REQUIRED FOR FIRST VISIT

Email to: PatientConsentForm@CuranaHealth.com
Or Fax to: 877-384-3106

Consent to Treat

Patient Name: ____________________

Date of Birth: __________ **Patient State:** __________ **Patient Zip Code:** __________

Patient Gender: ☐ Female ☐ Male ☐ Other ☐ Unknown

Patient or Patient Representative Phone Number: ____________________

Patient or Patient Representative Email Address: ____________________

Community Name (If your healthcare providers visits you in your home, please write 'home'):

____

Residential Setting (please check a box that best describes your senior living residence):

☐ Independent Living ☐ Assisted Living ☐ Home

☐ Memory Care ☐ Long-Term Care/Skilled Nursing

☐ **Primary Care Opt Out:** If you already have an established Primary Care Doctor and do not need Primary Care Services from Curana Health at this time, check here.

COMMUNICATION PREFERENCES

I prefer to be contacted by: ☐ Email ☐ Phone ☐ Both email and phone

☐ I consent to receiving marketing messages from Curana Health.

General Consent to Treat: TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision to undergo any suggested treatment or procedure after knowing the potential benefits as well as the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form provides us with your permission to perform any reasonable and necessary evaluation to identify the appropriate treatment and/or procedure for any identified condition(s), as well as any reasonable and necessary medical examinations, testing, and treatment for the same.

By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; (2) you consent to treatment by any Curana Health and its affiliated entities' provider, (3) you consent to communication via electronic and/or written format, and (4) you consent to the release of information to your healthcare providers as necessary for continued patient care and other related purposes. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your provider, including the purpose, potential risks, and benefits of any test or treatment ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions of your Curana provider.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or their designees as deemed necessary (collectively "Curana Provider"), to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice.

I authorize Curana Health to seek emergency medical care on my behalf if deemed necessary.

I understand that my Curana provider may be required by law to repost suspected abuse or neglect or to disclose my private information if they believe I may harm myself or others.

Consent to Use of Telehealth: Circumstances may arise where medically necessary telehealth visits are required to address your medical needs, including but not limited to after hours and on weekends. By signing below, (1) I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; (2) I consent to treatment by any Curana Health and its affiliated entities' provider; (3) I consent to communication via electronic and/or written format; and (4) to the extent I initiate any such virtual or telephonic visit, I consent to medical examination and treatment via telephonic, video, or other virtual modalities. This consent will remain fully effective until it is revoked in writing. I have the right at any time to discontinue services. I have the right to discuss the treatment plan with my provider, including the purpose, potential risks and potential benefits of any test or treatment ordered for me. If I have any concerns regarding any test or treatment recommended by my health care provider, Curana encourages me to ask questions of my Curana provider.

Consent to Use of Remote Medical Monitoring Devices: I voluntarily request my Curana Provider to use remote medical monitoring devices as reasonable and medically necessary to identify, evaluate, and monitor any medical conditions or diagnoses I may have and determine appropriate treatment and/or procedures for those conditions or diagnoses. Remote medical monitoring devices may include, as determined by my Curana Provider, devices to monitor blood pressure, heart rate, weight, falls, sleep disturbances, and blood sugar, among other clinically important measures. I acknowledge and consent that some of these devices may involve devices that are installed in my room at my medical facility that will continually monitor my relevant health measures. I acknowledge that any remote medical monitoring devices are not intended to be emergency response devices and that while data is collected continually, the data stream is only reviewed at set intervals for limited purposes. I expressly acknowledge and agree that I will not rely on the existence of these devices in the event of a medical emergency but will contact 911 or the medical staff on duty in my facility. **This paragraph will only apply if my Curana Provider and I agree that remote medical monitoring is an appropriate treatment for me.**

Consent to Behavioral Health Treatment: This paragraph will only apply if Behavioral Health Services are requested. You have the right, as a patient, to be informed about your condition and the recommended behavioral health or diagnostic procedure to be used so that you may make the decision to undergo any suggested treatment or procedure after knowing the potential benefits as well as the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form provides us with your permission to perform any reasonable and necessary evaluation to identify the appropriate treatment and/or procedure for any identified condition(s), as well as any reasonable and necessary behavioral health examinations, testing, and treatment for the same.

