart Attack: Year _____ Irregular Heart Rate - Atrial Fibrillation/flutter
- Congestive Heart Failure Other - Please explain: _____

LUNG CONDITIONS

- Asthma
- Bronchitis: Acute (<6 weeks) Chronic (>6 weeks) Wears oxygen
- Pneumonia: Year: _____
- COPD/Emphysema
- Other - Please explain: _____

BONE AND JOINT CONDITIONS

- Arthritis
- Bone Fractures - Please list: _____
- Gout
- Osteoporosis
- Other - Please explain: _____

METABOLIC/NUTRITIONAL CONDITIONS

- Diabetes: Insulin is part of treatment Medication and diet Diet only
- Thyroid disorder: Overactive Underactive
- Anemia B12 deficiency Vitamin D deficiency Other – Please explain: _____

KIDNEY AND URINARY TRACT CONDITIONS

- Kidney infections (Pyelonephritis) Incontinence of urine
- Prostate disorder: Enlarged prostate Prostate cancer Surgery Frequent urinary tract infections (bladder)
- Other - Please explain: _____

GASTROINTESTINAL CONDITIONS

- Gastric ulcers Colon polyps
- Heartburn / Hiatal Hernia / Reflux disease Rectal bleeding
- Diverticulosis Persistent diarrhea/constipation
- Liver disease / Cirrhosis Other - Please explain: _____

NERVOUS SYSTEM PROBLEMS

- Stroke Migraine headaches Bipolar disorder
- Memory loss TIA or “mini strokes” Schizophrenia
- Parkinson’s disease Sleep apnea - Wears CPAP/BiPAP Depression
- Seizures Other - Please explain: _____

GYNECOLOGY PROBLEMS

- Vaginal bleeding (other than periods) Vaginal itching, burning, pain
- Vaginal discharge Breast lumps or pain

OTHER HEALTH PROBLEMS

- Hernia Blood clots
- Sexual function problems Cancer - Please explain: _____
- Other - Please describe: _____

OTHER PAST MEDICAL HISTORY:

Is there a past history of head trauma? No Yes - Please explain: _____

Have you had a scan (MRI or CT) of your **BRAIN**? No Yes: Please list date, location, and reason it was performed (if known).

FAMILY HISTORY OF MEMORY LOSS:

Have any of your first degree relatives (mother, father, siblings or children) been diagnosed with a memory problem?
 No Yes - If YES, please provide your relationship to the person with the problem and their diagnosis, if known. _____

MEDICATION - Please bring all of your medications with you to the appointment for review.

Gather **all** your prescription and non-prescription medicines (pills, eye drops, nasal sprays, ointments, laxatives, herbal supplements, vitamin supplements, etc. – **everything that you used at least twice in the last year**. Separate those that you use regularly from those that you use only as needed.

List **all** medicine you use **regularly** at this time (prescriptions, vitamins, and herbal remedies). Attach additional sheet if necessary.

Name of medication used <i>regularly</i>	What strength? (Dose)	How many? How many times per day?

List medicines that you take **“as needed”** at least twice per year. Attach additional sheet if necessary.

Medication used “as needed” at least twice in the last year	How often? Daily, weekly, monthly?	What strength? (Dose)	How many? How many times per day? Reason for taking?

ALLERGIES: List any medication allergies AND your reaction to them.

PREFERRED PHARMACY: _____ **PHONE:** _____

FUNCTIONAL HISTORY

Please indicate if you need help with any of the following tasks, and who helps you.

Task	Independent	Need Assistance	Name and relationship of person who provides help
Ambulation			
Bathing			
Dressing			
Toileting			
Transferring (ex: bed to chair)			
Feeding yourself			
Doing housework			
Climbing Stairs			
Shopping for groceries			
Cooking			
Taking medications			
Managing finances			
Using the telephone			
Simple home repairs			
Driving			

Is someone *employed* in the home to provide care? No Yes - If YES, indicate how many hours a day and how many days a week: _____

Does a family member or friend help in the home? No Yes - If YES, indicate how many hours a day and how many days a week: _____

DRIVING

Do you now drive a car? No Yes

If YES, during the past week, how many days did you drive? _____

During the past year, have you changed the way you drive? No Yes - If YES, how has it changed?

