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

Dear Family Member:

I appreciated the opportunity to speak with you about our program. Enclosed is the information we discussed. **To schedule your appointment, we must receive the enclosed items that are stapled together within 2 weeks (due _____), and either include the $100 non-refundable deposit with the stapled packet, or plan to provide credit card payment over the phone when the scheduler calls to make the appointment.** We will call you to schedule an appointment as soon as we receive your stapled sheets. Currently we are scheduling appointments in the month of _____. You must give at least 2 full business days (48 hours) notice if you are unable to make the appointment. If we do not receive the needed items by the due date, we will assume you are not interested and will notify your referring physician, Dr. _____.

Your non-refundable $100.00 deposit will be applied to your caregiver support services fee of $695 and the remaining $595.00 will be due in full at time of check-in for the initial appointment. This fee covers services for the supportive care and training of caregivers for a one-year period. These services include caregiver support, use of our library resources, workshops, and our proprietary caregiver training and education courses.

Please complete the discount application included in this packet if you need financial assistance. Our practice is a charitable, non-profit organization committed to spending extensive time with patients and caregivers. We pursue charitable funding to ensure our services remain accessible to those with need.

We look forward to seeing you and hope our program will be of assistance to you and your family. Please visit our website at www.memorycare.org.

Best Regards,

Kellie Dillingham
Scheduler

Items to be returned to proceed with scheduling an appointment:
___Completed Stapled Information Packet that includes the financial agreement
___Completed Discount Application (if requesting fee adjustment or waiver)
___$100 non-refundable deposit check included OR
___$100 non-refundable deposit provided to scheduler via phone at time of scheduling call

Non-stapled items are to be maintained by you for your records

AUTHORIZED CONTACT INFORMATION

PATIENT NAME: _____

List Name and Relationship of each contact provided.

Name	Mailing Address	Phone Number ✓ Check Preferred Number	Relationship
DESIGNATED PATIENT REPRESENTATIVE: Date: PR Sig:		__ Home: _____ __ Work: _____ __ Cell: _____ *Email: _____	
Date: PR Sig:		__ Home: _____ __ Work: _____ __ Cell: _____ *Email: _____	
Date: PR Sig:		__ Home: _____ __ Work: _____ __ Cell: _____ *Email: _____	
Date: PR Sig:		__ Home: _____ __ Work: _____ __ Cell: _____ *Email: _____	
Date: PR Sig:		__ 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: _____

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CAREGIVER SUPPORT SERVICES FEE FINANCIAL AGREEMENT

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, bills patient insurance, and charges a caregiver support services fee.

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. 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 Services Fee*: I understand that MemoryCare's program includes services for families that are *not* covered by Medicare or any type insurance, ***an additional fee of $695 per year is charged to*** cover the cost of services to support family and other caregivers. ***This fee is renewed annually.***
  - This annual *Caregiver Membership Fee* is payable from the caregiver or the patient on the initial visit.
  - I understand that the $100 non-refundable deposit for our appointment will be applied to the caregiver support services fee and *the remaining $595 will be due in full at check in for the initial appointment.*

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 financial assistance is needed,*** *I can complete the discount application form.*

I understand that the caregiver support services fee covers the extensive care, education, and training for caregivers/families over a one-year period. These services include, but are not limited to personalized caregiver support, direct email/phone access to your care team during office hours, exclusive access to educational resources, use of our library resources, workshops, and our proprietary caregiver training and education course with supporting materials.

For caregiver membership fee billings:

Patient or Caregiver Name (please print whoever 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: _____

NOTE: Please see our website at www.memorycare.org for more detailed explanation of what is covered by our Caregiver Support Services Fee.

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

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:**_____

◄◄Please complete both sides of the form►►

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**:** _____

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 $31,300? □ No □ Yes

Is patient's annual income less than $42,300? □ No □ Yes

Is patient's annual income less than $53,300? □ 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

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

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 of patient/patient representative**

MemoryCare utilizes a secure portal in our electronic medical record per health care information standards to maximize the security of our patient/patient representative's protected health information (PHI) under HIPAA and secure texting for appointment reminders. There is no failsafe method to fully secure PHI utilizing ***regular office email*** for communication. MemoryCare recognizes that a patient/patient representative has the right to choose to take the risk of a security breach in receiving non-portal communication or unencrypted email, if so preferred. MemoryCare is not responsible for any breach of PHI during transmission or after delivery, a non-secure method of communication is chosen.

