

Thank you for choosing our community for your nursing and rehabilitation needs. As one of Atlanta's most reputable nonprofit organizations, A.G. Rhodes has set the standard for serving an aging community since 1904. We take great pride in being one of the very few not-for-profit nursing organizations in Georgia, and for providing high quality health care to Atlanta's seniors.

Our vision is to provide personalized, quality care to our residents while preserving their dignity, independence, and quality of life. We commit ourselves to care for all who need our services and believe that the primary purpose of our work is to serve our residents, while striving to maintain open lines of communication with their families. We are proud to be *caring people, caring for people*.

We value your input and want to hear from you. Your feedback is important in our ability to provide individualized care for our residents. If we can do anything to improve your stay, please let us know. If you encounter an A.G. Rhodes employee who exemplifies our vision, please complete a nomination form in their honor

Upon admission, please ask any of our staff members for assistance. We are happy to help.

**Items to bring to your admission**

- Medicare Card
- Insurance Card(s) (if applicable)
- Medicare Part D Insurance Card (if applicable)
- Medicaid Card (if applicable)
- Georgia Advance Directive for Health Care (if applicable)
- Living Will (if applicable)
- Durable Power of Attorney (if applicable)

**Personal Items to bring for your stay at A.G. Rhodes**

- 5 to 7 days of comfortable, loose-fitting clothing
- Rubber-soled shoes
- Personal toiletries

Please make sure all clothing and personal items are properly labeled. A.G. Rhodes offers laundry services free of charge, or family members may choose to launder Resident clothing. ALL items must be properly labeled by our laundry department whether they are laundered at the Facility or elsewhere. To assist you with this task, our Laundry Department can apply cloth laundry labels.

Clothing, blankets, comforters and pillows should also be brought for labeling. Please place all items in a disposable bag with the Resident's name and room number clearly printed on the bag or on a sheet of paper placed inside of the bag. Televisions, cell phones and personal communication devices are welcome. All items should be properly labeled. Labeling all personal possessions may assist in avoiding lost items. It will be the Resident and/or his or her family's responsibility to replace any missing or lost items.

If you would like to set up satellite or phone service, please see your Admissions Director for more information. Personal décor is welcome, and encouraged. If you would like assistance with hanging photographs or shelving, please see someone in the front office. Throw rugs and alternate window treatments are not allowed.

Admission information reviewed with Resident

Notes: \_\_\_\_\_

ADMISSION ASSESSMENT & HISTORY SCREENING

We strive to provide quality, personalized care, and we want to know about the Resident's typical daily activities, interests, preferences and patterns. Please provide us with answers to the following questions so that we can better tailor the care we provide. Thank you for your help!

Resident's Preferred Name \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Birth place (State) \_\_\_\_\_ Number of children \_\_\_\_\_

Referred by \_\_\_\_\_ County of residence \_\_\_\_\_

Highest level of education \_\_\_\_\_ Religious affiliation \_\_\_\_\_

Maiden name \_\_\_\_\_ Hospital preference \_\_\_\_\_

Former occupation \_\_\_\_\_ Would you like the Facility to do Laundry? \_\_\_\_\_

Prior Living Situation: \_\_\_\_\_ Goals: Home / ALF / PCH / LTC / Other

Previous SNF or Rehab dates of stay & locations \_\_\_\_\_

Previous hospitalizations w/in last year (dates and location) \_\_\_\_\_

Funeral Arrangement Information \_\_\_\_\_

# of Brothers \_\_\_\_\_, # of Sisters \_\_\_\_\_, # of Brothers Living \_\_\_\_\_, # of Sisters Living \_\_\_\_\_

**1<sup>st</sup> Contact and Fiduciary Party** (shall act on behalf of the Resident for all financial purposes during Resident's stay, and pay any applicable fees or charges on behalf of the resident from the resident's assets, income or estate. Fiduciary party does not assume financial responsibility for resident out of Fiduciary Representative's personal funds.)

NAME \_\_\_\_\_ **RELATIONSHIP** \_\_\_\_\_

ADDRESS \_\_\_\_\_

**HOME** \_\_\_\_\_ **WORK** \_\_\_\_\_ **CELL** \_\_\_\_\_

**EMAIL** \_\_\_\_\_

**Emergency Contact if 1<sup>st</sup> contact not reached**

NAME \_\_\_\_\_ **RELATIONSHIP** \_\_\_\_\_

ADDRESS \_\_\_\_\_

**HOME** \_\_\_\_\_ **WORK** \_\_\_\_\_ **CELL** \_\_\_\_\_

**EMAIL** \_\_\_\_\_

**One Additional Emergency Contact**

NAME \_\_\_\_\_

HOME \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_

Please indicate the most appropriate response for each of the following:

**Demographic Information**

Gender:

Male  Female

Race/Ethnicity:

American Indian  Asian  Black or African American  Caucasian or White  Hispanic or Latino  
 Native Hawaiian or Other Pacific Islander

Preferred language: \_\_\_\_\_

Marital Status:

Never Married  Married  Widowed  Separated  Divorced

**Assistance Devices**

Use the assistance of Hearing aid(s):  No  Yes: Left  Right  Both

Use the assistance of Eyeglasses:  No  Yes

Dentures and/or Partials:  Both  Lower  Upper

Additional Information: \_\_\_\_\_

**Preferences and Interests** (please check all that apply)

Tub bath  Shower  Bed Bath  Sponge Bath  Snacks between meals

Staying up past 8:00PM  Reading books, newspapers or magazines

Listening to music  Being around pets  Watching television or movies

Group activities  Participating in religious activities or practices

Other (please list): \_\_\_\_\_

Has the Resident had a weight loss of 5% more in 30 days or 10% or more in 180 days?  Yes  No

**Accidents**

Has resident had any falls prior to admission?       NO    YES

If yes, please list occurrences within 30 days of admission: \_\_\_\_\_

Please list any occurrences 2-6 months prior to admission: \_\_\_\_\_

Has resident had any fracture prior to admission?       NO    YES

If yes, please list: \_\_\_\_\_

**ADMISSION AGREEMENT**

This Admission Agreement (Agreement) is entered into by A.G. Rhodes Health & Rehab Atlanta/Cobb/Wesley

Woods (Facility) and «RESIDENT» and/or \_\_\_\_\_,

Fiduciary Party on this \_\_\_\_\_ day of \_\_\_\_\_.

The Facility shall admit those persons whose nursing care and physical needs can be met by the Facility. The Facility shall assume 24 hour responsibility for following physician orders regarding the care and treatment of the resident. The Facility will abide by applicable laws, regulations and protocols. A.G. Rhodes is not an insurer of Resident’s safety or welfare and assumes no liability for such.

The Facility is not responsible for the health, safety or welfare of any Resident who is away from the Facility under the care of any person not directly employed by the Facility.

Items of a Personal nature will not be replaced by the Facility.

The Facility will provide the resident with a 30-day notice prior to a change in fees and charges associated with Facility services. The current room rates and the ancillary charge list are provided in the information packet.

In accordance with the Civil Rights Act of 1964 and its implementing regulations, it is the policy of the Facility to admit and treat all residents without regard to protected class status. No distinction in eligibility for, or in the manner of, providing resident services, are made on this basis.

**Designated Health Care Agents** (if applicable as named in a properly executed Advance Directive)

Below is information provided by the Georgia Department of Human Services Aging Services Division relative to responsibilities and duties of Health Care Agents. Full information can be accessed online at: <http://aging.dhr.georgia.gov>.

**Authorized responsibilities/duties of the health care agent related to the necessary care of the declarant (Resident)**

- Consent to, authorize, withdraw consent from, refuse, withhold, any and all types of medical/surgical care, treatment, programs and/or procedures.
- Sign and deliver all instruments (documents).
- Negotiate and enter into all agreements and contracts binding the declarant.
- Accompany him/her in an ambulance or air ambulance.

- Admit to or discharge the declarant from any health care facility.
- Visit and consult with the declarant as necessary.
- Examine, copy and consent to disclosure of all the declarant's medical records deemed relevant.
- Do all other acts reasonably necessary and carry out duties and responsibilities in person or through those employed by the health care agent; this does not include delegating the authority to make health care decisions.
- Consent to an anatomical gift of the declarant's body, in whole or part, and autopsy and direct the final disposition of declarant's remains, including funeral arrangements, burial, or cremation. *(Note: the law states that the agent can bind the declarant to pay but does not expressly mention binding the estate of the declarant. It may be a good idea to make all arrangements prior to the death of the declarant.)*

### **Fiduciary Party**

The Fiduciary Party shall act on behalf of the Resident for all purposes permitted under applicable law. Fiduciary Party shall pay fees and charges incurred under this Agreement by or on behalf of Resident from the Resident's assets or estate. The Fiduciary Party does not assume the responsibility for payment of fees and costs related to the Resident's care out of the Fiduciary Party's personal funds and will not become personally liable for the payment of the Resident's fees and charges unless misappropriation of Resident funds occurs. I acknowledge that such misappropriation (e.g. Social Security checks, state pension, income checks or other income) of such payments is a violation of the law.