During the past year, have you had any accidents while driving? No Yes

During the past year, have you had any near misses while driving? No Yes

List any OPERATIONS you have had, the month/year they occurred, and the reason for the surgery. Please attach an additional page if more space is necessary.

Date	Operation/Reason

List any HOSPITALIZATIONS you have had (for anything *other* than surgery), the month/year they occurred, and the reason for the hospitalization. Please attach an additional page if more space is necessary.

Date	Hospitalization/Reason

HEALTH SCREENINGS

Have you had a test for blood in your stool? No Yes - If YES, when? _____

Have you had an examination of your bowel with a scope (Sigmoidoscopy or Colonoscopy)? No Yes - If YES, when was it most recently done? _____

Have you ever had a:

COVID-19 vaccine? No Yes - If YES, which vaccine? _____ When? Dose #1: ___/___/___ Dose #2: ___/___/___

Shot to prevent pneumonia? No Yes - If YES, when? _____

Tetanus shot? No Yes - If YES, what is the date of the last booster? _____

Flu shot for the current season? No Yes - If YES, when? _____

Shingles vaccine? No Yes - If YES, when? _____

Bone density test? No Yes - If YES, when? _____

For women only

Date of your last mammogram: _____

Do you perform monthly breast self-exams? No Yes

Date of you last pelvic exam and/or Pap smear: _____

FAMILY HISTORY

Please indicate if family members are living or deceased, what illnesses they had, and their age or cause of death.

Relative	Living or Deceased	Age	Current Illness or Cause of Death
Father			
Mother			
Sister(s)			
Brother(s)			
Spouse			
Children			

SOCIAL HISTORY

Where were you born and raised? _____

With whom do you currently live? Please specify names and ages of those in the household. _____

Describe your residence (house, apartment, etc.) _____

Employment status: _____ If retired, at what age did you retire? _____

Years of schooling? _____ If you have a degree, which type? _____

Describe your occupation(s) _____

Have you ever served in the military? No Yes - If YES, which branch? _____

Dates of service: _____

Has your spouse ever served in the military? No Yes - If YES, which branch? _____

Dates of service: _____

VA service connected? No Yes - If YES, self or spouse? _____

Are there firearms in the home? No Yes Ammunition? No Yes

If YES, are they kept in a locked place? No Yes Specify: _____

Are there any pets in the home? No Yes Specify: _____

HABITS

Do you currently use oral tobacco? No Yes

Have you ever smoked? No Yes

Are you smoking now? No Yes

If NO, when did you quit? _____

If YES, how many years have you smoked? _____ How much do/did you smoke? _____

Do you drink any alcohol? No Yes - If YES, describe: _____

Did you formerly drink alcohol but have now quit? No Yes - If YES, describe: _____

Do you currently participate in any regular activity or exercise program? No Yes

If YES, please describe what activity, and how often: _____

ADVANCE DIRECTIVES – Please bring a copy of these forms with you to the appointment.

Do you have: Living Will No Yes

Health Care Power of Attorney No Yes (Agent named is: _____)

Durable Power of Attorney No Yes (Agent named is: _____)

Medical Orders for Scope of Treatment Form (MOST form): No Yes

(Out of Hospital) Do Not Resuscitate form (DNR form): No Yes

Do you have a Long Term Care Insurance policy? No Yes

CURRENT CONCERNS

Do you have any *other* health problems that you would like your doctor to know about before your visit? Please describe.

What are your goals for this visit?

RESOURCE ASSESSMENT

MemoryCare is a community-based, charitable, non-profit organization because of the comprehensive care provided that includes families. We rely on the support of grants, foundations and individual donors in order to function. **Many of the agencies that fund our program require us to provide the following information about families we serve. Your personal identifying information will never be shared in association with the information you provide below.** We serve anyone with need. Thank you.

The following questions are in reference to the patient scheduled to be seen at MemoryCare.

