SWGeriatrics

Welcome,

Thank you for choosing **SWGeriatrics**.

We are so glad you have chosen us! Our goal is to provide you with the highest quality and compassionate care. If you have questions about our admission process, please call our Admissions Direct Line: **520-314-3412,** then press option **0**.

We accept most insurance plans. If you have questions about your insurance coverage, please contact your insurance carrier.

To process patient admission, we require the registration packet to be filled out completely. This includes the signature of the patient. If a Power of Attorney is signing for the patient, then the proper documents are required.

In addition, please attach:

1. A copy of the front and back of the insurance cards

2. A list of medications

3. Medical records, including lab tests, recent hospitalization, and the most recent physical exam from your previous medical provider

4. Any end-of-life decision paperwork, including Power of Attorney, Do Not Resuscitate, or Full Code documents

Please send completed documents via email to **info@swgeriatrics.com** or you can fax to **(520) 314-3413**.

Sincerely,

The **SWGeriatrics** Team

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(520) 314-3412

This form must be filled out completely prior to admission.

How did you hear about us?

Primary contact email address:

Patient Information

Patient Name: SS#: - - DOB: / /

Address: Phone:

City/State/Zip: Facility:

Marital Status: S M W D Sex: M F Height: Weight:

Preferred Pharmacy: Phone: Fax:

Financially Responsible Party (please print)

Name:

Phone:

Address:

City/State/Zip:

Medical Power of Attorney*

Name:

Phone:

*IMPORTANT: *Include the Medical Power of Attorney documents when submitting this form.*

Billing Information

Primary: ID# Group#

Secondary: ID# Group#

Authorization to Treat, Release Information, Photo & Assignment of Benefits

I hereby authorize Linda Wroten, PC, dba, SWGeriatrics and any Nurse Practitioner legally contracted with SWGeriatrics to treat, release medical information, bill my insurance and take my photo for use in the Electronic Medical Record (EMR). I permit a copy of this authorization to be used in place of the original. I request that payment from my insurance company be made directly to SWGeriatrics. I understand that services not covered by my insurance are my financial responsibility. I certify that the information I have provided regarding my insurance coverage is correct. I may revoke this authorization at any time by written notification to SWGeriatrics.

Patient, POA, or Legal Guardian

Signature: Date:

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Credit Card on File Authorization

SW Geriatrics is now keeping a credit or debit card on file as a convenient method of payment for the portion of services that your insurance does not cover, but for which you are liable. Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to your account.

Information to be completed by the card holder

Patient Name:

Cardholder's Name:

Card Number:

Card Type: ☐ VISA ☐ MasterCard ☐ American Express ☐ Discover

Expiration Date:

Security Code:

Billing Address:

Email:

I, , authorize SW Geriatrics to charge the above credit card account for payments owed to my account for services rendered at their office. This authorization relates to all payments not covered by my insurance company for services provided to me by SW Geriatrics. This authorization will remain in effect until I (we) cancel this authorization. To cancel I (we) agree to give a 30 day notification in writing and the account must be in good standing. I agree to update any information regarding this account. The above information is complete and correct to the best of my knowledge.

Cardholder's Name:

Cardholder's Signature: Date:

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Arizona HIPAA Medical Release Form

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I, _____ , authorize _____
(patient name) (name of clinic, individual, etc)

to disclose my health information to SWGeriatrics.

I authorize the following persons (or class of persons) to receive my Protected Health Information (PHI):

Please list anyone that is not on the POA documents or if you do not have POA.

_____
Name (Please print)

_____
Address

_____ ( )
City / State / Zip Phone Number

_____
E-mail Address

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Form B: HIPAA Privacy Program

HIPAA Authorization

I understand information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, genetic testing, Developmental/Behavioral Health/Psychiatric Care, and treatment of alcohol and/or drug abuse. My signature authorizes such release as indicated above.

I understand that the information disclosed by this authorization may be subject to redisclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996 or other applicable federal and state law. However, redisclosure by school officials may be subject to student education records privacy laws.

I understand that if I agree to sign this authorization, I may keep a signed copy of the form. I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. However, if my treatment is related to my participation in a research study, I understand that I may be refused treatment if I do not sign this Authorization.

I have read and understood the terms of this Authorization and I have had a chance to ask questions about the use or disclosure of my health information. I authorize the named entity above (page 1) to use or disclose my health information in the manner described above.

Signature: _____ Date: _____

Description of Authority to sign if personal/legal representative:

_____

MAILING ADDRESS ONLY: 6890 E Sunrise Drive, Suite 120-176, Tucson, AZ 85750

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Current Medications List

Patient Information

Name: DOB: Phone:

Emergency Contact

Name: Phone:

Allergies

Prescription Medications*

Name of Medication	Strength and Frequency

**If you are unsure, most of this information can be found on your prescription bottle.*

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Behavioral Health Consent for Treatment

I, _____ (name), request and authorize SW Geriatrics to provide and arrange for a behavioral health evaluation, diagnosis and treatment. I further consent to such treatment and examination as advised by the professional staff of SW Geriatrics.

I understand that I am financially responsible for any services received.

I understand that information regarding my treatment may need to be shared with other providers for continuity of care and coordination of treatment.

I understand that my consent for treatment shall remain in effect from this date until such time as I am discharged from care.

Patient, POA, or Legal Guardian

Signature: _____ Date: _____

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Consent for Psychotropic Medications

I have discussed the following information with my provider regarding each medication that has been or will be prescribed to me while under their care.

- The diagnoses and target symptoms for the medication being recommended
- The possible benefits/intended outcomes of treatment, as applicable, all available procedures involved in the proposed treatment
- The possible risks and side effects of the medications
- The possible alternatives
- The possible results of not taking the recommended medication
- The possibility that my medication dose may need to be adjusted over time, in consultation with my provider
- My right to actively participate in my treatment by discussing medication concerns or questions with my provider
- My right to voluntarily withdraw consent for medication at any time unless the patient is court ordered for treatment

I understand the medication information that has been provided to me and by signing below I agree to the use of psychotropic medications.

Patient, POA, or Legal Guardian

Signature: _____ Date: _____

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Informed Consent for Psychotherapy

- I understand the purpose of psychotherapy is to assist me in reducing symptoms related to a mental health concern or to improve my interpersonal functioning
- I understand that therapy is a cooperative effort and that I have the right to participate in treatment decisions. I also have a right to assist in developing the treatment plan and to review it periodically for any necessary revisions
- I have the right to refuse any recommended treatments
- I may decline therapy at any time
- I understand that therapy does not guarantee results but working collaboratively with my provider can help improve results
- I understand that my involvement in therapy will be kept confidential
- I understand that I am financially responsible for any treatments received while under the care of my behavioral health provider
- I understand that treatment, in regard to psychotherapy, provided by the psychiatric nurse practitioner, may include but is not limited to: Cognitive behavioral therapy, dialectical behavioral therapy, reminiscence therapy, art therapy and alternative and complimentary methods of therapy such as therapeutic touch. Multiple modalities may be used in a single session and appropriateness of interventions will be based on the psychiatric nurse practitioner's assessment of the patient's ability to participate and engage.

Patient, POA, or Legal Guardian

Signature: _____ Date: _____

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