The Fiduciary Party agrees to deliver all of the Resident's funds sufficient to timely pay fees and costs owed to Facility by Resident. The Fiduciary Party agrees not to utilize the Resident's funds for any purpose that does not directly benefit the Resident.

### **Request for Admission and Treatment**

The Resident/Fiduciary Party represents the Resident's condition is such that the Resident requires the care and treatment services provided by the Facility and is requesting voluntary admission. The Resident and/or Fiduciary Party consents and authorizes the Facility to provide physician ordered treatments as reasonable and necessary.

The Resident/Fiduciary Party consents and authorizes any holder of medical or other pertinent information related to the Resident's medical treatment and health benefits to release any and all requested information to A.G. Rhodes.

### **One-Time Assignment of Medicare/Medicaid/Medigap/Supplemental/Commercial Health Insurance and Health Plan Benefits**

The Resident and/or Fiduciary Party hereby requests payment of authorized Medicare, Medicaid, Medigap, Supplemental and Commercial Health Insurances and Health Plan Benefits be made on Resident's behalf directly to the Facility for any services, equipment, supplies and/or medications furnished to me by the Facility.

The Resident and/or Fiduciary Party is responsible for any and all Facility private pay charges incurred related to Resident's care including, but not limited to Room & Board, Private Room Differential, Supplies, Treatments, Medications, Physician services, Laboratory and X-ray fees and Transportation costs not covered, approved or reimbursed by Medicaid, Medicare or Private Insurance or if the Resident is Private Pay.

If the Resident's third-party eligibility coverage is denied for any reason, the Resident and/or Fiduciary Party shall pay any and all charges for care previously rendered to the extent permitted by law.

**Private Pay Residents**

The Facility will provide the Resident with a 30-day notice prior to a change in fees and charges associated with Facility services. Room rates include room, linens, meals, laundry services, general nursing care, activities and social services.

**Ancillary Charges Not Included with Room and Board**

- **Therapy Charges**

Physical Therapy, Occupational Therapy and Speech Therapy are provided based on medical need and physician's order. These treatments may be covered at 80% of the Medicare-approved amount if the resident is eligible for Medicare Part B coverage. There may be yearly coverage limits; if so, there may be exceptions to these limits.

- **Medical Supplies, Oxygen and Durable Medical Equipment**

Provided based on treatment plan and physician's orders and are billed based on cost.

- **Ambulance Services, Physician Fees, X-Rays**

Provided by an outside contractor and will be billed directly from the provider of the services. Services may be covered at 80% under Medicare Part B.

- **Laboratory Studies and Medications**

Provided by an outside contractor and will be billed directly from the provider of the services.

- **Personal Items/Services**

Telephones, telephone services, televisions, cable/satellite services, dry cleaning, beauty/barber shop services, private duty sitters, personal clothing, postage, massage, manicures, pedicures, hobby supplies and personal sundries.

**Daily Private Pay Room Rates**

All rates are subject to change.

**Atlanta Daily Private Room Rate Charges**

Jesse Parker Williams Wing Semi-Private:	\$205.00	Jesse Parker Williams Wing Private:	\$220.00
Taylor Wing Private:	\$210.00	Taylor Wing Suite K:	\$250.00
A-Wing and ICF Wing Semi-Private:	\$200.00	A-Wing and ICF Wing Private:	\$210.00

**Cobb Daily Private Room Rate Charges**

Semi-Private:	\$230.00	Private:	\$260.00
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**Wesley Woods Daily Private Room Rate Charges**

2<sup>nd</sup> (Alzheimer's Unit) & 4<sup>th</sup> (Long-Term Care Unit) Floors:

Semi-Private Room:	\$210.00	Private Room/Shared Bath:	\$220.00	Private Room/Private Bath:	\$230.00
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3<sup>rd</sup> floor Short-term Rehabilitation:

Semi-Private Room:	\$225.00	Private Room/Shared Bath:	\$255.00	Private Room/Private Bath:	\$265.00
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A list of additional ancillary charges is available upon request.

**Medicaid**

The Fiduciary Party and/or Resident will immediately apply for Medicaid if Resident does not have the resources to pay privately. Medicaid regulations stipulate monthly total income limitations (total income refers to all sources of income including, but not limited to Veteran's Assistance, Social Security, pensions, annuities, rental income as well as interest income). More information on Medicaid benefits may be obtained from the county Medicaid office or our Billing office.

The Fiduciary Party and/or Resident is advised to begin paying the Resident's estimated liability amount to Facility if applying for Medicaid. Most Medicaid liability payments consist of a resident's total income minus fifty dollars (\$50.00) per month. Please see the Accounts Receivable Coordinator immediately after admission to discuss Medicaid policies.

### **Items and Services Provided by the Facility and Covered by Medicaid**

1. Semi-private (shared) room and board (including special diets and special dietary supplements, when specifically prescribed by a Physician). Medicaid does not pay for private rooms. Private pay subsidies for private rooms may fluctuate according to Medicaid's reimbursement rate which is assessed on a quarterly basis.
2. Laundry, including reasonable personal laundry only. Ironing and dry cleaning is not included.
3. Nursing services (excluding private duty nurses), Social Services, Physical Therapy, certain durable medical equipment (such as beds, bedrails (if appropriate), walkers, wheelchairs), incontinence care, hand feedings, special mattresses and pads, syringes, enemas, nursing supplies and dressing (other items of personal comfort or cosmetic items), extra linens, assistance in personal care and grooming, laboratory procedures not requiring laboratory personnel, non-prescription drugs such as antacids, stool softeners and laxatives, dilutants/irritants, aspirin, suppositories, milk of magnesia, mineral oil, rubbing alcohol, prophylactic medications and items on the Medicaid medical assistance drug list. Supplies such as oxygen, catheters, catheter sets, drainage apparatus, intravenous solutions, administration sets and water for injections are also included.
4. Certain items and services not listed, such as Physician services and prescription medications, are not included in the Facility Medicaid Per Diem rate but are covered by Medicaid and can be billed to the appropriate agency by the providers.
5. Pastoral services are included.
6. Wireless internet service is included.

### **Items and Services Not Covered by Medicaid**

#### **Personal Items/Services**

Telephones, telephone services, televisions, cable/satellite services, dry cleaning, beauty/barber shop services, private duty sitters, personal clothing, postage, massage, manicures, pedicures, hobby supplies and personal sundries.

#### **Medicare Part A**

Medicare Part A will help pay for a maximum of 100 days in each skilled care benefit period for residents meeting qualifying conditions. A benefit period begins on the day you are admitted to a Skilled Nursing Facility and ends the last day skilled services are received. Medicare beneficiaries may be eligible for new benefit periods after 60 days if qualifying conditions are met.

If the Resident meets the qualifying conditions, *Medicare Part A will pay 100% of the daily room rate, plus all covered ancillary charges for the remainder of the first twenty (20) days.* Beginning on day **21 up to 100** of each covered benefit period, a portion of the charge, established by the Federal Government, is required (called co-insurance). The daily co-insurance amount for calendar year 2014 is **\$152.00 per day**. Medicare pays the remaining portion. Some private supplemental insurances will cover the co-insurance amount.

#### **Qualifying Conditions:**

- Resident has been fully admitted in a hospital for at least three consecutive midnights, not counting the day of discharge or
- Resident is admitted to the Facility within 30 days of discharge from the hospital and met the three midnight hospitalization requirement and
- Resident has qualifying physician orders that certifies the need for skilled nursing or rehabilitation services on a daily basis and

- Your care in the Facility is for a condition that was treated in the hospital.
- Resident has had a 60-day break from using Medicare Part A benefits or receiving a skilled service, which can include a hospital or a skilled nursing facility stay.

**The Fiduciary Party and/or Resident is responsible for verifying coverage with your particular insurance company and supplying the Facility with all Primary and Supplemental insurance information.** In the event the Resident's insurer or benefit plan should send an assigned payment to the Resident and/or Fiduciary Party, the check will immediately be endorsed payable to the Facility and forwarded as such.

#### **Items and Services Covered by Medicare Part A (Certified, Skilled Care)**

Including the following services:

- Room and Board in a Semi-Private Room, Routine Nursing Care, Routine Supplies and Equipment
- Medicare also covers charges for the following ancillary services, if and when approved: Pharmacy, Radiology, Laboratory, Medical Supplies, Physical, Occupational and/or Speech Therapies

#### **Items and Services Not Covered by Medicare**

- **Personal Items/Services**

Telephones, telephone services, televisions, cable/satellite services, dry cleaning, beauty/barber shop services, private duty sitters, personal clothing, postage, massage, manicures, pedicures, hobby supplies and personal sundries.

#### **Medicare Part B** (To see if you have Part B benefits, see your Medicare Card.)

When the beneficiary meeting qualifying conditions is no longer covered for Medicare Part A inpatient services, Medicare Part B may pay 80% of covered services. The Resident and/or Fiduciary Party is responsible for the remaining 20% co-insurance amount. Medicare Part B funding coverage is limited per beneficiary with calendar year restrictions. If coverage is exhausted, the Resident may be billed privately for provided services. The Resident and/or Fiduciary Party will be made aware of available options as they arise. Coverage is subject to change.