Patient or Patient Representative select communication preference by initialing the blank beside the option you choose.

Secure Portal Communication

____ Please utilize secure portal communication to communicate with me or my representative about my treatment at MemoryCare.

____ Please do not utilize secure portal communication to communicate with me or my representative about my treatment at MemoryCare.

Encrypted Email Communication

____ Please communicate with me or other authorized entities on the authorized contact form by **ENCRYPTED** email.

_____ Please use **Non-portal, Unencrypted** email to communicate with me or other authorized individuals on the contact form about my treatment at MemoryCare.

I acknowledge there is a risk of a security breach in communicating outside of the electronic health record portal and that MemoryCare cannot ensure its security. I understand that I can change my mind regarding this decision at any time by notifying MemoryCare in writing and that it is my responsibility to notify MemoryCare of any changes in my email address or the email addresses of other entities I have authorized to receive email in this same manner as the authorized contact form. I will notify MemoryCare immediately of any change in email address.

Phone Communication

_____ You have permission to communicate with me or other authorized entities on the authorized contact form by phone voicemail or text message (used for appointment reminders). I will let MemoryCare know immediately about any change in phone number.

_____ Do not communicate with me or other authorized entities on the authorized contact form by voicemail or text for appointments and reminders.

Education and Development Information

I understand MemoryCare is a non-profit charitable organization and sends educational information that may contain development/fundraising-related material, including, but not limited to, annual reports and caregiver newsletters. Since my identity and contact addresses are considered protected health information, MemoryCare must have your approval to include you and other authorized contacts in such mailings. I understand my decision regarding this authorization does not affect my access to care and that I may revoke this consent at any time by notifying MemoryCare in writing.

_____ You have permission to send information to me or other authorized entities on the authorized contact form educational materials that may contain development activities.

_____ Do not send information to me or other authorized entities on the authorized contact form educational materials that may contain development activities.

_____	_____	_____
Patient Name	Signature of Patient or Patient Representative (and relationship)	Date

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_____

MemoryCare Caregiver Support Program Membership Fee Discount Application

To be completed only if requesting fee waiver for Initial visit

If you are unable to pay part or all the caregiver support services fee, you are required to complete this application for waiver consideration. Any balance due after a waiver is granted is due in full at the check-in desk at the time of the initial visit. This financial information is regarding <u>the person paying the Caregiver Membership Fee</u>. Medical insurance continues to be billed for the patient's clinical part of the visit, and you are expected to pay any amount not covered.

Name of Patient: _____ Patient Date of Birth:_____ Today's Date:_____

Name and address of Caregiver for Patient (person responsible for payment of Caregiver Membership Fee):

Name: _____ Address:_____

Number of adults living in the payor's home: _____
Number of children under 18 years of age living in the payor's home: _____

Amount of Total Household ANNUAL Gross Income (everyone in the payor's home) for the last <u>12</u> Months

Type of Income	Amount of Income
Work Wages	
Social Security	
Disability	
Unemployment	
Workers Comp	
Child Support	
Other Income	
Total:	

Return this application with stapled paperwork and deposit. MemoryCare will contact you regarding the caregiver fee waiver and appointment setup.

The information provided is accurate to the best of my knowledge.

Caregiver signature: _____ Date: _____

<u>Caregiver Services Include:</u>

At each visit based on need:

- Review test results with Caregivers
- Education and training about dementia care
- Counseling and support to Caregivers
- Discuss strategies and problem-solving with Caregivers
- Assess Caregiver needs, including stress impact on Caregivers
- Refer to local resources for additional services offered through other agencies
- And others based on Caregiver need

Between visits based on individual need:

- Phone/Email communication during office hours to assist with issues
- Enrollment in "Caregiver College" and Deep Dive Topic Education Series
- Lending Library/Resource Center
- Workshops/Seminars
- Caregiver E-Newsletter
- MemoryCaregiver Network Peer Support Groups

For office use only:
Amount of waiver approved: _____ Amount to collect at initial visit: _____
P:Administrative/Office Docs/Patient-CG forms/Discount Application-Initial Visit