160 West Street, Milford MA 01757
Phone: 508-473-CARE (2273)
Fax: 508-473-2275

Authorization for Service

Facility Name: _____

We are committed to providing the best comprehensive, quality health services to our residents. We offer in-house ancillary services. We have chosen ***TransCare Mobile Health Services*** to be our primary provider for these services.

I hereby give permission to TransCare Mobile Health Services, to examine and/or administer treatment as necessary in the diagnosis & treatment related to the following specialties:

Audiology **Yes**_____ **No**_____ **Dentistry** **Yes**_____ **No**_____

Optometry **Yes**_____ **No**_____ **Podiatry** **Yes**_____ No_____

Resident & Guarantor Information:

Resident Name:_____ **Date of Birth:**_____

Address: _____ **SSN:** _____

Phone #: _____ **Cell Phone #:** _____

Email:_____ **Last PCP Visit:** _____

Race/Ethnicity: _____ **Marital Status:** _____

Insurance Information: (Skip if facility face sheet is up to date and is attached.)

Primary Insurance Carrier: _____**Primary Dr:**_____
Insurance I.D. #: _____ **Group #:**_____
Insurance Address as listed on card: _____
_____
Secondary Insurance Carrier: _____
Insurance I.D. #: _____ **Group #:**_____
Insurance Address as listed on card: _____
_____
Pharmacy:_____
Pharmacy Location:_____

_____ **Resident is self - guarantor.**

_____**Health Care Proxy (HCP) or Power of Attorney(POA) is invoked. (See info below)**

_____ **Another party is financially responsible for resident's medical care. (See info below)**

Patient name: _____ **Date of birth:** _____

Person financially responsible for this account; (skip if resident is self guarantor):

Name: _____ **Home Phone:** _____

Work Phone: _____ **Cell Phone:** _____

Address: _____

Email Address: _____

Relationship to Resident: _____

RESIDENT HEALTH & MEDICATION HISTORY (Skip this section if facility face sheet is up to date, contains this information and is attached.)

Medical History: *(check if you had or have any of the following)*

___Diabetes ___Type 1 ___Type 2 ___Controlled ___Uncontrolled
___Hypertension (High Blood Pressure) ___Tuberculosis ___Asthma ___Kidney Disease
___Bleeding/Clotting Disorders ___Rheumatic Fever ___Anemia ___Gout
___PVD (Circulation Disease) ___Arthritis ___Cancer ___Epilepsy
___Heart Disease ___Other(s):_____
___High Cholesterol _____

Past Surgical History: *(Please include date of surgery):*

_____
_____
_____

Medications & Allergies:

Current Medications: (Including Non-Prescription and Herbal Medications you are currently taking)

_____
_____
_____
_____
_____
_____

Allergies: *(Please list any known allergies and reactions)*

____No Known Allergies ___Penicillin: _____
___Local Anesthetic:_____ ___Iodine: _____
___Sulfa: _____ ___Aspirin:_____
___IV Dye: _____ ___Latex: _____
___Tape:_____ ___Other: _____

Patient name: _____ **Date of birth:** _____

HIPPA: Notice of Privacy Practices : This note describes how medical information about you can be used and how you can get access to this information. Please read carefully.

Your medical record is protected under HIPAA federal law. There are limitations upon to whom and under what circumstances your medical information can be disclosed. **We do not share your private medical information with anyone including your spouse, parent or employer unless you request it or unless required by law.**

The law allows us to share your medical information with your insurance company in order to verify eligibility and that payment is appropriated for the visit. They may also review your record to ensure that we meet quality standards.

We share information with other providers who are treating you or who referred you to us for consultation or treatment. We also provide information about your care and diagnosis when we request tests at the hospital or labs, such as x-ray or laboratory testing. These other providers are also required to protect the confidentiality of your health information under HIPAA.

We may consult you by mail or leave a general message by phone, but we will not give your test results or other private information to a family member without your permission.

We are not affiliated with any drug companies or other marketing services and will not release your health information to anyone for the purpose of marketing services to you.

We may, however, give you a reminder by phone of an upcoming appointment.

We may disclose information to the FDA in the event of an adverse drug reaction, as required by law, to the Dept. of Public Health in the event of certain communicable diseases.

You may review your medical records or obtain a copy of them upon request. There is a charge for copying depending on the number of pages involved.