- **Qualified Medicare Part B Services:** Physical Therapy, Occupational Therapy, Speech/Language Pathology, Tube Feedings, Radiology, Prosthetic Devices, Surgical Dressings, Laboratory

#### **Private Insurance**

As a courtesy, A.G. Rhodes will file insurance claims only for accepted plans. We will allow sixty (60) days from the date of service for your insurance to pay. If a claim has not been paid within sixty (60) days of submission, the Resident and/or Fiduciary Party will be responsible for all outstanding balances on care received. Any balances not paid in full are subject to late payment and interest rate charges.

If the Resident's third-party eligibility coverage is denied for any reason, the Resident and/or Fiduciary Party shall pay any and all charges for care previously rendered to the extent permitted by law.

**The Fiduciary Party and/or Resident is responsible for verifying coverage with your particular insurance company and supplying the Facility with all Primary and Supplemental insurance information.** In the event the Resident's insurer or benefit plan should send an assigned payment to the Resident and/or Fiduciary Party, the check will immediately be endorsed payable to the Facility and forwarded as such.

#### **Medical Services and Equipment**

The Resident shall be financially responsible for all medical and other services, equipment and supplies necessary for the Resident's personal use. The Resident and/or Fiduciary Party hereby authorizes the Facility to bill Medicare Part B or any other applicable payer for equipment, supplies and services furnished directly by the Facility or by



others to the Resident. The Resident is not required to purchase any item or service as a condition of admission or continued stay in the Facility.

**Change in Assets**

It is essential for the Resident and/or Fiduciary Party to communicate changes in the Resident’s assets, resources, income or benefits, such as insurance, to the Facility. If changes occur, it may affect the Resident’s payer source status. The Facility can assist in giving direction to ensure the Resident will be able to continue to pay for the services provided to the Facility.

**Responsibility of Personal Items and Property**

The Resident shall provide all items for his/her personal use, including but not limited to, appropriate and comfortable clothing, personal and other items as needed/requested. The Resident may have and use personal possessions to the extent possible so long as it does not interfere with their safety or with the rights, health or safety of others in the Facility. The Facility will not be liable for Resident’s clothing or personal items except to the extent required by applicable law.

The Facility shall make reasonable efforts to safeguard the Resident’s Personal belongings. However, the Facility will not be liable for any damage or loss of the Resident’s property. The Facility may dispose of any personal items and belongings if not claimed within thirty (30) days of discharge or transfer, or in accordance with applicable law. It is advised that no personal items of great sentimental or monetary value be brought into the Facility. All personal items, including clothing, personal linens, photographs, picture frames, etcetera, are required to be labeled with the Resident’s full name. Insurance may be obtained by the Resident and/or Fiduciary Party in the event of missing or lost items.

**Photo Identification**

The Resident may be photographed by the Facility for proper identification for drug administration and staff orientation.

**Billing**

Payment is due by the 10<sup>th</sup> of each month for that month. All accounts not paid on or before the 10<sup>th</sup> of the month in which services are rendered may be charged a late payment fee of \$35.00 and/or an interest rate of 18% on all charges (exclusive of interest) for which the Resident was billed. The Resident will be responsible for any and all collection fees, including attorneys’ fees associated with delinquent accounts.

**A.G. Rhodes Health & Rehab and «RESIDENT»/\_\_\_\_\_ , hereby**  
(Fiduciary Party Print Name in Space Above)

**agree to all terms and conditions set forth and outlined in the above Agreement.**

\_\_\_\_\_  
Signature of Fiduciary Party Date

\_\_\_\_\_  
Signature of Facility Representative Date

MEDICAL RELEASE OF INFORMATION CONSENT

Do you consent for the Resident’s name to be listed on the Resident Directory?

- Yes – I CONSENT for A.G. Rhodes staff to provide individuals, groups and outside callers with limited resident information including, but not limited to, room number and to include my name and room number in the printed Resident Directory located inside the building.
  
- No – I DO NOT consent for A.G. Rhodes staff to release any information to anyone calling and requesting information whose name is not listed below. All callers will be denied any information and will be directed to contact the resident’s family. The Facility will not be responsible for providing contact information.

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The following individuals are authorized to *obtain and access the Resident’s confidential medical information* including, but not limited to, current treatments, medications and diagnoses. This consent will allow the individuals listed below to speak with staff regarding confidential medical records and matters of medical nature. This form authorizes A.G. Rhodes Health & Rehab to acquire any previous medical information pertaining to the Resident.

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Signature of Resident/Representative

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Date

ADVANCE DIRECTIVE RECORD

Georgia honors properly executed Advance Directives from other states. Below is information provided by the Georgia Department of Human Services Aging Services Division relative to Health Care Agents and Advance Directives. Additional information can be accessed online at: <http://aging.dhr.georgia.gov>.

**Duty of the health care agent to act**

- A health care agent has no duty to act, even if named.
- If the health care agent does choose to act, s/he must not make decisions that are different or that contradict the decisions of the declarant (Resident).
- All of the health care agent’s actions must be consistent with the intentions and desires of the declarant.
- If those intentions and desires are not clear, the health care agent’s actions must be in the best interests of the declarant considering all of the benefits, burdens, risks and treatments options.

**PLEASE INITIAL THE FOLLOWING STATEMENTS THAT APPLY:**

\_\_\_\_\_ I have executed the following advance directive(s) and have provided copies to the Facility. I understand that the staff and physicians of this Facility will not be able to follow the terms of my advance directive until I provide a copy of it to the staff. **Denote EFFECTIVE DATES for all that apply:**

_____ <b>Living Will</b>	_____ <b>Power of Attorney - General / Healthcare</b> (circle applicable)
_____ <b>Georgia Health Care Directive</b>	_____ <b>Do Not Resuscitate (Facility-specific)</b>

\_\_\_\_\_ I have not executed an Advance Directive. I have received written information concerning Advance Directives including the Georgia Healthcare Directive.

I have been provided with written materials on the rights to accept or refuse life-sustaining treatments, other medical procedures or interventions and the right to formulate Advance Directives.

I understand that I am not required to have an advance directive in order to receive medical treatment at this Facility.

I understand that the terms of and advance directive(s) that I have executed will be followed by the staff and physicians of this Facility to the extent permitted by law.

\_\_\_\_\_  
Signature of Resident/Representative                      Date

\_\_\_\_\_  
*Form Amendment (If changes occur)*                      Date  
Signature of Resident/Representative

DO NOT RESUSCITATE FORM

«RESIDENT»

It has been determined by the undersigned physician(s) that the Resident qualifies as a candidate for non-resuscitation in the event of cardiac/respiratory arrest, for the below indicated reason or reasons: (Primary Physician should check reason or reasons.)

- 1. The Resident has requested not to be resuscitated.
- 2. The Resident has a medical condition which can reasonably be expected to result in the imminent death of the Resident.
- 3. The Resident is in a non-cognitive state with no reasonable possibility of regaining cognitive functions.
- 4. The Resident is a person for whom cardiopulmonary resuscitation would be medically futile in that such resuscitation will likely be unsuccessful in restoring cardiac and respiratory function or will only restore cardiac and respiratory function for a brief period of time that the resident will likely experience repeated need for cardiopulmonary resuscitation over a short period of time.

Date: \_\_\_\_\_ Primary Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Concurring Physician's Signature: \_\_\_\_\_

**Residents With Decision-Making Capacity:** (Resident completes this section)

I, do hereby request that no resuscitative measures be initiated upon me to restore cardiac/respiratory function, and I direct that this be written into my medical record. I understand that this agreement pertains only to the provision of cardiopulmonary resuscitation (CPR) and not to other life-sustaining procedures. I also understand that although CPR will not be performed in the event of cardiac/respiratory arrest, all efforts will be made to keep me comfortable. I understand that I may revoke this request at any time.

Date: \_\_\_\_\_ Resident's Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Facility Witness Signature: \_\_\_\_\_

**Residents Without Decision-Making Capacity:** (Authorized person consenting and signing for the Resident fills in this section)

I, the undersigned hereby request that no resuscitative measures be initiated upon the Resident to restore cardiac/respiratory function, and I direct that this be written into the resident's medical record. This has been discussed with the resident's attending physician and I understand that this agreement pertains only to the provision of cardiopulmonary resuscitation (CPR) and not to other life-sustaining procedures. I also understand that although CPR will not be performed in the event of cardiac/respiratory arrest, all efforts will be made to keep the Resident comfortable. I further declare that if the Resident is unable to express his/her own wishes in this matter, I am the highest authorized person who may consent to this "Do Not Resuscitate" agreement in the order of priority listed below (check below the relationship of the authorized person to the resident). I understand that consent for this order for non-resuscitation may be revoked by me, as the authorized person, at any time.