By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; (2) you consent to treatment by any Curana Health and its affiliated entities' provider; (3) you consent to communication via electronic and/or written format, and (4) you consent to the release of information, including diagnostic and treatment information, to your healthcare providers as necessary for continued patient care and other related purposes. Psychotherapy notes will be kept confidential as required by HIPAA. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your provider, including the purpose, potential risks, and benefits of any test or treatment ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions of your Curana provider.

I voluntarily request a physician and/or mid-level provider (Nurse Practitioner, Physician Assistant, or licensed psychotherapy provider), and other health care providers or their designees as deemed necessary (collectively "Curana Provider"), to perform reasonable and necessary behavioral health examination, testing, and treatment for the condition which has brought me to seek care at this practice. I authorize Curana to seek emergency medical care on my behalf if deemed necessary.

I understand that my Curana provider may be required by law to report suspected abuse or neglect or to disclose my private information if they believe I may harm myself or others.

Medication Consent: I consent to the following regarding medication(s) and or therapies to be prescribed for their intended treatment process. I understand that there are risks, side effects, benefits, and possible drug-drug interactions of possible prescribed medication(s) as well as those of all medications currently prescribed. I understand, where applicable, there are increased risks in pregnancy, in the elderly, and other pertinent risk factors, such as FDA black box warnings. Alternatives to medications, such as therapy and non-medication strategies, are understood to be prescribed for their intended use as part of the treatment process.

Consent to Use of Ambient Recording of Medical Visit for Charting Purposes: I understand that my Curana Provider has access to a tool to assist them in completing their medical charts. This tool will record the conversation between me and my Curana Provider during my medical visit so that my Curana Provider will be able to have a record of our conversation for charting purposes after the visit. The conversations are stored securely where no one else can access them and are deleted after the provider has completed the medical chart documentation. The provider will turn the tool on to record at the beginning of the medical visit with me and turn it off at the end of the visit with me. The tool will not record any other conversations outside of the medical visit nor will it remain in my room when the provider is not in my room. The tool will assist my Curana Provider in completing the medical chart by providing the content of our conversation during the visit in a written format that the Curana Provider can then use to complete the chart. I consent to my Curana Provider's use of this tool for the purpose of ensuring that my medical records are complete and accurate.

Consent to Share Medical Records with Other Providers: I understand that in order for my Curana Provider to provide the best care to me, my Curana Provider needs a complete picture of my medical history and medical care. I hereby authorize Curana and my Curana Provider to share my medical records, including both receiving records and providing records, with all other health care providers, past or present, from whom I have received or am receiving care or treatment, in any form, including, without limitation, from any Health Information Exchange or Electronic Health Record in which those records might be stored. This authorization is continuing for as long as I am a patient of Curana and my Curana Provider unless I revoke this authorization in writing addressed to the Curana Chief Compliance Officer at 8911 North Capital of Texas Hwy Building I, Suite 1110, Austin, TX 78759.

Assignment of Professional Benefits: I hereby assign all insurance benefits and/or Medicare/ Medicaid benefits to Providers and/or medical professionals providing services to me and authorize direct payment to Providers. This assignment specifically includes, but is not limited to, major medical and disability insurance proceeds and benefits. I agree to pay for any and all charges not paid pursuant to this assignment. A photocopy of this assignment shall be valid as the original.

Statement of Responsibility: I understand that the patient is financially responsible to the Curana provider for all charges not covered by the above assignment. Charges may include co-payments, insurance deductibles, co-insurance or out-of-pocket expenses.

Health Plan Statement: Unless I am a member of the following health plans, I understand that my Curana Provider is not providing treatment on behalf of health maintenance organization membership: Align Senior Care, AgeRight Advantage, Pruitt Health Premier, ProCare, NHC Advantage, KeyCare, Perennial, and Lifeworks Advantage.

Notice of Privacy Practice: I understand that the Medical Group Notice of Privacy Practices describes how medical information about me may be used and disclosed. I acknowledge that the Medical Group Notice of Privacy Practices is available for me to access online, at CuranaHealth.com/Privacy-Policy/ and is also available upon request.

NOTICE OF PRIVACY PRACTICE

To read the Notice of Privacy Practice, scan the QR code on the left.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents. I also acknowledge that I have been given a copy of Curana's Notice of Privacy Practices.

REQUIRED: MEDICAL PATIENT REPRESENTATIVE

Signature of Patient or Medical Patient Representative — Date

Printed Name of Patient or Medical Patient Representative — Relationship to Patient

FINANCIAL PATIENT REPRESENTATIVE

Required only if different than the Medical Patient Representative above.