HIPAA also allows you to make additions or corrections to your medical records. If you have questions about our policy of protecting your private medical record, you may discuss them with our Executive Director.

Authorization: I authorize the release of all necessary medical and insurance information to secure payment for services provided. I hereby assign all insurance benefits to the ***TransCare Mobile Health Services'*** provider for their services rendered for the above resident. This assignment includes any benefit payable by Medicare, Medicaid, and other health insurance programs of which the resident is a beneficiary.

Managed Care Patients: I understand that it is my responsibility to have proper authorization from my primary care physician prior to each date of service. If I do not have the proper authorization, I understand that I may be denied treatment or billed accordingly. I further understand that it is my responsibility to insure the provider is on the insurance plan.

I have read the above Privacy Practices.
I have received the patient Bill of Rights (see reverse side)
I certify the information given on this form is true and correct to the best of my knowledge.
I will notify you of any changes in my status or the above information.

Signature: _____ Date: _____

Relationship to Resident: _____

Patient name: _____ Date of birth: _____

PATIENT BILL OF RIGHTS

These Are Your Rights:

- You have the right to receive considerate care that is respectful of your personal beliefs and cultural and spiritual values.
- You have a right to know all the facts we have about your illness, treatments and possible outcomes, and to have these facts explained to you in terms you can understand & to have your questions answered concerning your condition, prognosis and treatment. Your doctor or other health care giver will give these facts to you.
- You have the right to know the name and specialty of the doctor responsible for your care.
- You have the right to say yes to treatment. You also have the right to say no or refuse treatment.
- You have the right to be examined in private by your doctor or other health care giver, and you have the right to talk to your doctor in private.
- You have the right to have all things explained to you.
- You have the right to look at your medical records and get a copy for a reasonable fee.
- You have the right to receive written notice of how your health information will be used and shared in order for you to receive the highest quality of care. This is called our Privacy Notice and it contains patient rights and our legal duties regarding your health information. You may request a copy of this Privacy Notice from any staff member.
- You, your family, your significant other or your guardian have the right to report concerns about safety to your doctor, nurse or other health care giver or by calling our executive director at 508-473-2273 or emailing to services@transcaremobilehealth.com
- You, your family, your significant other or your guardian have the right to tell us when something is wrong. This is called presenting a complaint. If you present a complaint, your care will not be affected in any way. If you have a problem that you cannot solve with your doctor, nurse or other caregiver, please call the Executive Director at 508-473-2273. If you send a complaint by fax, e-mail or written letter, TCMHS will acknowledge your communication within two business days. A representative from TCMHS will contact you, review your complaint, and make every effort to resolve your concerns at that time. If your complaint cannot be resolved in a timely manner it will become a grievance. TCMHS will review and resolve the grievance within 10 business days. A TCMHS representative will communicate with you if there is no resolution within the above time frames. A letter will be sent to you with the resolution. A letter will be sent to you that will include the name of the TCMHS contact, steps taken for the review, results of the review, and the completion date.
- You have the right to file a complaint with an outside agency. You can file a quality of care complaint to the Massachusetts Division of Healthcare Quality at 617-753-8150 or to The Joint Commission at 800-994-6610. If you think your civil rights have been violated, you can call the Massachusetts Attorney General's Office at 617-727-2200. You may also call your local ombudsmen and we will provide a list of ombudsmen phone numbers at your request.

These Are Your Responsibilities:

- Be honest with us and tell us all you know about your present illness, including other times you have been in the hospital, your health history, your current symptoms and anything else you know about your health that would help us treat you.
- Tell us the medicines you are taking, including the strength and how often you take them. Include over the counter medications, dietary supplements and herbal products you take and/or alternative medicines or treatments that you receive. Talk about any allergies or reactions you have had to any medications in the past.
- Follow the treatment plan recommended by the practitioner primarily responsible for your care.
- Tell us if you do not understand what our staff is saying to you or if you do not understand what they are telling you to do; also please tell us if you think you will not be able to do what is asked of you during your care.
- Accept the responsibility for your actions if you refuse treatment or do not follow your practitioner's instructions.
- Report unexpected changes in your condition to your doctor, nurse or other caregiver.
- Respect the property and privacy of others.
- To know your insurance coverage and referral requirements and to provide TCMHS with all insurance and payment information. If you have any questions about any of this information, or would like a copy of the law called the Massachusetts Patient Bill of Rights, please call the office at 508-473-2273.

Patient name: _____ **Date of birth:** _____