- 1. Appointed Health Care Agent in Resident's Advance Directive
- 2. Resident's Spouse
- 3. Resident's Legal Guardian
- 4. Resident's Son or Daughter (18 years of age or older)
- 5. Representative of Facility's Ethics Committee
- 6. Resident's Sibling (18 years of age or older)
- 7. Other \_\_\_\_\_

Date: \_\_\_\_\_ Signature of Authorized Person: \_\_\_\_\_

Date: \_\_\_\_\_ Facility Witness Signature: \_\_\_\_\_

**INFORMED VACCINATION ADMINISTRATION CONSENT FORM**

**ANNUAL INFLUENZA (FLU) VACCINATION**

An inactivated (killed) Influenza Vaccine, given as a shot, has been used in the United States for many years. Influenza viruses are constantly changing. Therefore, influenza vaccines are updated every year, and an annual vaccination is recommended. For most people, the influenza vaccine prevents serious illness caused by the influenza virus. It will not prevent "influenza-like" illnesses caused by other viruses. It takes about 2 weeks for protection to develop after the shot, and protection can last up to a year. Inactivated influenza vaccine may be given at the same time as other vaccines, including pneumococcal vaccine. It is recommended by the Centers for Disease Control and Prevention National Immunization Department that people 65 years of age and older receive the vaccine. A vaccine, like any other medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of a vaccine causing serious harm, or death, is extremely small. Serious problems from the influenza vaccine are very rare. The viruses in inactivated influenza vaccine have been killed, so you *cannot* get influenza from the vaccine. Mild problems may include soreness, redness or swelling at the injection site, fever, aches and chills. If these problems occur, they usually begin soon after the shot and last 1-2 days. Life-threatening allergic reactions from vaccines are very rare. If they do occur, it is within a few minutes to a few hours after the shot. In 1976, a certain type of influenza (swine flu) vaccine was associated with Gullian-Barre Syndrome (GBS). Since then, flu vaccines have not been clearly linked to GBS. However, if there is a risk of GBS from current vaccines, it would be no more than 1 or 2 cases per million people vaccinated. This is much lower than the risk of severe influenza, which can be prevented by vaccination. Persons allergic to eggs, chickens or chicken dander should not receive the influenza vaccine.

**Do you consent for the Resident to receive an annual flu vaccine while residing in A.G. Rhodes?**

- Yes
- No

**Date of last flu vaccination:** \_\_\_\_\_

By agreeing to this consent, an order for the annual administration of the flu vaccine will be placed in the resident's medical chart. In order to rescind this order, a written request must be furnished to the Admissions Director.

**PNEUMOCOCCAL VACCINE**

The pneumococcal polysaccharide vaccine (PPV) protects against 23 types of pneumococcal bacteria. Most healthy adults who get the vaccine develop protection to most or all of these types within 2 to 3 weeks of getting the shot. It is recommended by the Centers for Disease Control and Prevention National Immunization Department that people 65 years of age and older receive the vaccine. Usually, one dose of PPV is all that is needed. However, under some circumstances a second dose may be given. A second dose is recommended for those people aged 65 and older who received their first dose when they were less than 65 years of age if 5 or more years have passed since that dose. A vaccine, like any other medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of a vaccine causing serious harm, or death, is extremely small. Serious problems from PPV are very rare. Mild problems may include soreness, redness or swelling at the injection site, fever, aches and chills. If these problems occur, they usually begin soon after the shot and last 1-2 days. Life-threatening allergic reactions from vaccines are very rare. If they do occur, it is within a few minutes to a few hours after the shot. Getting the disease is much more likely to cause serious problems than getting the vaccine.

**Do you consent for the Resident to receive a pneumococcal vaccine while residing in A.G. Rhodes?**

- Yes
- No

**Date of last pneumococcal vaccination:** \_\_\_\_\_

(If resident was under age 65 or five (5) or more years have passed since receiving the vaccine, a second dose is recommended.)

\_\_\_\_\_  
Signature of Resident/Representative

\_\_\_\_\_  
Date

## BED HOLD POLICY

Residents that are physically out of the Facility on midnight for any reason are considered to be discharged from the Facility unless there is an agreement between the Facility and/or the Fiduciary Party to pay for a bed hold. The Fiduciary Party will be notified by the Facility by phone at the time of the Resident's leave. At that time, verbal authorization for payment will be accepted for a period of no more than three days. The Fiduciary Party will be sent a confirmation of the verbal authorization to extend the paid bed hold beyond three days if so desired. The written authorization to extend the paid bed hold must be signed and returned to the Facility within 24 hours of receipt to ensure the bed hold. The Facility is entitled to admit another Resident into the room if verbal authorization is not granted at the time of initial contact or if the Bed Hold Authorization Form is not signed and returned. Any discharged Resident may be readmitted to the first available semi-private room if he/she requires Facility-provided services and is eligible for Medicaid nursing Facility requirements.

### Private Pay Residents

- A Private Pay Resident will be charged the posted basic daily rate in effect at the time of the Resident's absence from the Facility.

### Medicare Recipients

- Medicare does not cover a bed hold. If the Resident and/or Fiduciary Party desires a bed hold under a private pay arrangement, the charge will be the posted basic daily rate in effect at the time of the Resident's absence from the Facility.

### Medicaid Recipients

- Georgia regulations require long-term care facilities to maintain bed hold coverage for seven (7) days. Should the state allowed bed hold expire, you will be notified by phone and be provided the opportunity to hold the bed under a Private Pay arrangement at the time of the phone call according to the policy at the posted daily rate in effect at the time of the Resident's absence from the Facility.
- A Medicaid recipient may spend two consecutive days *Therapeutic Leave* with a relative or friend without reduction in the amount of medical assistance payment to the Facility provided that the attending physician documents in the plan of care that such visits are therapeutic in nature. A recipient is not permitted to exceed four such visits for a total of eight (8) days in any calendar year. If the Resident exceeds the approved 8 days of Therapeutic Leave, the Resident will be discharged from the Facility. The Resident may have an opportunity to hold the bed under a Private Pay arrangement according to the policy at the posted daily rate in effect at the time of the Resident's absence from the Facility.

### Medicaid Pending (For hospitalized residents who have applied for Medicaid and are awaiting DFACS approval.)

- The Facility is under no obligation to extend a bed-hold for non-authorized Medicaid residents. However, A.G. Rhodes may offer a bed-hold if the Bed Hold Form is signed on the day of hospital admission and if the Resident's estimated monthly liability payment is current (estimated liability equals total monthly income minus fifty (50) dollars). If the Resident's hospital stay is longer than 7 days, the bed-hold charge will change to the current private-pay bed-hold rate on the 8th day. The Fiduciary Party may choose to cancel the bed-hold at any time in writing, however, past days balance will be due. The Facility will comply with all regulations in re-admitting residents after absence from the Facility.

### HMO/Insurance Residents

- Insurance does not typically cover bed hold. If the Resident or Fiduciary Party desires a bed hold under a private pay arrangement, the charge will be the posted basic daily rate in effect at the time of the Resident's absence from the Facility.

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Signature of Resident/Representative

---

Date

## CONSENT FORM

### Activity Outings and Trips

I understand that sufficient staff will accompany the Resident on all Facility outings. The Facility will not be liable for injuries which may occur during these trips. I understand the Resident may request or refuse to attend any and all activities held on or off of Facility grounds. I may rescind this authorization in writing at any time.

- I CONSENT for the Resident to choose to attend activity outings and trips.
- I do not consent for the Resident to choose to attend activity outings and trips.

### Photography and Audiovisual Recordings

I hereby give my consent for the above named Resident to be photographed or videotaped with no form of compensation by the Facility for communications purposes such as photo displays, printed publications such as brochures or marketing materials, web-based publication such as the company website and social media sites, or broadcast. I acknowledge that notwithstanding the foregoing, photographs (including video photography) may be taken in or around the facility from time to time by employees, family members, visitors and other residents, or representatives of the news media. While the facility will endeavor to maintain my privacy from any such undesired photographs, such privacy cannot be assured. I may rescind this authorization in writing at any time.

- \_\_\_ I consent to facility photography and audiovisual recordings.
- \_\_\_ I DO NOT consent to facility photography and audiovisual recordings.

### Written Correspondence

The Facility may send and receive mail promptly for residents. When requested, Facility staff may offer assistance by opening, reading or forwarding any and all mail, which may include checks, medical bills, Medicaid, and Medicare correspondence. I may rescind this authorization in writing at any time.

- I CONSENT for Resident to receive personal mail at the Facility with the opportunity to request staff assistance.
- I do not consent for Resident to receive personal mail at the Facility. Any mail received by the Facility addressed or related to the Resident will be forwarded to the Fiduciary Party.

### Use of Antipsychotic Medications

Antipsychotic medications are sometimes used to treat behavioral symptoms in residents with dementia. These symptoms include delusions (fixed beliefs that are not real), hallucinations (seeing or hearing things that are not real), and others. While the FDA has not approved these medications in treatment of behavioral symptoms of dementia, physicians may use them for “off-label” purposes if it is believed they will help the resident.

- I CONSENT for Resident to receive
- I do not consent for Resident to receive

### Professional Services

The Facility develops and implements a Plan of Care for each Resident upon admission with quarterly reviews. Please denote if you are interested in discussing the Resident’s Plan of Care prior to the regularly scheduled conference.

The Facility will make every effort to provide me with the physician of my choice. If the physician of my choice is unavailable or lacks staff privileges or credentialing related to standardized nursing care, as determined by the Facility in their discretion, the Facility will have the obligation, after informing me, to seek alternative physician participation.

