**SHAE PARTNERS SERVICE REQUEST**

**ASSISTED LIVING**

***DEMOGRAPHIC INFORMATION***

**Facility Partner Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_

Facility Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

 (Last) (First) (MI)

DOB\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ Social Security # \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

Gender: [ ] Male [ ] Female

**Insurance Information:**

Medicare: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicaid: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party:**

Is patient capable of making own healthcare decision: [ ] yes [ ] no

Check One: [ ] Healthcare POA [ ] Legal Guardian [ ] No current POA or Legal Guardian

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent for Services and Acknowledgement of Receipt of Policies:**

I request the above services of Carol Gibbs, MD and/or clinicians supervised by Carol Gibbs, MD as Senior Health and Education Partners, PLLC (SHAE) and request that payment authorized insurance (including Medicare) benefits be made on my behalf to SHAE for these services. I authorize any holder of medical information about me to release to my insurance company or to the Centers for Medicare and Medicaid Services and its agents and information needed to determine these benefits or the benefits payable to /for related services, including but not exclusive of a clinical diagnoses, treatment plans and summaries and/or copies of the entire record. By signing this agreement, you agree that SHAE Partners can provide the requested information to your carrier. I understand that my insurance company may assign a portion of the bill as patient liability. I understand that my records will be kept on file at the facility where services are provided and securely in an Electronic Medical Record. I authorize the release of information to my Attending Physician and /or facility as applicable. My responsible party (financial agent) may be informed that I am receiving services for billing purposes unless I request otherwise. I authorize SHAE Partners to seek emergency medical care on my behalf if deemed necessary. I have received SHAE’s Notice of Privacy Practices and Client Rights and Grievance Policies. I acknowledge that I have the right to refuse treatment as described in the statute without threat or termination of services except as outlined in G.S. 122-C-57(d); 10A NCAC 27D . 0303 (c). This consent for treatment may be withdrawn at any time.

**Medication Consent**

The risks, side effects, benefits, and possible drug-drug interactions of possible prescribed medication(s), as well as those of all medications currently prescribed by this office for this patient, are understood by the patient or his/her legal guardian, including, where applicable, their risks in pregnancy, in the elderly, and other pertinent risk factors, such as any FDA black box warnings. Alternatives to medications, such as therapy and non-medication strategies, are understood. The patient or his/her legal guardian are indicating understanding and have given informed consent for medication(s) and or therapies to be prescribed for their intended use as part of the treatment process. Some of the major relevant side-effects reviewed, listed below, by class, include:

**Donepezil, galantamine, and rivastigmine** improve the function of nerve cells in the brain and are used to treat dementia. People with dementia usually have lower levels of the chemical acetyl-choline, which is important for the processes of memory, thinking, and reasoning. Possible side effects include nausea, vomiting, loss of appetite/weight loss, diarrhea, weakness, dizziness, drowsiness, and shakiness (tremor) may occur as your body adjusts to the drug. These effects usually occur when you start the medication or increase the dose and then lessen.

**Antidepressant/Anxiolytic/Sedative-Hypnotic/Alpha-1 Agonist** If patient was or is being prescribed one of these classes of medications for his/her condition(s), possible side effects and risks include the risk of nausea, sedation, headaches, falls, insomnia, agitation, and possible suicidal or homicidal ideations or gestures, especially in children and adolescents, as well as other relevant risks and side effects that might pose a risk or danger to the patient, including off-label use, if applicable.

 **Antipsychotic/Mood Stabilizers/Anti-Epileptics** If patient was or is being prescribed one of these classes of medications, possible side effects and risks include the risk of side effects such as blood dyscrasias, weight gain, diabetes, insulin resistance, endocrine abnormalities, tardive dyskinesia, dystonic reactions, EPS, NMS, renal and liver impairment, sedation, nausea, insomnia, agitation, and possible suicidal or homicidal ideations, especially in children and adolescents, risk of sudden death in the elderly, as well as other relevant risks or side effects that might pose a risk or danger to the patient, including off-label use, if applicable, and the possible requirement for routine lab/blood monitoring.

The patient or his/her parent or legal guardian may ask any additional questions about, and discuss, these and other possible risks, side-effects, and off-label uses by calling 919-457-1517.

