



RESIDENT'S NAME

Initial Approval

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received a copy, if applicable, of the State's Medical Assistance (Medicaid) Program and information regarding the requirement for Medicare Admission to a skilled nursing facility.

BEAUTICIAN SERVICES

I hereby authorize this facility to allow the facility beautician to cut and generally work with said resident's hair according to the indicated schedule. I release the facility from any liabilities for any or all services provided in the beauty/barber shop. (Refer to Charge Description Listing for extra charges not covered.) Bill to Resident Account

CONSENT TO USE AND DISCLOSE NAME AND BIRTHDAY INFORMATION

Please select one of the the following choices regarding your name and birthday information.

I consent to the use and disclosure of my name and birthday by the facility in the published monthly birthday list and calendar for activity purposes within the facility.

I do not consent to the use and disclosure of my name and birthday by the facility in the published monthly birthday list and calendar for activity purposes within the facility.

FUNERAL HOME ARRANGEMENTS

I understand that in the absence of a stated choice, the facility, by law must contact a funeral home to begin the necessary arrangements. I understand that all financial responsibilities are the expense of the resident and/or responsible party.

My choice of a funeral home is: _____

LAUNDRY CARE

Laundry services will be performed by the facility.

Laundry services will be performed by the family and picked up on a weekly basis, or as needed.

MAIL

I authorize the facility to handle my mail as follows:

I hereby consent that facility staff and/or volunteers may OPEN my mail for me.

I hereby consent that facility staff and/or volunteers may READ my mail for me.

I choose to open and read my mail myself.

MEDICARE ASSIGNMENT

I certify that the following information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. (I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize each physician or organization to submit claim to Medicare for payment to be made.) All treatment must be ordered by my attending physician. This authorization shall apply to the period of time I am a resident of this facility.

NOTIFICATION OF OTHERS

I authorize the facility to notify the following individuals in the event of accident, injury, or adverse change in my condition and/or to discuss any medical information regarding my case, plans for discharge, plans for room change, or financial matters:

1. _____ Phone number: _____

2. _____ Phone number: _____

(cont'd.)
AUTHORIZATION AND RELEASES

RESIDENT'S NAME

Initial Approval

OMBUDSMAN/RESIDENT RIGHTS

I certify that I have received a copy of the Ombudsman letter and a copy of the Texas Department of Human Services, Chapter 102, Human Resources Code Senate Bill 190 and the Federal Statutes, Public Law 10203, Subtitle C., Section 4201, Resident Rights, which guarantees specific rights to Nursing Facility Residents. I have also been given information pertaining to the List of Services for residents of this facility. The contents of these documents have been explained to me, and I understand my rights as set forth therein.

ORGAN DONATION

- As indicated in my authorized, written advance directives, I wish my organs to be available for transplantation upon my death. The facility is to contact: _____ to make the necessary arrangements.
- I do not wish to donate my organs.

OUTING RELEASE

I hereby authorize this facility to transport said resident to various recreational events outside the premises of the facility (with his/her permission) where the attending physician approves such activity for the resident and absolve the facility from responsibility or liability for any unforeseen events or accidents.

Authorization for appointments only.

PHARMACY APPROVAL

I hereby authorize _____ (pharmacy) or the facility contractual service to provide medicines for said resident while at this facility. The pharmacy will send their statement to the resident or responsible party for any co-payment and noncovered medications. This is to be paid within 30 days of the statement date.

I further agree or do not agree to accept generic equivalent medications as designated by my physician.

PHOTO RELEASE

I give permission for said resident to be photographed for social purposes such as films, video tapes and audio recordings, to be published or broadcast in the facility and/or in the public media, and/or publications issued by the facility and for medical purposes.

Medical purposes only.

PHYSICIAN ASSIGNMENT

I have chosen _____ as my attending physician.

PODIATRIST/DENTAL/HEARING/EYE

Upon Physician Orders, I hereby authorize _____ for Podiatry treatment, _____ for Dental treatment, _____ for Hearing services, _____ for Eye care, or facility contractual service(s) to perform and administer such treatments and/or procedures as may be deemed necessary.

RESIDENT NAME (PRINT)	RESIDENT SIGNATURE	DATE
RESPONSIBLE PARTY (IF APPLICABLE)	POWER OF ATTORNEY (MEDICAL/FINANCIAL/BOTH, IF APPLICABLE)	LEGAL GUARDIAN (IF APPLICABLE)
FACILITY REPRESENTATIVE	IF APPLICABLE, REASON RESIDENT UNABLE TO SIGN	