Number of individuals living in household: _____(please include all)

Check yearly income:

_____ (Level 2) Less than \$13,590

_____ (Level 4) \$18,311 - \$27,465

_____ (Level 6) Greater than \$36,620

_____ (Level 3) \$13,590 - \$18,310

_____ (Level 5) \$27,466 - \$36,620

Please indicate if you receive the following sources of income:

Social Security: No Yes

SSI: No Yes

Employment: No Yes

Veterans Benefits: No Yes

Food Stamps: No Yes

Medicaid Eligible: No Yes

Is your residence:

Owned No Yes

Rented No Yes

Other - Please describe: _____

With which of the following does the patient identify (optional):

African American

Alaska Native

Asian

Caucasian

Hispanic/Latino

Native American

Other - Please specify: _____

Please have all insurance cards, including Medicare, available for your appointment.

THANK YOU FOR COMPLETING THIS FORM

Initials of Care Manager: _____



The SECU Center for MemoryCare
100 Far Horizons Lane, Asheville, North Carolina 28803
(828)771-2219, www.memorycare.org

CAREGIVER FINANCIAL AGREEMENT

I understand MemoryCare is a community-based, charitable, non-profit organization established to provide support and care for families impacted by dementia. The care includes education, support and training for caregivers and expert medical care for the person living with dementia. To cover the cost of their services, MemoryCare raises charitable funds, charges patient insurance and has a cost-sharing caregiver fee that can be reduced or waived if there is financial hardship. The following is information about the fees, including the caregiver fee portion, for which I am acknowledging that I will be responsible:

- *Patient (person with cognitive impairment) Fees:* I understand MemoryCare will file Medicare or other insurance for the medically necessary care given to the patient/caregiver. The patient will be responsible for any deductible amount that has not been met by their insurance or any co-payment that results from the clinical portion of the visit.
- *Family/Caregiver Fees:* I understand that because MemoryCare’s program includes services for families that are known to be vital for the best care of a person living with dementia, but are *not* covered by Medicare or any type insurance, ***an additional fee of \$695 per year is charged to the caregiver/family*** to help cover the cost.
 - This annual *Caregiver Fee* is payable from the caregiver on the initial visit.
 - Because medically necessary services to the patient are covered by Medicare or other insurance, but services we provide families are not fully covered, I understand that *this caregiver fee is charged to the family/caregiver and cannot be paid by the patient.*
 - I understand that the \$50 deposit for our appointment will be applied to the caregiver fee and *the remaining \$645 will be due at the time of the initial appointment* unless other arrangements have been made.

MemoryCare pursues charitable funds to keep this caregiver fee as low as possible and to ensure that no family will be denied service due to inability to pay. ***If the fee is a financial burden, I can contact the Scheduler to make arrangements-*** I have been told that they will work with families to ensure all receive the care needed.

I understand that the caregiver fee covers services for the supportive care, education, and training caregivers/families receive over a one year period and that such service is an integral part of MemoryCare’s program. Such services include, but are not limited to caregiver support, use of our library resources, workshops, and our caregiver training and education course.

I understand that I should contact the scheduler *prior to the visit* to make special arrangements if needing financial assistance.

For Caregiver fee billings:

Caregiver Name (please print): _____

Please check if also to receive patient fee billings

Caregiver Signature _____ Date _____

Caregiver Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: Home _____ Work _____

NOTE: Please see our website at www.memorycare.org for more detailed explanation of what is covered by our Caregiver Fee. MemoryCare will reduce or waive this fee for anyone unable to pay. Thank you.

CAREGIVER CONTACT INFORMATION

PATIENT NAME: _____

List Name and Relationship of each contact provided.

Name	Mailing Address	Phone Number ✓ <u>Check Preferred Number</u>	Relationship
<u>PRIMARY CONTACT:</u>		___ Home: _____ ___ Work: _____ ___ Cell: _____ *Email: _____	
		___ Home: _____ ___ Work: _____ ___ Cell: _____ *Email: _____	
		___ Home: _____ ___ Work: _____ ___ Cell: _____ *Email: _____	
		___ Home: _____ ___ Work: _____ ___ Cell: _____ *Email: _____	
		___ Home: _____ ___ Work: _____ ___ Cell: _____ *Email: _____	

*By providing an email address, you are accepting the potential security breaches that can occur with internet communications. Standard safeguards are taken to protect sensitive health information but potential risks remain.

*All contacts will receive educational and development mailings twice yearly unless opted out.