The Facility will make every effort to provide me with the pharmacy or pharmacist of my choice for pharmaceutical supplies and services not provided by the Facility as part of the basic daily rate. All participating pharmacies or pharmacists must package medications in accordance with state and federal nursing home regulations. If the Resident and/or Fiduciary Party chooses to use a pharmacy different than the Facility's, he/she will be solely responsible for ensuring all current medications are made available to the Facility per physician orders.

\_\_\_\_\_  
Signature of Resident/Representative                      Date

AGREEMENT CONCERNING MANAGEMENT OF PERSONAL FUNDS

I, the Resident and/or Fiduciary Party, hereby acknowledge that I have been advised of the right to manage my financial affairs and that I am not required to deposit personal funds with the Facility.

For any funds I choose to deposit into a personal Resident account, I authorize the Facility to hold, safeguard, manage, and account for the following receipts or disbursements on my behalf in accordance with the policy on protection of Resident funds set forth below:

RECEIPTS:

- 1. Checks cashed (social security, personal, etc.)
- 2. Cash received on Resident's behalf
- 3. Cash received from Resident

EXAMPLES OF DISBURSEMENTS:

- Room and Care charges, Beauty Shop payments, Cable service, Telephone service, Cash to resident, Cash to other(s), Checks to others and Verbally requested disbursements

Per Social Security Guidelines, upon discharge, the remaining funds in a family opened account will be delivered to the Fiduciary Party. If remaining funds are from Resident's Social Security income, upon death, all funds will be made payable to the Fiduciary Party on behalf of the resident's estate. Fiduciary Party acknowledges their responsibilities in the distribution of these funds. If a Resident is discharged with Social Security funds remaining in the account, the remaining balance will be returned to the Social Security office.

\_\_\_\_\_  
Signature of Resident/Representative                      Date



MEDICARE SECONDARY PAYER SCREENING FORM

**PART 1: ILLNESS/INJURY RELATED ACCIDENT**

Is illness/injury due to a work related accident?

- NO GO TO PART II
- YES Date of Accident/Injury: \_\_\_\_\_

Check appropriate box below and complete the following:

Automobile: Name of Resident's auto/no-fault and/or third party auto insurer: \_\_\_\_\_

Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_

**AUTO INSURANCE IS PRIMARY**

- Work Related: Name/Address of Worker's Comp Insurer: \_\_\_\_\_  
Name/Address of your employer: \_\_\_\_\_  
Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_

**WORKER'S COMP INSURANCE IS PRIMARY for claims related to work related injuries**

- Slip and Fall: Where did fall occur: \_\_\_\_\_

If fall occurred at place other than Resident's home, determine if liability claim or suit will be filed or if any kind of compensation can be made:  YES  NO

If yes: Name of Third Party/Insurer/Attorney: \_\_\_\_\_

Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_

- Other Accident: No third party can pay. Give description of accident and location.  
\_\_\_\_\_

**MEDICARE IS PRIMARY**

**PART II: COVERAGE THROUGH OTHER GOVERNMENTAL ENTITITY**

Is Resident receiving Black Lung Benefits?

- NO
- If YES, date benefits began: \_\_\_\_\_

**BL IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO BL**

Are the services to be paid by a government research program such as a research grant?

- NO
- YES, **GOVERNMENT RESEARCH PROGRAM WILL PAY**

**PRIMARY BENEFITS FOR THESE SERVICES**

Has the Department of Veteran's Affairs (DVA) authorized and agreed to pay for your care at A.G. Rhodes?

- NO, GO TO PART III
- YES, **DVA IS PRIMARY FOR THESE SERVICES**

**PART III: EMPLOYER GROUP COVERAGE FOR THOSE 65 AND OLDER**

Is the resident 65 or older and employed at the time of this service?

- NO, List Date of Retirement: \_\_\_\_\_ GO TO PART IV BELOW
- NO, never employed
- If YES: Enter Resident's date of birth: \_\_\_\_\_

Name of Resident's employer: \_\_\_\_\_

Does employer have 20 or more employees?  YES  NO

Does the Resident have an Employer Group Health Plan (EGHP) through current employment?  NO

YES-Enter name of EGHP:\_\_\_\_\_ Membership ID#:\_\_\_\_\_  
Policy #:\_\_\_\_\_ Claim #:\_\_\_\_\_

\*If Resident has an Employer Group Health Plan, obtain copy of insurance card and call to verify coverage.

**If the Resident answered NO to all primary questions in this section, MEDICARE IS PRIMARY. If the Resident is aged 65 or older and has answered YES to both questions, the EGHP shown is PRIMARY and should be billed. Medicare is secondary.**

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#### **PART IV: SPOUSE EMPLOYER GROUP COVERAGE**

Does the Resident have a spouse who is employed at the time of this service?

NO, List Date of Retirement:\_\_\_\_\_ GO TO PART V BELOW

NO, never employed

If YES: Enter **Resident's** date of birth:\_\_\_\_\_

Name of spouse's employer:\_\_\_\_\_

Does employer have 20 or more employees?  YES  NO

Does the Resident have an Employer Group Health Plan (EGHP) through current employment?  NO

YES-Enter name of EGHP:\_\_\_\_\_ Membership ID#:\_\_\_\_\_

Policy #:\_\_\_\_\_ Claim #:\_\_\_\_\_

\*If Resident has an Employer Group Health Plan, obtain copy of insurance card and call to verify coverage.

**If the Resident answered NO to all primary questions in this section, MEDICARE IS PRIMARY. If the Resident is aged 65 or older and has answered YES to both questions, the EGHP shown is PRIMARY and should be billed before Medicare. If Resident has an EGH (see Part III above), Medicare is tertiary payer.**

Are you covered under the group health plan of a family member other than your spouse?

NO

If, YES, **GHP IS PRIMARY.** List your family member's GHP information:\_\_\_\_\_

**If NO, MEDICARE IS PRIMARY UNLESS RESIDENT ANSWERED YES TO QUESTIONS IN PART III OR PART IV.**

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#### **PART V: EMPLOYER GROUP COVERAGE FOR THOSE WITH END STAGE RENAL DISEASE (ESRD)**

Does the Resident have coverage through a GHP or some other Federal or State program other than Medicaid?

NO

If YES: Enter **Resident's** date of entitlement to GHP:\_\_\_\_\_

List GHP information:\_\_\_\_\_

Does the Resident have coverage through spouse's EGHP?

NO

If YES: List GHP information:\_\_\_\_\_

**If Resident answered YES to both questions, the EGHP shown is PRIMARY. Medicare is secondary.**

Have you received a kidney transplant?

NO

If YES: Date of transplant:\_\_\_\_\_

Have you received maintenance dialysis treatments?

- NO
  - If YES: Date dialysis began: \_\_\_\_\_
- If you participated in a self-dialysis training program, provide date training started: \_\_\_\_\_

Are you within the 30-month coordination period that starts \_\_\_\_\_?  
(The 30-month coordination period starts the first day of the month an individual is eligible for Medicare (even if not yet enrolled in Medicare) because of kidney failure (usually the fourth month of dialysis). If the individual participating in a self-dialysis training program or has a kidney transplant during the 3-month waiting period, the 30-month coordination period starts with the first day of the month of dialysis or kidney transplant).

- NO **STOP. MEDICARE IS PRIMARY.**
- YES

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Are you entitled to Medicare on the basis of either ESRD and age or ESRD disability?

- NO
- YES

Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?

- YES **STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD**
- NO **INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY**

Does the working aged or disability MSP provision apply (i.e., is the GHP primarily based on age or disability entitlement)?

- YES **STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD**
- NO **MEDICARE CONTINUES TO PAY PRIMARY**

**If no MSP date is found in the Common Working File (CWF) for the beneficiary, the provider still asks the types of questions above and provides any MSP information on the bill using the proper uniform billing codes. This information will then be used to update CWF through the billing process.**

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#### **PART VI: EMPLOYER GROUP COVERAGE FOR THOSE ENTITLED TO MEDICARE SOLELY BECAUSE OF DISABILITY**

Is the Resident under the age of 65 and entitled to Medicare solely (does not have/has not had ESRD) because of disability?

- NO
- If YES: Enter **Resident's** date of entitlement to GHP: \_\_\_\_\_

List GHP information: \_\_\_\_\_

\*obtain copy of insurance card and call to verify

**If Resident answered YES, the EGHP shown is PRIMARY. Medicare is secondary.**

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#### **PART VII: HMO/MEDICARE ADVANTAGE PLAN, HOSPICE**

Is the Resident enrolled in an HMO that has Medicare benefits assigned or a Medicare Advantage Plan?

- NO **GO TO PART VIII BELOW**

- If YES: Name of HMO/Medicare Advantage Plan: \_\_\_\_\_  
Policy #: \_\_\_\_\_

**If yes, IMPORTANT: Contact HMO/Medicare Advantage Plan to obtain authorization and copy of card. HMO/Medicare Advantage Plan is primary, “Informational” claim only submitted to Medicare.**

\*obtain copy of insurance card and call to verify

Is the Resident currently receiving Hospice benefits or ever been under Hospice care?

- NO GO TO PART VIII BELOW
- If YES: Name of Hospice: \_\_\_\_\_  
Enrollment/Effective Date: \_\_\_\_\_ Date of Termination: \_\_\_\_\_

\*If hospice coverage was terminated, please submit written revocation correspondence from the Hospice provider.

