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
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). _________________________________

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*Please complete both sides of the form***
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.

<table>
<thead>
<tr>
<th>Name of medication used regularly</th>
<th>What strength? (Dose)</th>
<th>How many? How many times per day?</th>
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</table>

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

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

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.

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

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.

<table>
<thead>
<tr>
<th>Date</th>
<th>Operation/Reason</th>
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</table>

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.

<table>
<thead>
<tr>
<th>Date</th>
<th>Hospitalization/Reason</th>
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<tbody>
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</table>
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 your 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.

<table>
<thead>
<tr>
<th>Relative</th>
<th>Living or Deceased</th>
<th>Age</th>
<th>Current Illness or Cause of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Mother</td>
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<tr>
<td>Sister(s)</td>
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<tr>
<td>Brother(s)</td>
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<td></td>
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<tr>
<td>Spouse</td>
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<tr>
<td>Children</td>
<td></td>
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</tbody>
</table>

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: ______________________________

◄◄Please complete both sides of the form►►
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:  
Check yearly income:
   (Level 2) Less than $13,590  
   (Level 3) $13,590 - $18,310  
   (Level 4) $18,311 - $27,465  
   (Level 5) $27,466 - $36,620  
   (Level 6) Greater than $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:  

P:/Scheduling/Referrals-Admin/Referral Packet 2023/Packet 1-2023/PRE Visit Questionnaire for Packet 1 for 2023 01/23
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](http://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.

<table>
<thead>
<tr>
<th>Name</th>
<th>Mailing Address</th>
<th>Phone Number</th>
<th>Relationship</th>
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<tbody>
<tr>
<td>PRIMARY CONTACT:</td>
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<td>__ Home:</td>
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<td>__ Cell:</td>
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<td>*Email:</td>
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* 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: ______________

P/Scheduling/Referrals-Admin/Referral Packet 1/Caregiver-Physician Contact Information 01/23
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)

________________________________________

(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
The SECU Center for MemoryCare

NOTICE OF PRIVACY PRACTICES
Acknowledgement of Receipt

- I have reviewed MemoryCare’s Notice of Privacy Practices and been given an opportunity to ask questions. I understand that MemoryCare may use or disclose my personal health information for the purposes of treatment, payment, and healthcare operations, including evaluating the quality of services provided and reporting to funding agencies. I understand that, if I notify the practice in writing, I have the right to restrict how my information is used and disclosed for treatment, payment, and healthcare operations. I also understand that MemoryCare will consider requests for restrictions on a case-by-case basis, but does not have to agree to such requests.

  __________ initial

- I hereby authorize MemoryCare, a charitable nonprofit organization, to use my protected health information for development activities. I understand this authorization does not affect my consent to use my protected health information for treatment, billing, or other healthcare operations and that I may revoke this consent at any time by notifying MemoryCare in writing.

  __________ initial

- I understand that MemoryCare is willing to communicate with me or my family via email, but cannot ensure its security. Please initial below if you approve of email communication with you or your family.

  I approve using email to communicate.

  __________ initial

Patient Name

___________________________ __________________________
Signature of Patient or Patient Representative Date

Relationship of Representative to Patient

FOR MemoryCare USE ONLY
If acknowledgement of receipt of Notice of Privacy Practices is not obtained from patient or representative, please explain efforts to obtain acknowledgement and the reasons you could not obtain it:

_________________________________________________________________________________________________________________________________________

_________________________________________________________________________________________________________________________________________

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4/7/2003 vht rev 4/1/2005 wdm rev 9/03/13 aph10/05/16 aph 10/18 aph