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 non-refundable deposit check for $100, or you can pay by credit card over the phone when the scheduler calls to make the appointment.

All pages of the Pre-Visit Packet must be completed for an appointment to be scheduled. Make sure to enclose:

- Pre-Visit Questionnaire (6 pages)
- Caregiver Membership Fee Financial Agreement
- Caregiver Contact Information
- Patient Consent Form
- Notice of Privacy Practices- Acknowledgement of Receipt
- Authorization for Release of Information
- Cancellation and Missed Appointment Policy

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 MemoyCare
100 Far Horizons Ln
Asheville NC 28803-2046
Ph: 828-771-2219 Fax: 828-771-2634

IMPORTANT
Please return 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

◄◄Please complete both sides of the form►►

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).

_____

_____

◄◄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.

Name of medication used *regularly*	**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

◄◄Please complete both sides of the form►►

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**:** _____

◄◄Please complete both sides of the form►►

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)

Is patient's annual income less than $30,120? □ No □ Yes

Is patient's annual household income less than $40,880? □ No □ Yes

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

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

CAREGIVER MEMBERSHIP FEE 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.
- *Caregiver Support Membership*: 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*** help cover the cost of services to support family and other caregivers.
  - This annual *Caregiver Membership Fee* is payable from the caregiver or the patient on the initial visit.
  - Because medically necessary services to the patient are covered by Medicare or other insurance, but the extensive personalized education, training and support services we provide caregivers are not covered, I understand that MemoryCare charges this fee. I understand that the $100 non-refundable deposit for our appointment will be applied to the caregiver membership fee and *the remaining $595 will be due at the time of the initial appointment* unless other arrangements have been made.

MemoryCare pursues charitable funds to keep this caregiver membership 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 membership fee covers services for the extensive 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 personalized caregiver support, direct email/phone access to your care manager during office hours, exclusive access to a member only section of educational resources on our website, use of our library resources, workshops, and our caregiver training and education course. MemoryCare is specialized to include a partner in care for all persons with cognitive disorders without exception.

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

For caregiver membership fee billings:

Patient or Caregiver Name (please print whomever will be paying this fee):
_____

□ Please check if also to receive patient fee billings

Caregiver Signature _____ Date _____
Responsible Party for Caregiver Membership Fee 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 Membership 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 ✓ Check Preferred Number	Relationship
PRIMARY CONTACT:		__ 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

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:

_____
_____
_____
_____
_____

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: _____

Cancellation and Missed Appointment Policy

Our goal is to provide quality individualized medical care in a timely manner. Not showing up for a scheduled appointment without notice and late cancellations impose a burden on the others in our practice who are waiting for appointments. **Please be advised of our office policy regarding missed appointments without notice and last-minute cancellations.** In order to be respectful of the medical needs of other patients, please be courteous and call MemoryCare promptly if you are unable to keep an appointment. This time will be reallocated to someone who needs treatment.

Cancellation of a **New Patient** Appointment:

New Patient Appointments last 3 hours and involve considerable time resources. If you are unable to make the appointment and you fail to give at least 2 full business days (48 hours) notice, we will apply the non-refundable deposit if you desire to reschedule. We will require a new referral after two cancellations without adequate notice.

Cancellation of a **Follow-Up** Appointment:

If it is necessary to cancel your scheduled appointment, we require that you call **828-771-2219** at least 1 full business day (24 hours) in advance. Appointments are in high demand, and your early cancellation will give another person the opportunity to access timely, high-quality medical care. If the late cancellation (less than 1 full business day notice) is due to illness or a patient is refusing to come to clinic, you will be asked to convert the appointment time being missed to a tele-health or caregiver conference.

Fees for late cancellation and no shows on follow-up appointments:

- First late cancellation or no show: no fee will be billed to your account; you will be reminded of this policy.
- Second late cancellation or no show within a one-year timeframe: a $50 fee will be billed to your account.
- Third late cancellation or no-show within a one-year time frame: if there are extenuating circumstances, please discuss with your care team. If not, the patient will not be re-scheduled and will be discharged from the practice and notified of this policy.

Please sign and date below indicating that you have read and agree to this policy.

Patient Name:_____

Patient/Caregiver signature_____ Date_____