Consent to Treat

Resident Name: _____

Room Number: _____

Resident Number: _____

DOB: _____

SS#: _____

Resident Demographic Information

Address _____ City/State/Zip _____

Home Phone _____ Cell Phone _____ Marital Status _____

Email Address _____

Denomination _____ Church _____

Pharmacy _____ Hospital Preference _____

Does the resident have an active contract with TRAA? ☐ No ☐ Yes #_____

Funeral arrangements in place? ☐ No ☐ Yes, with _____

Primary Emergency Contact

Name _____ Relationship _____

Address _____ City/State/Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Email _____

Secondary Emergency Contact

Name _____ Relationship _____

Address _____ City/State/Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Email _____

Other Emergency Contact

Name _____ Relationship _____

Home Phone _____ Other Phone _____

Please specify above if there is a preference for which phone number should be contacted first: **home, work,** or **cell**

CC: Admission Department and Accounting Office

I understand that my medical information will only be released to and discussed with the individual I have legally designated as my Legal Representative/Power of Attorney/Court Appointed Guardian. This individual is listed as the Primary Emergency Contact. I understand that it is my responsibility, or that of my Representative, to update my family, friends, etc… regarding my medical condition. The other emergency contacts that I have provided will only be contacted by the Facility when my Representative is not available. I understand that Saint Anne Communities is not responsible to contact all emergency contacts provided. I also understand that any changes in my personal information, or that of my Representative and emergency contacts, needs to be given to the Nurse's Station.

It is a regulation that your medical condition(s) be monitored routinely by a Physician during your stay at Saint Anne Communities. Physicians bill separately for these visits. **Please select ONE option below**:

- ☐ **I would like the House Physicians at Saint Anne Communities to oversee my care during my stay at the Facility, and authorize my Primary Care Physician to release my medical information to the Facility for reasons involving my medical care and condition.**
- ☐ **I would like my Primary Care Physician, _____, to follow my care at Saint Anne Communities. I understand that transportation arrangements and costs will be my responsibility.**

Specialty Physician(s)

Ophthalmologist: _____ Dentist: _____

Cardiologist: _____ Other: _____

I voluntarily consent to receive care and treatment at Saint Anne Communities. This includes, but is not limited to nursing care, routine diagnostic procedures, and routine medical treatment by my physician, his/her designees, and the nursing staff of the Facility as is necessary.

Health information can be communicated by fax, mail, computer transmission, and telephone to physicians' offices, clinics, hospitals, pharmacies, laboratories, x-ray companies, and other health care facilities to provide on-going care for a medical or physical condition. Health information is also made available to health care professionals who provide services within the Facility, such as podiatrist, dentist, audiologist, etc…

Health information may be transmitted to Medicare, Medicaid, and insurance companies for Facility reimbursement.

I understand that it is necessary for my photograph to be taken for identification purposes.

_____ _____

Resident/Resident Representative Date

_____ _____

Facility Representative/Witness Date