Signature of Financial Patient Representative — Date

Printed Name of Financial Patient Representative — Relationship to Patient

**If signed by a Patient Representative, please include signing authority paperwork along with this consent form. If more than one representative (i.e., separate Medical and Financial POA) please include authorizing paperwork for each role.*

Facility:______________________________

Veteran Services

The New York State Department of Health now requires ______________________________ to collect data on the Veteran status of our residents and their spouses and report that information to the Office of Veteran's Affairs. As a result, please answer the following questions so that we may comply with the requirement.

Veteran Status	**Yes**	**No**	**If so, which branch did you serve in?**
Have you ever served in the Armed Forces?			
Has your Spouse ever served in the Armed Forces?			

______________________________ will provide you information through https://veterans.ny.gov/content/contactdivision-veterans-services on:

- The name, address, and telephone number of the New York State Division of Veterans' Services;
- The nearest Division of Veterans' Services office;
- The nearest county or city Veterans' Service agency; and
- The nearest accredited veterans' service officer.

Resident's signature: ______________________________ Date: __________

Facility Representative signature: ______________________________ Date: __________

Copy to be placed in the resident's Case Management File

VILLAGE at BASSETT PARK
245 Bassett Road, Williamsville, NY 14221
office (716) 688-4011 fax (716) 204-5947
elderwood.com

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION AND DOCUMENTS

I, ______________________________ hereby authorize professional health care and administrative staff at Elderwood Village at Bassett Park to release medical record information and documents of ______________________________ to appropriate health care professionals or fiscal intermediaries upon request.

Signature (Resident or Responsible Party): ______________________________

Date: ______________________

Signature (Facility Representative): ______________________________

Date: ______________________

WOODMARK PHARMACY

Dear Residents/Responsible Parties:

With the recent passage of the Health Information Portability and Accountability Act (HIPPA) by the Federal government, we are required to inform you of Woodmark Pharmacy's policy regarding the privacy and protection of your health information. This notice describes how medical information about you may be used and disclosed, as well as how you can get access to this information.

As a division of Elderwood Administrative Services, Woodmark Pharmacy must abide by the same rules and regulations set forth in the Elderwood facility's policy regarding medical information. If you have already reviewed the privacy notice carefully, please sign this letter indicating that you have read it, and return it to the facility's receptionist.

Thank you for your understanding and cooperation. Should you have any questions about HIPPA, please feel free to contact our facility's privacy officer or call Woodmark Pharmacy at (716) 631-3381.

Sincerely,

Privacy Officer

****

I have read and understand the privacy notice provided to me by Elderwood Administrative Services and Woodmark Pharmacy:

Print Name: ____

Signature: ____

Facility: Elderwood Village at Bassett Park ____________

8/08 H6-(Pham)-RR (ALF)

Elderwood Village at Bassett Park
245 Bassett Road
Williamsville, NY 14221

BED CHECK WAIVER

I hereby ☐ do ☐ do not want to be part of the bed check program.

______________________________ ______________________
Resident Signature Date

______________________________ ______________________
Agent for Facility Date

Right Moves

Informed Consent and Assumption of Liability

Resident: ______________________________

You are being invited to participate in testing to evaluate your physical fitness. Your participation is entirely voluntary. If you agree to participate, you will be asked to perform a series of assessments designed to evaluate your mobility, upper and lower body strength, aerobic endurance, flexibility, agility and balance. These assessments involve activities such as walking, standing, lifting, stepping and stretching. The risk of engaging in these activities is similar to the risk of engaging in all moderate exercise and may possibly result in muscular fatigue and soreness; sprains and soft tissue injury; skeletal injury; dizziness and fainting; and the risk of cardiac arrest, stroke and even death.

If any of the following apply, you should ***not*** participate in testing without written permission of your physician:

1 Your doctor has advised you not to exercise because of your medical condition(s).
2 You have had congestive heart failure.
3 You are currently experiencing joint pain, chest pain, or dizziness or have exertional angina (chest tightness, pressure, pain, heaviness) during exercise.
4 You have uncontrolled high blood pressure (160/100 or above)

During the assessment you will be asked to perform within your physical comfort zone and never to push to a point of overexertion or beyond what you feel is safe. You will be instructed to notify the person monitoring your assessment if you feel any discomfort or experience any unusual physical symptoms such as shortness of breath, dizziness, tightness or pain in the chest, irregular heartbeat, numbness, loss of balance, nausea or blurred vision. If you are accidently injured during testing, the test administers will be unable to provide treatment to you other than basic first aid. you will be required to seek treatment from your own physician, which must be paid for by you or your insurance company.

