SHAE Medical
Phone: 919-646-4858 Fax: 919-679-7112 shaemedical.com
5306 NC Highway 55, Suite 105 Durham, NC 27713-7812

PATIENT DEMOGRAPHICS: ☐ Attach photocopy of patient's ID Card, OR ☐ Emailed to info@shaemedical.com

First Name: _____ Middle _____ Last _____ Preferred Name: _____

DOB ___/___/___ Social Security # _____ Gender: ☐ Male ☐ Female

Phone number (please mark preferred): ☐ HOME (_____) _____ ☐ Cell Phone: (_____) _____

Patient Email Address: _____

FACILTY/LOCATION OF RESIDENCE

Home vs. Facility/Community Name: _____

Home/Facility Address (including room number): _____

INSURANCE INFORMATION: ☐ attach photocopy of insurance card(s), OR ☐ Emailed to info@shaemedical.com

Medicare #: _____ Medicaid #: _____

Other/Supplemental: _____

FORM OF PAYMENT: Card will be kept on file but not be charged until time of service for co-pays (if required) and after insurance has been billed for any deductibles required for collection by patient's insurance.

Name on Card: _____ Card Number: _____

Expiration (Month/Year): _____ CVV: _____

RESPONSIBLE PARTY: Is patient capable of making own healthcare decision: ☐ Yes ☐ No

Check One: ☐ Healthcare POA ☐ Legal Guardian ☐ No current POA or Legal Guardian

Healthcare POA/Guardian/Emergency Contact: ☐ legal documents attached to this form, OR ☐ emailed to info@shaemedical.com

Healthcare POA/Legal Guardian Name: _____ Phone (_____) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Relationship to Patient: _____ Email Address: _____

☐ Please check here if you consent to receive email updates regarding patient

Name and contact information of any other individuals allowed to obtain details in patient care information

Name: _____ Phone (_____) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Updated 11.14.21

SHAE Medical
Phone: 919-646-4858 Fax: 919-679-7112 shaemedical.com
5306 NC Highway 55, Suite 105 Durham, NC 27713-7812

PATIENT FULL NAME: _____ **PATIENT DATE OF BIRTH:** _____/_____/_____

Consent for Comprehensive Cognitive Assessment and Care Plan, Authorization of Payment & Record Release

1. I request for medical services of SHAE Medical, PLLC and request that payment authorized insurance (including Medicare) benefits be made on my behalf to SHAE Medical, PLLC for medical services including but not limited to:
    a. Chronic care management
    b. Integration of behavioral health integration care management services
    c. Tele-health visits and all communication-based technology services
2. I authorize the release of my medical records to SHAE Medical, PLLC upon its request for dates of treatment going back 2 years from the date below, including all discharge summaries, progress notes, consult notes, laboratory testing, and imaging studies.
3. I authorize SHAE Medical, PLLC to release to my insurance company and/or to the Centers for Medicare and Medicaid Services and its agents and information needed to determine these benefits or the benefits payable to/for related services, including but not exclusive of a clinical diagnosis, treatment plans and summaries and/or copies of the entire record. I also agree that SHAE Medical, PLLC can provide the requested information to my insurance carrier.
4. I acknowledge that I am financially responsible for all charges for services provided to me, including but not limited to any portions of my medical care that my insurance company assigns to me. Once insurance is filed, I authorize the use of my credit or debit card for payment of these balances owed. My responsible party (financial agent) may be informed that I am receiving services for billing purposes unless I request otherwise.
5. I understand my records will be kept on file at the facility where services are provided and securely in an Electronic Medical Record.
6. I authorize SHAE Medical, PLLC to seek emergency medical care on my behalf if deemed necessary.
7. I understand there are risks, side effects, benefits, and possible drug-drug interactions of medication(s) prescribed and myself and/or my legal guardian, understand there are risks, where applicable, during pregnancy, in the elderly, and other pertinent risk factors such as FDA black box warnings. I and/or my legal guardian are indicating awareness and have given informed consent for medication(s) and or therapies to be prescribed for their intended use as part of the treatment process.
8. I have received SHAE Medical, PLLC Notice of Privacy Practices and Client Rights and Grievance Policies. A copy is available on our website at shaemedical.com/npp
9. I acknowledge that I have the right to refuse treatment as described in the statute without threat or termination of services except as outlined in G.S. 122-C-57(d); 10A NCAC 27D . 0303 (c). This consent for treatment may be withdrawn at any time.

Printed Name of Patient/HCPOA: _____ Signature of Patient/ HCPOA _____

Specify relationship to patient _____ Date _____

HIPPA

I have received and read the complete HIPPA Form on the SHAE Medical, PLLC website at shaemedical.com/hippa

Printed Name of Patient/HCPOA: _____ Signature of Patient/ HCPOA _____

Specify relationship to patient _____ Date _____