**If yes, contact Hospice provider regarding current coverage or termination information. If Resident is receiving Hospice benefits at time of admission, Hospice is Primary. Resident would be private pay.**

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### **PART VIII: AUTHORIZATIONS**

**I hereby certify that, to the best of my knowledge, the above information is true.**

\_\_\_\_\_  
Signature of Resident/Representative

\_\_\_\_\_  
Date

ACKNOWLEDGEMENT OF RECEIPT OF HOME AND  
COMMUNITY-BASED SERVICES INFORMATION

It is the policy of the State of Georgia that services be delivered in the least restrictive manner that addresses the service needs of the individual while enhancing the promotion of social and community integration. Based on this policy, all potential residents and/or their authorized representative will be afforded an opportunity to make an informed choice concerning services.

Once an applicant/consumer is determined to be likely to require a different level of care, the applicant/consumer or his/her authorized representative will be informed of alternatives available under home and community based service options as described in the Georgia Department of Community Health *Home and Community-Based Services* booklet.

Verification

I have verified that the resident or his/her authorized representative has been given information about home and community-based services in the manner outlined above.

\_\_\_\_\_  
Signature of Facility Representative                      Date

Acknowledgment

I have been informed of home and community-based service options as an alternative to nursing home placement. I have received the information contained in the Georgia Department of Community Health *Home and Community-Based Services* booklet, which advises me of these options and provides information about how to apply for services.

\_\_\_\_\_  
Signature of Resident/Representative                      Date

RESIDENT AND FACILITY ARBITRATION AGREEMENT

Page 1 of 2

It is hereby understood and agreed by A. G. Rhodes Health & Rehab (Facility) and «RESIDENT»/Representative (the “Resident” or the “Resident’s Authorized Representative”, hereinafter collectively the “Resident”) that any and all controversies, claims, disputes, disagreements or demands of any kind (hereinafter collectively referred to as “Claim” or “Claims”) arising out of or relating to the Resident Admission Agreement (the “Agreement”) or any service or health care provided to the Resident by the Facility shall be settled exclusively by binding arbitration. For purposes of this Arbitration Agreement, a Claim shall include violations of any right granted to the Resident by law or by the Admission Agreement, breach of contract, fraud or misrepresentation, negligence, gross negligence, malpractice, or any other claim based on any departure from accepted standards of medical or health care or safety whether sounding in tort or in contract. A Claim shall not include a claim for payment, nonpayment, or refund for services rendered to the Resident by the Facility. This Arbitration Agreement shall in no way, however, limit the Resident’s right to file a grievance or complaint, formal or informal, with the Facility, the long-term care ombudsman, or any appropriate government agency.

It is understood by Resident/Representative that he or she is not required to use A.G. Rhodes Health & Rehab for his/her health care needs and there are numerous other health care providers in the State where A.G. Rhodes is located that are qualified to provide such care.

Any arbitration proceeding that is initiated under this Agreement shall be conducted in accordance with the applicable rules of the Alternative Dispute Resolution Service Rules of Procedure for Arbitration of the American Health Lawyers Association (AHLA). The arbitration shall be conducted where the Facility is located or as close to the Facility as is practical. The arbitration proceeding shall be conducted before one neutral arbitrator selected in accordance with the rules of the AHLA.

The Resident/Representative and Facility agree that damages awarded, if any, in an arbitration conducted pursuant to this Arbitration Agreement shall be determined in accordance with the provision of the state or federal law applicable to a comparable civil action, including any prerequisites to, credit against or limitations on, such damages. The arbitrator’s compensation and administrative fees related to the arbitration shall initially be paid by A.G. Rhodes. If the Facility prevails, then the arbitrator may order that the Resident/Representative reimburse the Facility for any compensation or administrative fees paid. Each party shall be responsible for their own attorneys’ fees. All Claims based in whole or in part on the same incident, transaction, or related course of care or services provided by the Facility to the Resident, shall be arbitrated in one proceeding. A Claim shall be waived and forever barred if it arose prior to the date upon which notice of arbitration is given to the Facility or received by the resident, and is not presented in the arbitration proceeding.

It is the intention of the parties to this Arbitration Agreement that it shall inure to the benefit of and be binding upon the parties, their successors and assigns, including the agents, employees and servants of the Facility, and all persons whose Claim is derived through or on behalf of the Resident, including without limitation that of any parent, spouse, child, guardian, executor, administrator, legal representative, or heir of the Resident.

RESIDENT AND FACILITY ARBITRATION AGREEMENT

Page 2 of 2

The Resident/Representative and the Facility acknowledge and agree that, because the Admission Agreement affects a transaction that involves interstate commerce, the enforcement of this Arbitration Agreement shall be governed by the Federal Arbitration Act (Title 9 of the United States Code), notwithstanding any contrary provision of the Admission Agreement or contrary state law. Furthermore, the provisions of this Arbitration Agreement shall survive any termination or breach of the Admission Agreement.

The parties understand and agree that by entering this Arbitration Agreement they are giving up and waiving their constitutional right to have any Claim decided in a court of law before a judge and a jury. The Resident/Representative understands that the Resident/Representative has the right to seek legal counsel concerning this Arbitration Agreement and that the execution of this Arbitration Agreement is not a precondition to the furnishing of services to the Resident by the Facility.

\_\_\_\_\_  
Signature of Resident/Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Facility Representative

\_\_\_\_\_  
Date

THERAPY TREATMENT NOTIFICATION FORM

Please be advised that during the Resident's stay in the Facility, he/she may be screened for physical therapy, occupational therapy and/or speech therapy. There is no cost for this screening.

This notification is being issued to advise you of our policy.

The potential financial implication, depending upon the Resident's payer source and qualifying conditions is as follows:

Medicare Part A: Included in the skilled Medicare rate. The Resident and/or Fiduciary Party will be made aware of available options as they arise. Coverage is subject to change.

Medicare Part B: 80% of the cost of these services will be covered. The Resident and/or Fiduciary party will be responsible for the remaining 20% co-insurance. Medicare Part B funding coverage is limited per beneficiary with calendar year restrictions. If coverage is exhausted, the Resident may be billed privately for provided services. The Resident and/or Fiduciary Party will be made aware of available options as they arise. Coverage is subject to change.

HMO/Managed Care: Under many HMO/Managed Care policies, provisions exist that allow therapy services to be covered under the plan. If for any reason, the policy does not cover the services, the Resident/Fiduciary Party will be billed privately. The Resident and/or Fiduciary Party will be made aware of available options as they arise. Coverage is subject to change.

Medicaid may pay a portion of Medicare co-insurance for inpatient and outpatient services and supplies. A list of all charges is available for review upon request.

Private Pay/Coverage Limitations: If as a result of this screening, the physician determines that the Resident is in need of an evaluation and/or further treatment, the Resident and/or Fiduciary Party will be notified and verbal approval of treatment will be requested. If the Resident does not have any other payer source coverage, the Resident/Fiduciary Party will be billed privately for any qualifying physician ordered services.

By signing below, you acknowledge receipt and understanding of the above policy notification.

\_\_\_\_\_  
Signature of Resident/Representative

\_\_\_\_\_  
Date



MEDICAL RELEASE OF INFORMATION AUTHORIZATION

I hereby consent and authorize any holder of medical or other pertinent information related to the above-named Resident's medical treatment and/or health benefits to release any and all requested information to A.G. Rhodes immediately upon request.

\_\_\_\_\_  
Signature of Resident/Representative

\_\_\_\_\_  
Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

By initialing each box and signing below, I acknowledge that I have received the documents and policies named below. I understand that I am responsible for the information stated in these documents and that if I have any questions at any time regarding any documents in this packet, I may contact the Admissions Director or designee for explanation.

**Facility Policies and Procedures including:**

- Visiting Information
- Anti-psychotic Medication use
- Tobacco-Free Campus Policy
- Comments, Suggestions and Grievances
- Family and Resident Councils
- Discharge Information/Ignoring or leaving against Medical Advice
- Transportation Information
- Prescription and Over the Counter Medication Administration
- Self-Administration of Drugs
- Private Duty Sitters
- Use of Physical Restraints and/or Safety Devices

**Georgia Advance Directives Information Patient Self-Determination Act**

**Resident Inventory List**

**Privacy Act Statement-Health Care Records**

**Federal and State Resident Rights**

**Notice of Privacy Practices**

\_\_\_\_\_  
Signature of Resident/Representative      Date

\_\_\_\_\_  
Facility Representative      Date

### **Facility Policies and Procedures Visiting Information**

A.G. Rhodes does not have set visiting hours. In order to accommodate our Resident's needs and preferences, we ask that you keep in mind Resident schedules, roommate requests and privacy. Visitors are not prohibited from visiting at night, however we cannot make overnight accommodations in our facilities, such as lodging.

With the exception of law enforcement, weapons, knives and guns are not permitted inside the facilities.

Certain items are not allowed in our resident rooms. Such items include, but are not limited to prescription and over-the-counter medications, spray air fresheners, plug-in air-fresheners, rugs, candles, incense or any flammable materials, laundry hampers, electric blankets, scissors, nail polish and nail polish removers, cleaning supplies, tobacco, electric outlet strip or extension cords, microwaves, coffee makers/pots, heating pads, poisonous plants or any heating apparatus.

