Daughters of Sarah Nursing Center, Inc.

STATEMENT TO PERMIT PAYMENTS TO FACILITY

(CHECK ALL APPROPRIATE BOXES)

_____ _____

(Name of Resident) (Medicare Number/ Insurance ID)

☐ **PAYMENT OF MEDICARE BENEFIT TO PROVIDER, PHYSICIANS AND RESIDENT**

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by or in Daughters of Sarah Nursing Center, Inc., including physician services. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services (and its agents) any information needed to determine these benefits or benefits for related services.

☐ **PAYMENT OF NO FAULT BENEFIT TO PROVIDER, PHYSICIANS AND RESIDENT**

I request that payment of authorized no fault benefits be made either to me or on my behalf for any services furnished to me by or in Daughters of Sarah Nursing Center, Inc., including physician services. I authorize any holder of medical or other information about me to release to the no fault carrier and its agents any information needed to determine these benefits or benefits for related services.

☐ **PAYMENT OF INSURANCE BENEFIT TO PROVIDER, PHYSICIANS AND RESIDENT**

I request that payment of authorized insurance carrier benefits be made either to me or on my behalf for any services furnished to me by or in Daughters of Sarah Nursing Center, Inc., including physician services. I authorize any holder of medical or other information about me to release to the insurance carrier (and its agents) any information needed to determine these benefits or benefits for related services.

☐ **PAYMENT OF INSURANCE BENEFIT TO PROVIDER, PHYSICIANS AND RESIDENT**

I request that payment under any pension or similar tax deferred account or plan be made either to me or on my behalf for any services furnished to me by or in Daughters of Sarah Nursing Center, Inc., including physician services.

_____ _____

Signature of Resident or Authorized Representative Date

(If Attorney-In-Fact, check here ☐, and attach a copy of the Power of Attorney)

Daughters of Sarah Nursing Center, Inc.

RELEASES

(CHECK ALL APPROPRIATE BOXES)

RESIDENT NAME: _____ ROOM NUMBER: #_____

RELIGIOUS WORSHIP

☐ I hereby give the Center permission to release my name to my place of worship.

Religion/Denomination:_____
Place of Worship: _____
Clergy name: _____

☐ I hereby give the Center permission to release my name to the Catholic Eucharistic Minister for purposes of receiving Communion/Sacrament of the Sick.

☐ Please do not release my name

☐ I am not affiliated with any place of worship.

USE OF PHOTOGRAPHS

☐ I hereby consent to the use by the Center of photographs of myself for general publication in newsletters, distribution with press releases, and/or for use in brochures.

☐ I hereby decline to allow my photograph to be used by the Center for publication. (I recognize that my photograph must still be taken by the Center upon my admission for internal identification purposes.)

RESIDENT TRUST ACCOUNTS

☐ I request monthly statements be delivered to the Resident.

☐ I request monthly statements be sent to the following designee: _____

OPENING OF RESIDENT MAIL

I hereby authorize the Center to open business mail addressed to the Resident and give to the appropriate staff for processing. Such mail may include, without limitation, items from: Social Security, Medicare, Medicaid, Veterans' Administration, Physicians and Hospitals.

Resident: ☐ has capacity, please give mail to ☐ resident ☐ business office

☐ does NOT have capacity, please give mail to ☐ family ☐ business office

_____ _____
Signature of Resident or Authorized Representative Date
(If Attorney-In-Fact, check here ☐, and attach a copy of the Power of Attorney)

Daughters of Sarah Nursing Center, Inc.

CONSENTS/AGREEMENTS

(LONG TERM)

RESIDENT NAME: _____ ROOM NUMBER: #_____

INSURANCE

The Center will make every attempt to have skilled services authorized by all of your applicable insurance companies. If any of your companies fails to authorize or pay for such services, you hereby agree to pay for such charges in full.

SMOKING POLICY

The Center is a **smoke-free** workplace. The following smoking guidelines shall apply:

- ❖ Residents may smoke only in designated areas.
- ❖ Family members who accompany residents to designated smoking areas may only smoke while at the location with the resident.

ANCILLARY MONTHLY BILLS

I hereby authorize the Center to pay the following bills from my Resident Trust Account, but only to the extent adequate funds are on deposit in the account:

- ☐ Verizon or other telephone service
- ☐ Time Warner Cable
- ☐ Newspaper delivery with: _____
- ☐ Other: _____

DRESSER / CLOSET LOCK

I ☐ do / ☐ do not want to receive a key for my bed side dresser. (Check one.)

I ☐ do / ☐ do not want to receive a key for my closet. (Check one.)

_____ _____

Signature of Resident or Authorized Representative Date

(If Attorney-In-Fact, check here ☐, and attach a copy of the Power of Attorney)

Daughters of Sarah Nursing Center, Inc.

DISCLOSURES

RESIDENT NAME: _____ ROOM NUMBER: #_____

MEDICARE COVERAGE

Provided that the type and nature of the care you require qualifies under Medicare criteria, Medicare may cover your care for **up to** 100 days in a benefit period (which "benefit period" must be preceded by a 3-day qualifying hospital stay). Medicare coverage will end if you use up all 100 days in the benefit period, **or** you no longer meet the Medicare criteria for care needs.

Medicare provides structured guidelines as to the necessity of qualified care, which our staff must follow. Please note that, as a result, the necessity to receive Medicare care could end anywhere within the 100 day period. At such time that you no longer meet the Medicare guidelines, the Center will give a much notice as possible given your medical progress.

If Medicare does apply, the first 20 days of care are paid in full by Medicare Part A. Thereafter, you will be liable for payment of a co-insurance amount, which will be billed to you.

PRIVACY RIGHTS

Daughters of Sarah Nursing Center respects the privacy of your medical records, and we will take all reasonable precautions to secure and protect that privacy. Only when we deem it appropriate and necessary, we will provide the minimum needed information to those we feel are in need of your health care information for the purposes of treatment, payment, or health care operations. We also want you to know that we support your full access to your personal medical records in accordance with applicable provisions of the law.

The Center has prepared a "**Notice of Privacy Practices**", a copy of which you hereby acknowledge has been provided to you. This notice outlines the Center's practices and policies regarding your Personal Health Information ("PHI"). The Center reserves the right to amend its privacy practices at any time. If the privacy practices are amended, a revised Notice will be posted in the Center. Further, you may request a copy of the current **Notice of Privacy Practices** from the Privacy Officer at any time.

You may refuse to consent to the use or disclosure of your PHI or you may request that restrictions be made, but you must to do in writing. However, if you refuse to disclose your PHI, we have the right to decline to treat you. If you consent to disclose your PHI, you may elect in the future to refuse to allow disclosure, but you may not revoke actions that were taken in reliance upon a previously signed consent.

I acknowledge receipt of the above Disclosures, receipt of the **Notice of Privacy Practices,** and I hereby consent to the disclosure of my Personal Health Information.

_____ _____

Signature of Resident or Authorized Representative Date