Please initial each section and sign below

CONSENT FOR TREATMENT

I Hereby consent to be treated by Long Life Care Management, LLC and the members of care team. I understand that this consent in no way compromises my rights as a client. Initial here, _____

CONSENT FOR LABS

Long Life Care Management, LLC may order the collection of blood samples necessary for visits. Your insurance company may or may not apply those labs towards your deductible therefore making it your responsibility. Although we do our best to justify the reason for ordering the labs, you could potentially receive a bill from the lab company. Initial here, _____

HIPAA CONSENT FOR SHARING MEDICAL RECORDS

We sometimes send your medical records to other medical facilities in order to obtain prior authorization for tests that we have ordered. Long Life Care Management, LLC may have to order medical records from other medical facilities for care management. We need your consent in order to do so. Initial here, _____

_____

Client/Guardian Signature

_____

Client/Guardian Printed Name

_____

Today's Date

Welcome! We are your aging life care managers and your care matters. Long Life Care Management honors our clients and families while accompanying and empowering them during the healthcare journey.

Long Life Care Management integrates expertise in chronic, transitional and palliative care. We conduct comprehensive in-home or telehealth assessments to identify problems, address safety and health care concerns, and collaborate to assure that our clients' have the highest quality of life possible.

In addition to the convenience and security, our geriatric care manager can save families money despite being an out-of-pocket cost because their proactive assessments align an individual's condition with services. If it is necessary or at that point in time, care mangers can assess or support home care providers and assisted living residences. We actively review all recommendations with the prescribing primary care provider or specialist.

PLEASE be prepared to provide the following Information:

Does the client currently have an Advance Care Directive or DNR order?	Yes☐ No☐
Is it difficult for the client to get to doctor's office?	Yes☐ No☐
Is the client receiving chronic care management from their doctor?	Yes☐ No☐
Is the client currently on Home Health or Hospice Care?	Yes☐ No☐

PLEASE be prepared to provide the following for your visits*:

Copy of Medicare Card and Secondary Insurance Card (if applicable)	[ ]
State ID, Copays or Co-insurance at the time services	[ ]
Most Recent Doctor or Hospital Summary, Lab or X-ray Results*	[ ]
Current Medications Bottles, including Over-the-Counter Drugs	[ ]
List of your Healthcare Resources or Concerns	[ ]

*Healthcare documents can be faxed to 470-300-1100 prior to visit. Thank you.

Long Life Care Management | CLIENT REGISTRATION FORM | Phone 404-310-3567

Please Write Clearly and Complete All Sections. Thank you.

Client Name	Date of Birth
Street Address	City, State, Zip Code
Primary Care Doctor	Phone Number
Cell phone Number	Home/Work Phone Number
Next of Kin Name	Next of Kin Relationship and Phone Number
Pharmacy Name	Pharmacy Phone Number
Email Address (No Protected Health Information)	
Medicare Number	Advantage Plan Number
Secondary Insurance	Policy Number

Authorization to Release Information and Assignment of Benefits

I authorize the release of any medical information necessary to process Long Life Care Management, LLC claim. I hereby authorize Long Life Care Management, LLC representatives to apply for benefits on my behalf for covered services rendered. I request that payment from my insurance company be made directly to Long Life Care Management, LLC. I certify that the information I have reported, including my insurance policy coverage is correct.

Client/Guardian Signature:	Date:

Financial Agreement

We, the care team of Long Life Care Management, LLC thank you for choosing us. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest quality care management and building a relationship with you and your family. We believe understanding of our clients' financial responsibility is vital to the relationship. Our goal is to not only inform you of the provisional aspects of the financial policy, but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities; please feel free to contact us at 404-310-3567.

Please understand that payment for services is an important part of the care manager/client relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor care management, payment for services will be due at the time of service unless a payment arrangement has been approved in advance. **We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account.**

We accept payments for your convenience: cash, money order, MasterCard, Visa and in-state checks. A $35.00 service fee will be charged for all returned checks. Additionally, you may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security.

Insurance

Please remember that your insurance is a contract between you and your insurance carrier. It is your responsibility to provide all necessary insurance eligibility, identification, authorization, and referral information and to notify our office of any information changes when they occur. Even a pre-authorization of services does not guarantee payment from your insurance carrier. It is the client's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate client payment for all charges. When insurance is involved, we are contractually obligated to collect co-payments, co-insurance, and deductibles, as outlined by your insurance carrier. Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. You as the guarantor are responsible for all out-of-network fees. If we are not contracted with your carrier, we will **not** negotiate reduced fees with your carrier.

Miscellaneous Forms, Additional Information, and Authorizations

We will provide all necessary information to have your benefits released. However, if it becomes necessary to submit redundant or unnecessary information for the completion of the claim forms; there will be an administrative fee, not to exceed **$25.00**, for the additional information.

Missed Appointment Visits

We require notice of cancellations 24 hours in advance. This allows us to offer the appointment visit to another client. If you fail to keep your appointment visits without notifying us in advance: a missed appointment visit fee of **$35.00** will apply. Repeated missed appointment visits without notification may cause you to be discharged from the practice so that we can provide care to other clients. We will provide text, voice or email appointment visits reminders with your written consent by signature below and initial here: _____

Medical Records Fees

Clients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines and exceptions to ensure compliance to client rights. However, **licensed professionals also have the right to be compensated for records, filling of forms, or any administrative paperwork**. Our fees are a reasonable cost-based fee for copies including the copying, supplies, labor, and postage of the files and or summaries in accordance to Georgia law.

I have read and understand the above financial policy. I agree to assign insurance benefits to Long Life Care Management LLC whenever applicable. I also agree, in addition to the amount owed, I am responsible for all costs of collections if such action becomes necessary.

Client/Guardian Signature: _____

Client/Guardian Printed Name: _____

Today's Date: _____