### **Tobacco-Free Policy**

The A.G. Rhodes communities are tobacco-free campuses.

### **Comments, Questions, Suggestions and Grievances**

We aim at providing quality, personalized health care for all of our residents with the goal of a positive and enjoyable experience. We know that during the course of staying with us, situations may occur when questions arise or you have the need to share experiences and comments with us. We encourage our residents and their families to speak with our knowledgeable Social Services staff members regarding any questions, comments or problems that may arise during your stay. We will make every effort to resolve any issues brought to our attention. Any formal complaints or grievances will be investigated and resolved within a reasonable and timely manner.

### **Family and Resident Councils**

If you would like to become involved in our Family and/or Resident Councils, please contact our Social Services Department.

### **Use of Antipsychotic Medications**

Antipsychotic medications are sometimes used to treat behavioral symptoms in residents with dementia. These symptoms include delusions (fixed beliefs that are not real), hallucinations (seeing or hearing things that are not real), and others. While the FDA has not approved these medications in treatment of behavioral symptoms of dementia, physicians may use them for "off-label" purposes if it is believed they will help the resident.

### **Discharge Information**

We are thrilled to assist many of our residents back into the community once their rehabilitation is completed. Our Social Workers will assist you with the discharge process. Many of our residents are able to return to their homes or independent living facilities with assistance from home health care agencies that offer skilled services; and if qualified for skilled services, are billed through Medicare. If appropriate and ordered by a physician, therapy and nursing services can be arranged through home health agencies per Medicare guidelines. Other residents need a bit more assistance with their activities of daily living upon discharge. Assisted Living Facilities or Personal Care Homes can provide prepared meals as well as housekeeping and laundry services. (Note that some services may incur additional charges.) If appropriate and ordered by a physician, home health care agencies can provide home visits from nurses and therapists. For residents who require additional assistance that surpasses home health coverage through Medicare, private duty home care is also available. These agencies offer private duty sitters and companions that can provide assistance with activities of daily living. These services are only available with private pay resources. For additional discharge information, please contact our Social Services Department.

### **Use of Physical Restraints and/or Safety Devices**

A.G. Rhodes is committed to providing the least restrictive method of restraints for residents of this skilled nursing Facility in accordance with the Omnibus Budget Reconciliation Act (OBRA) of 1987. The purpose of the Restraint Reduction Program is to eliminate or reduce the use of restraints for a resident while ensuring a safe and functional environment that promotes independence. In certain cases, residents may require physical restraints or safety devices in order to maintain a safe and secure environment for all of our guests. In order to assess each individual and their safety needs, a variety of factors are examined.

### **Prescription and Over the Counter Medication Administration**

No outside medications are allowed in the Facility. If you feel that the Resident requires an additional medication, please see your nurse. Families and residents are asked to NOT bring in any type of medication into the Facility without a physician's order as well as proper medication packaging. Please do not bring in mainstream over the counter medications such as pain relievers, antacids, eye drops, etc. as they could inadvertently cause harm. If you have additional questions regarding this policy, please see the Director of Nursing.

### **Self-Administration of Drugs**

A Resident of this Facility may self-administer drugs when the Interdisciplinary Team has determined this practice safe and an order has been obtained from the Facility physician. This determination may list specific categories of drugs (i.e. lotions, ointments, inhalants, eye drops, etc.) If the medication is to remain in the Resident's room, the physician's order will include that information.

#### Procedure

- Prior to the self-administration of drugs, the Interdisciplinary Team will assess the Resident to determine that self-administration is a safe practice.
- Obtain the Physician's order. This order must include the location of the drug, i.e. "May keep at bedside."
- Explain the medication administration procedure to the Resident.
- Include the appropriate information in the Resident's Plan of Care.
- Complete the "Self-Administration of Drugs" form.
- The frequency of administration will be documented on the Medication Administration Record by the charge nurse for the Resident. The nurse will obtain this information by questioning the Resident as to the number of times the drug was administered each shift.

### **Private Duty Sitters**

Residents and or their families are welcome to hire private duty sitters.

#### Procedure

- See Social Services for a list of Private Duty providers.
- All sitters must undergo a mini-skills check-off with our Staff Development Coordinator.
- If certified, our Facility must also have a copy of their nursing assistant or nursing license. All private duty sitters must undergo a criminal background and abuse registry check as well as provide the Facility with written results of a recent tuberculosis test or chest x-ray. A.G. Rhodes is not liable for any acts committed by or omitted by a Resident/family hired private duty sitter.
- Any mal-occurrence will strictly be the responsibility of the hiring party and will in no way be held against A.G. Rhodes. Sitters may only provide care and/or assistance to the Resident he/she is hired to assist.
- Private duty sitters must sign in upon the start of their workday and sign out upon leaving the Facility at any time (i.e. lunch) as well as sign out at the end of each workday. The "Extended Services Book" can be found at the front office window. Private duty sitters may not interfere with the duties of A.G. Rhodes employees in relation to any aspect of patient care.

### **Transportation Information**

A.G. Rhodes contracts with outside transportation vendors for residents who require transportation to outside appointments and is not responsible for arrival and departure times. As with any travel within the metro-Atlanta area, delays may occur. A family member or responsible party must accompany the Resident at all times while out of our community. Please keep availability for accompanying the Resident in mind when scheduling appointments. Staff members cannot accompany residents to outside appointments. Our Social Services office has information on companies that can be contracted for such services. Arrive to the Facility at least one hour before transportation pick up is scheduled. Stay with the Resident once he or she arrives at their destination. Once the Resident's appointment is close to completion, you or the doctor's office staff can contact your transportation company to arrange for pick-up using the number provided to you during arrival at the appointment. Please give any follow-up information to the Resident's nurse or Social Worker.

### **Ignoring or going against Medical Advice**

At times, your loved one may ask for things that are not included in his or her Plan of Care. Such an example of this would be a Resident who is only allowed to eat food that has been pureed asking their family for a hamburger and french fries. This policy also includes, but is not limited to going against medical advice regarding therapy, special diets, medications and treatments.

#### Procedure

- In order for the Facility and its staff to provide care and safety for the Resident, it must be understood that at no time can we ignore a physician's order. Medical orders are written for residents not only to provide care medically, but also for safety reasons.
- If the Resident or any member of his/her family chooses to "go against medical advice," you must know the dangers you are exposing to the Resident. Choking, falling, fractures, allergic reactions and possible death can all occur when not following medical advice.
- If the Resident/family member(s) still choose to reject medical advice, the Facility must have in writing that you understand what the orders call for and why and that you chose to disregard those medical orders at the health risk of the Resident in residence at A.G. Rhodes.

### **Georgia Advance Directives Information Patient Self-Determination Act**

The "Patient Self-Determination Act" of 1990 is a federal law that went into effect on December 1, 1991. The legislation was created to ensure the legal right of each competent adult, 18 years and older, to make his or her own medical decisions. The act mandates Medicare and Medicaid certified nursing facilities, as well as other agencies, to give residents information about their right to make decisions concerning medical or surgical treatment and the right to complete advance directives. In order to make informed decisions, residents are entitled to adequate information about their condition, treatment alternatives, likely risks and benefits of the alternatives and possible consequences.

### **Advance Directives**

Advance Directives are written documents that are set up in advance in case a person is unable to communicate his or her desires about medical treatment. These are documents that state your choices about medical treatment and/or name someone to make choices about medical treatment for you, if you become unable to make decisions. Advance directives only come into effect when the individual is unable to make medical decisions on their own. The intent of the advance directives provisions is to enhance an adult individual's control over medical treatment decisions. Whether you choose to execute an advance directive is a personal matter and will never be a condition of whether you receive services from a health care provider.

There are two primary purposes of advance directives that are recognized in Georgia:

1. A document which appoints a health care agent, and

2. A document that directs treatment preferences when a person is in a terminal condition or state of permanent unconsciousness.

The Advance Directive for Health Care form provides a document that allows one or both of these purposes for advance directives to be completed on one form.

### **Advance Directive Procedures**

The Facility recognizes the right of competent individuals to control decisions related to his or her medical care. This includes the right to consent to, refuse, or alter treatment plans and formulate advance directives. Advance directives relate to the provision of health care when the resident lacks the capacity to make such decisions. Advance Directives, executed in accordance with applicable state law, will be honored by the Facility. Without written directive, usual Facility policy and procedures will be followed. Whether or not a resident chooses to execute an advance directive is a personal matter and will never be a condition of providing care or a basis for or against the resident.

### **Health Care Agent**

A person can appoint a “health care agent” to act for and on their behalf to make decisions related to consent, refusal or withdrawal of any type of health care when the person is unable or chooses not to make health care decisions for him or herself. You should sit down with this agent and discuss your views; thus, giving your health care agent instructions or guidelines, you want them to follow.

As long as you are competent and able to communicate, you make your own decisions. Your health care agent is involved only when and if it is determined that you are unable to understand or communicate your decisions. You can make changes in or revoke or cancel the document at any time.