You may discontinue participation in testing whenever you wish by asking to do so. By signing this form you acknowledge the following:

1 I have read the full content of this document. I have been informed of the purpose of the testing and of the physical risks I may encounter.
2 I agree to monitor my own physical condition during tests I am asked to perform, and I agree to stop my participation and inform the person administering the assessment if I feel uncomfortable or experience any unusual symptoms.
3 I assume full responsibility for al risk of bodily injury and death as a result of participating in testing. Should I suffer an injury or become ill during testing, I understand that I must seek treatment from my own physician and that I or my insurance will have to pay for this treatment.

My signature below indicates that I have had an opportunity to ask and have answered any questions I may have had, and that I freely consent to participate in the physical assessment.

Signature: ______________________ Date: ______________________

Print Name: ______________________

THE
MedServ
GROUP
Medical Service Professionals

Facility: ______________________ Patient Name (Last, First): ___________________
Date of Service: _____/_____/______ Patient DOB: _____/_____/______

Following examination, my Podiatrist has informed me that I have a/n (please circle)

* ingrown toenail(s)
* infected ingrown toenail(s)
* ulcer(s)

and that treatment on my ______________ toenail(s) is recommended.

I understand that the procedure will be performed using local anesthetic, and my podiatrist has explained the procedure to me in full and has let me know what to expect.

Complications resulting from treatment of ingrown toenails are very rare. Although the risks are low and are not limited to those listed below, I am aware that:

- Some medical conditions may increase the possibility of complications and I have fully disclosed my medical history to my podiatrist.
- I may have a reaction or experience side effects from some of the drugs used in my procedure.
- There are risks associated with any procedure and any anesthetic
- The wound may become infected post operatively and be painful. These symptoms may require oral antibiotic treatment and I may need to see my Primary care physician (PCP) to have these prescribed.
- If I have reduced blood supply due to specific medical conditions, (e.g., Diabetes, smoking, etc.) I understand that healing may be delayed and or non-wound healing.
- I understand that the condition of ingrown toenail(s) may recur.
- I understand that there will be a change to the appearance of my nail.

I further agree that should a needle-stick or sharps injury occur, I will cooperate with testing for blood borne disorders with a medical practitioner and will provide this information to DOH in a timely manner.

FACTORS SPECIFIC TO YOUR CONDITION:

____
____
____

Patient Name: ____________________ Signature: ________________

(If patient is not Alert/Oriented x3, Podiatrist has consulted with the individual listed below and received verbal or written consent by:

* PCP/Unit Manager/Director of Nursing name: __________________________
* Medical Proxy, POA, or family member name: __________________________

914-351-2299 260 Christopher Lane, Suite 102-A
Staten Island, NY 10314 info@themedservgroup.com

CONSENT TO PHOTOGRAPH AND AUTHORIZATION FOR USE OR DISCLOSURE

Name of Subject: ____

I hereby authorize Elderwood and its facilities, their legal representatives and assigns, those for whom Elderwood is acting, and those acting with Elderwood's authority and permission, the irrevocable and unrestricted right and permission to take, use, re-use, publish, and republish photograph(s) of me without restriction as to changes or alterations, whether intentional or unintentional; and, re-use, publish, and republish my name, comments, and demographic information such as age, hometown, and/or affiliation. The term "photograph" includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.

I hereby authorize the use or disclosure of the photograph(s), quotations, and/or demographic information for the following uses or purposes: dissemination to Elderwood staff, physicians, health professionals, and members of the public for educational, treatment, research, scientific, public relations, marketing, news media and/or charitable purposes. I consent to be photographed and authorize the use or disclosure of such photograph(s) in order to assist scientific, treatment, educational, public relations, marketing, news media, and charitable goals, and I hereby waive any right to compensation for such uses by reason of the foregoing authorization.

I waive any right that I may have to inspect or approve the finished product or products and the advertising copy or other matter that may be used in connection therewith or the use to which it may be applied.

I and my successors or assigns hereby hold Elderwood and its facilities, their legal representatives and assigns, those for whom Elderwood is acting, and those acting with Elderwood's authority and permission harmless from and against any claim for injury or compensation resulting from the activities authorized by this agreement.