**Please Check All boxes to Acknowledge:**

[ ] Psychiatric Medication Management and/or Psychotherapeutic Services are Requested

[ ] I acknowledge that I have read and understand SHAE’s consent policies and consent for services by SHAE Partners

[ ] I acknowledge that I have received SHAE’s Notice of Privacy Practices, Client Rights and Grievance Policies.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

 (Last) (First) (MI)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Signature\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Legal Representative Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Signature\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature (Required)

**Verbal Consent (if signature cannot be obtained):**

[ ] Verbal Consent by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_ Time:\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (must have **2 witnesses** for verbal consent)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1st Witness Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2nd Witness Signature

Patient consents to treatment but was unable to sign acknowledgement forms due to

(be specific-i.e., blind, has dementia, has legal guardian):

When complete, please fax to **919-363-7697** along with patient’s demographics and insurance.

***\*\*PLEASE ATTACH A PHOTOCOPY OF***

 ***PATIENT FACE SHEET \*\*\****

**SENIOR HEALTH AND EDUCATION PARTNERS, PLLC**

**SHAE Partners**

**NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION**

***THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY***

**A. INTRODUCTION**

During the course of providing services and care to you, SHAE Partnersgathers, creates, and retains certain personal information about you that identifies who you are and relates to your past, present, or future physical or mental condition, the provision of health care to you, and payment for your health care services. This personal information is characterized as your “protected health information.” This Notice of Privacy Practices describes how SHAE Partnersmaintains the confidentiality of your protected health information, and informs you about the possible uses and disclosures of such information. It also informs you about your rights with respect to your protected health information.

**B. SHAE Partners’S RESPONSIBILITIES**

SHAE Partners is required by federal and state law to maintain the privacy of your protected health information. SHAE Partners is also required by law to provide you with this Notice of Privacy Practices that describes SHAE Partners’slegal duties and privacy practices with respect to your protected health information. SHAE Partners will abide by the terms of this Notice of Privacy Practices. SHAE Partners reserves the right to change this or any future Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that it maintains, including protected health information already in its possession. If SHAE Partners changes its Notice of Privacy Practices, it will personally deliver or mail a revised notice to you at your current address.

**C. USE AND DISCLOSURE WITH YOUR AUTHORIZATION**

SHAE Partnerswill require a written authorization from you before it uses or discloses your protected health information, unless a particular use or disclosure is expressly permitted or required by law without your authorization. SHAE Partnershas prepared an authorization form for you to use that authorizes SHAE Partnersto use or disclose your protected health information for the purposes set forth in the form. You are not required to sign the form as a condition to obtaining treatment or having your care paid for. If you sign an authorization, you may revoke it at any time by written notice. SHAE Partnersthen will not use or disclose your protected health information, except where it has already relied on your authorization.

**D. HOW SHAE Partners MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION**

**1. Permissive Disclosures**

SHAE Partners may, in its discretion, use or disclose your protected health without your written authorization in the following circumstances:

a. Your Care and Treatment

SHAE Partners may use or disclose your protected health information to provide you with or assist in your treatment, care and services. For example, SHAE Partners may disclose your health information to health care providers who are involved in your care to assist them in your diagnosis and treatment, as necessary. SHAE Partners may also disclose your protected health information to individuals who will be involved in your care if you leave the SHAE Partners.

b. Billing and Payment

i. Medicare, Medicaid and Other Public or Private Health Insurers – SHAE Partners may use or disclose your protected health information to public or private health insurers (including medical insurance carriers, HMOs, Medicare, and Medicaid) in order to bill and receive payment for your treatment and services that you receive at the facility. The information on or accompanying a bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. SHAE Partners will electronically transmit required health information according to Federal and State requirements.

ii. Health Care Providers – SHAE Partners may also disclose your protected health information to health care providers in order to allow them to determine if they are owed any reimbursement for care that they have furnished to you and, if so, how much is owed.

c. Health Care Operations

SHAE Partners may use your protected health information for health care operations at SHAE Partners. These uses and disclosures are necessary to manage the facility and to monitor our quality of services and care. For example, we may use your protected health information to review our services and to evaluate the performance of our staff in caring for you.

d. Licensing and Accreditation

SHAE Partners may disclose your protected health information to any government or private agency, such as to the North Carolina Department of Health Services and the North Carolina Department of Social Services, responsible for licensing or accrediting SHAE Partners so that the agency can carry out its oversight activities. These oversight activities include audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight.

e. SHAE Partners’s Special Directory

SHAE Partners maintains a Special Directory of patients to allow staff to provide certain basic information to members of the clergy who serve SHAE Partners or to other persons who ask for patients by name. Unless you notify SHAE Partners that you object, it will include certain limited information about you, such as your name, your location in SHAE Partners, your general condition, and your religious affiliation in its Special Directory.

f. Individuals Involved in Your Care or Payment for Your Care

Unless you specifically object, SHAE Partners may disclose to a family member, other relative, a close personal friend, or to any other person identified by you, all protected health information directly relevant to such person’s involvement with your care or directly relevant to payment related to your care. SHAE Partners may also disclose your protected health information to these same individuals to assist in notifying them of your location, general condition, or death.

