COMPLETE CARE GROUP

IN-HOUSE SENIOR SERVICES

Meadow Ridge	Maple Hill
____ MC	____ MC
____ AL	____ AL

In-House Senior Services Consent

I hereby request In-House Senior Services to assume responsibility of evaluation and treatment for resident: _____ for the following services (please check box):
(Resident's name)

Audiology Y ☐ | N ☐ **Optometry** Y ☐ | N ☐ **Podiatry** Y ☐ | N ☐

Demographic Information: ***Please attach face sheet and fill out form below.*** *(*) required fields*

Social Security #*: _____ Birthdate*: _____ Gender* (circle): M F

Primary Care Physician*: _____ Last Date Seen*: _____ Physician Phone*: _____

Medical History: Please check all that apply. *

___ Diabetes ___ High Blood Pressure ___ Kidney Disease
___ Ulcers ___ Glaucoma ___ Cataracts Present
___ Macular Degeneration ___ Wears glasses ___ Wears hearing aids

List allergies: _____

Billing Information: ***Please attach copy of insurance cards.*** *(*) required fields*

Primary Insurance: Medicare/MA/MSHO/HMO*: _____ ID #*: _____

Secondary Insurance*: _____ ID #*: _____ Group #*: _____

Responsible Party*: _____ Relationship*: _____

Primary Phone*: _____ Secondary Phone: _____ Email*: _____

Address*: _____
(city) (state) (zip)

_____ I certify that I have not had podiatry services in the past 62 days or I will be responsible for podiatry services.

I understand that In-House Senior Services takes assignment. All bills shall be directed towards Medicare, Insurance, and Public Aid carriers when possible. I am responsible for the deductible and co-insurance when not covered by supplemental insurance as well as non-covered services. I authorize Medicare and my insurance carriers to send payments directly to In-House Senior Services.

I authorize the release of any information from any agencies, or carriers to In-House Senior Services for purposes of administering the medical claims and medical care. I also authorize In-House Senior Services to release any required information to any agencies, insurance carries, or health care provider as needed.

_____ I authorize In-House Senior services to contact me or my responsible party to discuss all services.

I wish to receive a reminder phone call from In-House Senior Services prior to scheduled visits at the number provided here
NAME: _____ NUMBER: _____

I have read and understand In-House's privacy policies regarding the handling of protected health information available on www.inhss.com.

Signature of Patient: _____ Date: _____
(Guardian, Power of Attorney, or Responsible Party)