Physician Care Information

Primary Care Physician: _____ **Phone:** _____

Other medical providers involved in patient's care (seen at least once in the past 2 years):

Neurologist: _____ **Phone:** _____

Neuropsychologist: _____ **Phone:** _____

Cardiologist: _____ **Phone:** _____

Other: _____ **Phone:** _____

Other: _____ **Phone:** _____



The SECU Center for 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, and 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

Updated 04/19



AUTHORIZATION FOR RELEASE OF INFORMATION

1) If you have been seen by a neurologist and/or a neuropsychologist, please complete this form with their name(s) so we may obtain their evaluation(s) in advance of your visit to MemoryCare.

2) If a specialist of any kind referred you to our program, please complete this release so we may obtain records from your primary care provider.

I, _____, do hereby consent to and authorize
(Patient name)

_____ to release to:
(Provider name)

MemoryCare
The SECU Center for MemoryCare
100 Far Horizons Ln
Asheville NC 28803-2046
Phone: 828-771-2219
Fax: 828-771-2634

Information from the medical record relating to my identity, diagnosis, prognosis, or treatment, including psychological disorders and substance abuse, results of HIV testing, sickle cell anemia, diagnoses related to Acquired Immune Deficiency Syndrome, and any other sensitive information defined by law. This information may be communicated through written and oral means. **I understand the specific type of information/report to be disclosed includes:**

- **Progress notes**
- **Evaluation reports**
- **Labs**
- **Imaging**

This information will be held strictly confidential and cannot be released by the recipient without my explicit consent.

I understand that I may revoke this consent in writing to the extent that action has been taken in reliance thereon. This consent will expire without such express revocation upon the following date, event or condition ninety days from the date below.

DATE

SIGNATURE OF PATIENT

WITNESS

AUTHORIZED REPRESENTATIVE/LEGAL GUARDIAN

Patient Information:

Patient name: _____

Patient address: _____

Date of Birth: _____



NOTICE OF PRIVACY PRACTICES

In accordance with the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and the regulations required thereunder, this notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations which includes business management and general administrative activities. It, also, describes other purposes of disclosure that are permitted or required by law, including development of services. Additionally, it describes your rights to access and control of your protected health information.

All employees, students and trainees, volunteers, and vendors or independent contractors, who have access to your PHI, will follow the terms of this notice.

"Protected health information" is information about you, including demographic information that may identify you, that relates to your past, present, or future physical or mental health or condition and related health care services.

Every effort is used to safeguard your health information, but if a breach of protected health information occurs, the effected individual will be notified.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time and the new notice will be effective for all protected health information that we maintain at that time. When changes are made, a new Notice of Privacy Practices will be posted in the examination room and will be provided to you upon your request at your next appointment. You may also request an updated copy of our Notice of Privacy Practices at any time by calling the office and requesting that a revised copy be sent to you.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

1. **Treatment.** MemoryCare uses your protected health information primarily for *treatment*, including providing, coordinating, and managing your health care and any related services, such as lab work and physical therapy. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information, such as your primary care physician or other health care provider. We may, also, disclose medical information about you to people involved in your care such as family members, or others who provide services such as hospitals, therapists, or medical specialists that are a part of your care.

2. **Payment.** Your protected health information will be used, as needed, to obtain *payment* for your health care services. This may include activities that your health insurance plan requires before approving or paying for the health care services we recommend for you, such as determining eligibility for insurance benefits based on lab results, reviewing services provided to you for medical necessity, and undertaking utilization review activities. We are permitted by law to disclose the amount of medical information necessary for us to obtain payment for the care and services provided to you. Our disclosure of medical information for the purpose of obtaining payment for care and services provided to you may include our giving information to your family members or surrogates who are involved in your care or help pay for your care.

3. **Healthcare operations.** MemoryCare may use or disclose your protected health information in order to support the *healthcare operations* of the physician practice. For example, we may use your PHI to review our treatment and services and to evaluate the qualifications and performance of staff caring for you. We may, also, combine your PHI with that of others we serve to help us decide if there are additional services that would benefit those for whom we care. We may, also, use your PHI in assessing our business management needs and in the training of medical residents and nursing and social work students. We may contact you to remind you of appointments, including leaving a message on your telephone.