g. Disaster Relief

SHAE Partners may disclose your protected health information to a public or private entity authorized to assist in disaster relief efforts.

h. Business Associates

SHAE Partners may contract with certain individuals or entities to provide services on its behalf. Examples include data processing, quality assurance, legal, or accounting services. SHAE Partners may disclose your protected health information to a business associate, as necessary, to allow the business associate to perform its functions on the SHAE Partners’s behalf. SHAE Partners will have a contract with its business associates that obligate the business associates to maintain the confidentiality of your protected health information.

i. Hospital Peer Review

SHAE Partners may disclose your protected health information to hospital medical staffs to aid in the credentialing of applicants and in the peer review of members.

j. Organ Procurement

SHAE Partners may disclose your protected health information following your death to an organ procurement agency or tissue bank in order to aid in using your organs or tissues in transplantation.

k. Appointment Reminders

SHAE Partners may use or disclose your protected health information to remind you about appointments.

l. Treatment Alternatives or Health-Related Benefits and Services

SHAE Partners may use or disclose your protected health information to inform you about treatment alternatives or health-related benefits and services that may be of interest to you.

m. Members of Workforce

It is SHAE Partners’s policy to allow members of its workforce to share patients’ protected health information with one another to the extent necessary to permit them to perform their legitimate functions on SHAE Partners’s behalf. At the same time, SHAE Partners will work with and train its workforce members to ensure that there are no unnecessary or extraneous communications that will violate the rights of its patients to have the confidentiality of their protected health information maintained.

n. Veterans

SHAE Partners may use and disclose to components of the Department of Veterans Affairs medical information about you to determine whether you are eligible for certain benefits.

o. Workers’ Compensation

SHAE Partners may use or disclose your protected health information to comply with laws relating to workers’ compensation or similar programs.

**2. Mandatory Disclosures**

SHAE Partners will disclose protected health information to outside persons or entities without your written authorization as required by law in the following circumstances:

a. Court Order; Order of Administrative Tribunal

SHAE Partners will disclose protected health information in accordance with an order of a court or of an administrative tribunal of a government agency.

b. Subpoena

SHAE Partners will disclose protected health information in accordance with a valid subpoena issued by a party to adjudication before a court, an administrative tribunal, or a private arbitrator. Reasonable efforts will be made to notify you of the subpoena, or of efforts to obtain an order or agreement protecting your protected health information.

c. Law Enforcement Agencies

SHAE Partners will disclose protected health information to law enforcement agencies in accordance with a search warrant, a court order or court-ordered subpoena, or an investigative subpoena or summons.

d. Coroner

SHAE Partners will disclose protected health information to a coroner where the coroner requests the information to identify a decedent; to notify next of kin; or to investigate deaths that may involve public health concerns, suspicious circumstances, elder abuse, or organ or tissue donation.

e. Elder Abuse Reporting

SHAE Partners will disclose protected health information about a patient who is suspected to be the victim of elder abuse to the extent necessary to complete any oral or written report mandated by law. Under certain circumstances, SHAE Partners may disclose further protected health information about the patient to aid the investigating agency in performing its duties. SHAE Partners will promptly inform the patient about any disclosure unless SHAE Partners believes that informing the patient would place the patient in danger of serious harm, or would be informing the patients personal representative, whom the Provider believes to be responsible for the abuse, and believes that informing such person would not be in the patient’s best interest.

f. National Security and Intelligence Activities, Protected Services for the Patient and Others

SHAE Partners will disclose protected health information about a patient to authorized federal officials conducting national security and intelligence activities or as needed to provide protection to the Patient of the United States, certain other persons or foreign heads of states, or to conduct certain special investigations.

g. Other Disclosures Required by Law

SHAE Partners will disclose protected health information about a patient when otherwise required by law.