I hereby warrant that I am of full age and have the right to contract in my own name. I have read the above agreement in its entirety prior to its execution, and I am fully familiar with its contents. This release will be binding upon me and my heirs, legal representatives and assigns.

Date: ______________________________

Signature: ____

Print Name: ____

Representative for resident / registrant or minor (if applicable):

Date: ______________________________

Signature: ____

Print Name: ____

Indicate relationship (e.g., *representative/spouse/financially responsible party, etc.)*:

____

VILLAGE at BASSETT PARK
245 Bassett Road, Williamsville, NY 14221
office (716) 688-4011 fax (716) 204-5947
elderwood.com

Elderwood Village at Bassett Park

RESIDENT APARTMENT FIRE/SAFETY CHECKLIST

This checklist has been developed to assist you in your apartment. It is based upon regulations and recommendations for the New York State Department of Health. If you have any questions, please see Maintenance. Thank you for your cooperation.

- Each room may use one power strip. Extension cords and plug adapters are not allowed.
- Candles are not allowed in your apartment.
- Electric space heaters are not allowed.
- Your room must be kept clear of clutter to prevent falls. Excess newspapers, magazines, boxes, baskets, and furniture must be properly stored.
- Leftover food and spoiled fruit must be discarded in a timely manner. (Ask housekeeping staff for assistance).
- Furniture must not block doorways or pathways at any time.
- The Red magnets stating "ROOM CHECKED AND EMPTY" must be kept on the back of the entry door for use by Staff and Emergency personnel only.
- The use of halogen lamps is not permitted.

____

Resident or Responsible Party Signature

____/____/____

Date:

Designated Personal and Compassionate Caregivers

The New York State Department of Health issued emergency regulations regarding Personal and Compassionate Caregivers in Skilled Nursing Facilities. These regulations allow you to choose a "personal caregiving visitor" which can be a family member, a close friend, or a legal guardian designated by you, or your lawful representative, to assist with personal caregiving or compassionate caregiving for you. Personal caregiving is defined as care and support of a resident to benefit such resident's mental, physical, or social well-being, and compassionate caregiving is defined as personal caregiving provided in anticipation of the end of the resident's life or in the instance of significant mental, physical, or social decline or crisis.

Elderwood is inquiring as to whether you would like to designate a Personal or Compassionate Caregiver in the event of a Public Health Emergency. This would allow the individual you choose to be able to enter the facility after specific screenings to provide you with the care and support you need.

Resident Name: ______________________________ Room #: __________ Date: ______________

Resident's Representative (if applicable): ____

I designate the following individual(s) to be my personal caregiver(s):

____

I designate the following individual(s) to be my Compassionate Caregiver(s)

____

☐ I do not wish to designate a Personal or Compassionate Caregiver at this time.

The facility will periodically check with me to ensure that the above individual(s) remain as my caregivers, or I can change my caregiver(s) at any time by informing the social worker or case manager.

____ ________________

Resident or Resident Representative signature Date

____ ________________

Facility Representative or designee signature Date

☐ Verbal Information gathered by ________________________ Date: ________________

ELDERWOOD VILLAGE AT BASSETT PARK

CREDIT CARD PAYMENT FORM

Date: ________________ Resident Name: ____

Amount: _____________ Card Holder Name: ______________________________________

Billing Address: ____

Phone: _________________________

VISA MC Discover AMEX Card Number: _____ _____ _____ _____

Exp Date: ________________________ CVV: __________________________

Email: ____

Signature: ____

☐ One Time Payment ☐ Reoccurring Payment

Notes:

____

____

Send to Suzette Nugent at snugent@elderwood.com for processing; destroy hard copy after confirmation of receipt.

ELDERWOOD VILLAGE AT BASSETT PARK

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS

I (We) hereby authorize *Elderwood Village at Williamsville*, herein after called Company, to initiate debit entries to my (our) Checking Account / Savings Account indicated below at the Depository Financial Institution named below, hereinafter called Depository, and to debit the same to such account. I (We) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. Law.

Depository Name: ____

Routing Number (9 digits): ____

Account Number: ____

This authorization is to remain in full force and effect until Company has received written notification from me (or either of us) of its termination in such time and in such manner as to afford Company and Depository a reasonable opportunity to act on it.

Name(s): ____

Signature: ___________________________________ Date: _____/_____/_____

Signature: ___________________________________ Date: _____/_____/_____

Note: A voided check for the Checking/Savings Account indicated above MUST be attached to this authorization.

4/10-E60B (ALF)