4. **Business Associates.** MemoryCare will share your protected health information with third party "business associates" that perform various activities (e.g., transcription services) for the practice. MemoryCare and its ACO Providers/Suppliers participate in the Medicare Shared Savings Program Participation Agreement. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

5. **Fund-raising.** Because MemoryCare is a 501 (c)(3) nonprofit organization with some grant funding, we may be required to provide demographic information of our patients as a part of our healthcare operations. If so, only demographic information relating to the patient and date of service may be used but no personally identifying information. At times we will be asked to provide a summary of the types of diagnoses our patients have, but the information will be presented in such a way that it cannot be traced to individuals. Because MemoryCare has ongoing development efforts to build an endowment, this information may, also, be used to raise additional funds for the program. Though no health information will be shared, it is possible that family members of patients will be contacted with such a request. If you do not want to receive information about our development efforts, please contact our Privacy Officer in writing. If MemoryCare would like to use your personal information in development materials, such as photographs or videos, MemoryCare will obtain additional authorization prior to its use. You may refuse such a request with no affect on the services you receive from MemoryCare. Development materials prepared before April 14, 2003 are excluded from this requirement.

6. **Treatment Alternatives.** MemoryCare may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health related benefits or services that may be of interest to you. We may, also, use and disclose your protected health information for other activities such as but not limited to using your name and address to send you a newsletter about our practice or invite you to support groups. You may contact our Privacy Officer in writing to request that these materials not be sent to you.

7. **Individuals involved in your Care.** MemoryCare may disclose your PHI to a family member or friend who is involved in your medical care. If you cannot agree to this or object, we will use our professional judgement to decide whether it is in your best interest to disclose relevant information to someone who is involved in your care or to an entity assisting in a situation where your safety may be at risk.

8. **As Required by Law.** MemoryCare will provide information when required to do so by federal, state, or local law.

9. **Miscellaneous.** MemoryCare may use or disclose your personal health information without prior authorization for public health purposes, auditing purposes, research studies, and emergencies.

In any other situation, MemoryCare's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to stop further disclosures at any time. If you are not present or able to agree to the use or disclosure of the protected health information, then MemoryCare staff may, using professional judgement, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

PATIENT'S INDIVIDUAL RIGHTS

1. **Right to review and copy.** You have the right to review or obtain a copy of your personal health information. This means you may obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about you.

2. **Right to amend.** You have the right to request that we correct any inaccurate or incomplete information in your records.

3. **Right to an Accounting of Disclosures.** You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or healthcare operations. You have the right to receive specific information regarding disclosures that occurred after April 14, 2003.

4. **Right to Request Restrictions.** You may request in writing that we not use or disclose your personal health information for treatment, payment, and healthcare operations except when specifically authorized by you, when required by law, or in emergency circumstances. MemoryCare will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them. You may require MemoryCare to restrict disclosures to health insurance plans if you pay out of pocket instead of having the claim filed with insurance.

5. **Right to Request Alternative Communications.** You or your representative have the right to request that we communicate with you about medical matters in a certain way, such as by mail only or not at work. You may request email communications. At MemoryCare, we include a confidentiality notice at the bottom of each email-this notice states that the email may contain confidential information and should be discarded immediately if received in error. This statement cannot ensure full confidentiality. You must make your request in writing to the Privacy Officer and be specific about how or where you wish to be contacted. You do not have to provide a reason for the request and we will attempt to accommodate all reasonable requests.

6. **Right to Copy of Privacy Notice.** You have the right to have a paper copy of this Privacy Notice or any revised version and can request such a copy at any time. Please contact our office at 771-2219 to obtain your copy.

CONCERNS AND COMPLAINTS

If you are concerned that MemoryCare may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Privacy Officer at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on MemoryCare's health information practices or if you have a complaint, please contact the following person:

**MemoryCare Privacy Officer
MemoryCare
The SECU Center for MemoryCare
100 Far Horizons Lane
Asheville, NC 28803**

Telephone: 828-771-2219 Fax: 828-771-2634 e-mail: office@memorycare.org

This notice was revised and became effective on September 1, 2015. Revised 4/7/2003 vht, Revised 4/1/2005 wdm, revised 10/11/05 vht, 9/2/2009 vht, 4/01/2013ah, 9/01/15ah, 04/19ah