**E. YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION**

You have the following rights with respect to your protected health information. To exercise these rights, contact SHAE Partners at the following address: SHAE Partners, 5306 NC Hwy 55, Suite 105, Durham, NC 27713 Attention: Privacy Official.

a. Right to Request Access

You have the right to inspect and copy your protected health information maintained by SHAE Partners. In certain limited circumstances, SHAE Partners may deny your request as permitted by law. However, you may be given an opportunity to have such denial reviewed by an independent licensed health care professional.

b. Right to Request Amendment

You have the right to request an amendment to your protected health information maintained by SHAE Partners. If your request for an amendment is denied, you will receive a written denial, including the reasons for such denial, and an opportunity to submit a written statement disagreeing with the denial.

c. Right to Request Restriction

You have the right to request restrictions on the use and disclosure of your protected health information for treatment, payment or health care operations, or providing notifications regarding your identity and status to persons inquiring about or involved in your care. SHAE Partners is not required to grant your request, but if it does, it will comply with your request, except in an emergency situation or until the restriction is terminated by you or SHAE Partners.

d. Right to Request Confidential Communications

You have the right to request that SHAE Partners communicate protected health information to the recipient by alternative means or at alternative locations.

e. Right to an Accounting

You have the right to receive an accounting of disclosures of your protected health information created and maintained by SHAE Partners over the six years prior to the date of your request or for a lesser period. SHAE Partners is not required to provide an accounting of the following disclosures:

• To carry out treatment, payment, and health care operations;

• To respond to your requests for access to protected health information;

• To include your information in the SHAE Partners’s Special Directory;

• To aid in the identification or care of a patient; or

• To any recipient prior to April 14, 2003 or for protected health information created more than six years before the date of your request for an accounting.

f. Right to Receive a Copy of the Notice of Privacy Practices

You have the right to request and receive a copy of SHAE Partners’s Notice of Privacy Practices for Protected Health Information in written or electronic form.

**F. COMPLAINTS**

If you believe that your privacy rights have been violated, you may file a complaint with SHAE Partners at the following address: 5306 NC Hwy 55, Suite 105, Durham, NC 27713. Attention: Administrator. **SHAE Partners will not retaliate against you if you file a complaint.**

**The effective date of this Notice of Privacy Practices is October 15, 2014**

**CLIENT RIGHTS**

Each client has the right to treatment, including access to medical care and habilitation, regardless of age or degree of disability. G.S. 122C-51. Each client has the right to an individualized treatment plan. Each client has the right to be free from unnecessary or excessive medication. Medication shall not be used for punishment, discipline, or staff convenience. SHAE Partners Physicians, Physician Assistants, and Nurse Practitioners will prescribe medications in accordance with accepted medical standards and will document such prescriptions and such medications in the client's record. Unless treatment is under court order, each client or legally responsible person, or health care agent named pursuant to a valid health care power of attorney, has the right to consent to or refuse treatment offered by SHAE Partners. Consent may be withdrawn at any time by the person who gave consent. If treatment is refused, the clinician should determine whether treatment in some other modality is possible. If all appropriate treatment modalities are refused, the client may be discharged from services unless treatment is court-ordered.

SHAE Partners employees do not inflict or recommend corporal punishment of any client. SHAE Partners employees do not order or use physical restraints, seclusion, or isolation. Each client shall be free from unwarranted invasion of privacy. Generally, SHAE Partners staff does not conduct searches of the client or his/her living area or seizures of property, but SHAE Partners may recommend such searches to be conducted in accordance with facility policies.

SHAE Partners will provide each client/legally responsible person seen under a Mental Health Contract with a written summary of client rights. Clients shall be informed of their rights to contacts Disability Rights North Carolina (DRNC), the statewide agency designated under State law to protect and advocate for the rights of persons with disabilities. Explanation shall be in a manner consistent with the client's or legally responsible person's level of comprehension.

**GRIEVANCE POLICY**

A grievance is defined by Senior Health and Educations Partners, PLLC (SHAE) as:

Client complaint or expression of dissatisfaction regarding service delivery, or any

expression of dissatisfaction by the service provider.

II. **Procedures**

1. Client or service provider expresses dissatisfaction verbally or in writing.

b. SHAE staff member will attempt to resolve situation with the client or service

provider.

c. If this is not possible, then the SHAE staff who receives complaint shall

notify Terrence Laster, Quality Assurance Coordinator, who will document the complaint in the

Grievance Log. The Grievance Log shall include the following information:

**Client ID# (not name)**

**Nature of complaint**

**Identification of those involved**

**Date complaint received and by whom**

**Summary of follow-up activities**

**Date grievance referred to QA Committee, if necessary**

**Date of resolution**

d. The Quality Assurance Coordinator will be responsible for collecting relevant

information about the grievance, for taking action to resolve the grievance and for

documenting all progress.

e. The Quality Assurance Coordinator will attempt to resolve the complaint between the

parties involved. If no satisfaction results, and disenrollment or termination of a contract

might be appropriate, the Quality Assurance coordinator will present the situation to the

Quality Assurance Committee for a decision.

f. Thirty days after expressing grievance, clients or service providers will receive in writing

all grievance facts and decisions.

If this procedure is not clear, or you have any questions, please call Agency Director

at 919-457-1517