In Georgia, the current statutory form is the Advance Directive for Health Care and Part One of this form allows a person to appoint a health care agent and back-up agents. Other forms of advance directives for health care that substantially comply with this form may be used. If a person has completed a validly executed Durable Power of Attorney for Health Care on or before June 30, 2007, this advance directive document will remain valid unless you decide to revoke it.

### **Treatment Preferences (formerly Living Will)**

Another type of advance directive is a document that directs treatment preferences when and only when a person is in a terminal condition or state of permanent unconsciousness. One of the two conditions would have to be established by having two physicians personally examine and certify in writing that the condition exists. Statements about the withholding or withdrawal of life support as well as statements concerning whether the individual would want nourishment or hydration may be declared. The withholding or withdrawal of certain medical procedures does not include the administration of medication to alleviate pain or the performance of any medical procedure deemed necessary to alleviate pain.

In Georgia, the Treatment Preferences section of the Advance Directive for Health Care form allows you to state your treatment preferences if you have a terminal condition or if you are in a state of permanent unconsciousness. Other forms of advance directives for health care that substantially comply with this form may be used. If a person has completed a validly executed Living Will on or before June 30, 2007, this advance directive document will remain valid unless you decide to revoke it. These documents can be changed or revoked at anytime. If you choose to complete the new Advance Directive for Health Care, it will replace any other advance directive form that is currently in place.

### **Other Pertinent Information**

In addition, state law provides very specific procedures related to cardiopulmonary resuscitation (CPR). This law allows you to indicate if you do or do not want CPR in the event your heart stops beating or you stop breathing (cardiac or respiratory arrest). This is referred to as a “Do Not Resuscitate” Order (DNR).

### **Do Not Resuscitate Orders**

Cardiopulmonary resuscitation (CPR) involves performing chest compressions and mouth to mouth breathing when a person goes into cardiac or respiratory arrest in order to bring them back to life. Once CPR is started, it must be continued until the person gets to the hospital. For many, this may not be a desired treatment of choice. Our Facility recognizes a “Do Not Resuscitate” (DNR) order. All that a DNR order means is that the person does not want CPR if they go into cardiac or respiratory arrest. All other care and treatment continues the same. Residents who can understand what CPR is and its ramifications can make their own decisions about whether they would want CPR if their heart stops beating. If the resident cannot understand, an authorized person can consent to the DNR order if the physician has determined the resident to be a candidate for non-resuscitation. The decision about whether to have a DNR order should be made based on what the resident would have wanted had he/she been able to speak themselves.

The policy of this Facility is to perform CPR unless we have a DNR order. There is a procedure that we follow in order to comply with state law. If you would like more information or feel that you want to proceed with having a DNR order completed, please contact the Social Services or Admissions Departments.

### **Do Not Resuscitate Procedures**

Under certain specified conditions, an attending physician can order that no attempt be made at cardiopulmonary resuscitation (CPR) on his or her resident (“DNR” Order). Unless a DNR Order is entered on the resident’s chart, CPR will be performed unless it is medically futile. Medically futile is defined to mean that when all the conditions listed below are true, CPR will not be initiated until the physician orders it even if the resident does not have a DNR order documented on the chart.

1. Resident has no visible respiratory efforts;
2. Resident has no vital signs;
3. Resident is unresponsive to verbal or painful stimulation;
4. Resident’s pupils are fixed, dilated and non-reactive to light; and
5. Resident’s skin is cold to touch.

### **Additional Information Available**

If you have any questions concerning any of this material, would like standard forms or complete policies and procedures for a particular advance directive, please contact the Social Services Director.

### **Medicaid Application Information**

Medicaid eligibility is income-based. It is the responsibility of the Resident/Fiduciary Party to initiate the Medicaid application process and provide all required information to the appropriate Medicaid office. Applications can be obtained in the business office. Completed applications must be provided to county-specific Department of Family and Children’s Services to determine Medicaid eligibility. For residents receiving Medicaid benefits, a portion of the Resident’s total income will be due to the Facility on a monthly basis.

### **Medicare Information**

Medicare is health insurance for the following:

- People 65 or older
- People under 65 with certain disabilities

- People of any age with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant)

The different parts of Medicare help cover specific services:

Medicare Part A (Hospital Insurance)

- Helps cover inpatient care in hospitals
- Helps cover skilled nursing facility, hospice, and home health care

Medicare Part B (Medical Insurance)

- Helps cover doctors' services, hospital outpatient care, and home health care
- Helps cover some preventive services to help maintain your health and to keep certain illnesses from getting worse

Medicare Part D (Medicare Prescription Drug Coverage)

- A prescription drug option run by Medicare-approved private insurance companies
- Helps cover the cost of prescription drugs
- May help lower your prescription drug costs and help protect against higher costs in the future

Medicare began offering prescription drug coverage for all people with Medicare, regardless of income, health status or current health care coverage effective January of 2006. Enrollment is optional, but you must enroll to receive coverage. If you are currently eligible for Medicare Part D and choose not to enroll in a Medicare Part D Prescription Drug Plan, you will probably have to pay a higher premium by 1% of the average national monthly premium for each month (or 12% for each year) that you delay.

Medicare beneficiaries who also have full Medicaid coverage (dually eligible) must participate in the program. Dual eligibles will be or have been automatically enrolled in a randomly selected, low cost standard plan serving their area and will pay a monthly premium as determined by their prescription insurance carrier. Because the drugs covered on these plans may not meet their needs, they can change at any time. However, if they enroll in a plan that has a premium higher than a standard plan, they will have to pay the difference.

For dually eligible residents: any Part D plan used in this Facility must be long-term care friendly as well as accept dually eligible persons. Our Facility will work in conjunction with our pharmacy to ensure that each dually eligible resident is signed up for the correct standard prescription plan. If you are enrolled in a prescription drug plan prior to admission, you need to provide a copy of your prescription drug card to the Admissions Director upon admission in order for proper pharmacy billing. Medicare beneficiaries who will be privately paying for their nursing home care (are not dually eligible with Medicaid, are currently covered under a Medicare HMO or are currently being covered under Medicare Part A) can choose whether or not to sign up for a Medicare Part D prescription drug plan. Each Resident/responsible party is responsible for choosing their individual Medicare Part D prescription drug plan. You can use Medicare's Formulary Finder on their website at [www.medicare.gov](http://www.medicare.gov) or if you do not have internet access by calling 1-800-MEDICARE. Once you have chosen a plan, you can enroll with Medicare or directly with the plan of your choice.

Residents admitted under Medicare will need to follow the instructions above for either private pay residents or dually eligible Medicaid residents depending on their long-term care plans and Medicaid eligibility status.

For pharmacy-related specific questions, please contact our pharmacy provider:  
United Pharmacy Services Billing Department: 1-800-822-2749



If you have any additional questions regarding Medicare Part D, please see our Social Services Department.

Once you have chosen a Medicare Part D plan, please contact our Social Services department with that information.

Medicare Advantage Plans (like an HMO or PPO) are health plans run by Medicare approved private insurance companies. Medicare Advantage Plans (also called "Part C") include Part A, Part B, and usually other coverage like Medicare prescription drug coverage (Part D), sometimes for an extra cost.

**There are Two Main Choices for How You Get Your Medicare.** Follow These Steps to Help You Decide:

**Decide if You Want Original Medicare or a Medicare Advantage Plan**

STEP 1

Original Medicare	Medicare Advantage Plan (like and HMO or PPO)
<a href="#">Part A</a> (Hospital Insurance) and <a href="#">Part B</a> (Medical Insurance)	<a href="#">Part C</a> – Includes BOTH Part A (Hospital Insurance) and Part B (Medical Insurance)
Medicare provides this coverage. You have your choice of doctors, hospitals, and other providers. Generally, you or your supplemental coverage pays deductibles & coinsurance. You usually pay a monthly premium for Part B	Please refer to <a href="http://www.medicare.gov">www.medicare.gov</a> for more information.
Decide If You Want Prescription Drug Coverage ( <a href="#">Part D</a> )	Decide If You Want Prescription Drug Coverage ( <a href="#">Part D</a> )
If you want this coverage, you must choose and join a Medicare Prescription Drug Plan. These plans are run by private companies approved by Medicare.	If you want prescription drug coverage, and it's offered by your plan, in most cases you must get it through your plan. If your plan doesn't offer drug coverage, you can choose and join a Medicare Prescription Drug Plan.
STEP 2	
STEP 3	
Decide If You Want Supplemental Coverage	Continue Below
You may want to get coverage that fills gaps in Original Medicare coverage. You can choose to buy a <a href="#">Medigap</a> (Medicare Supplement Insurance) policy from a private company. Costs vary by policy and company. Employers and/or unions may offer similar coverage.	<b>Note:</b> If you join a Medicare Advantage Plan, you don't need a <a href="#">Medigap</a> policy. If you already have a <a href="#">Medigap</a> policy, you can't use it to pay for out-of-pocket costs you have under the Medicare Advantage Plan. If you already have a Medicare Advantage Plan, you can't be sold a <a href="#">Medigap</a> policy.

To obtain Medicare enrollment information, contact the Social Security office at 1-800-772-1213 or visit [www.medicare.gov](http://www.medicare.gov).

**RESIDENT INVENTORY LIST**

To assist in keeping track of personal items, the Resident and/or Family is encouraged to maintain a list of all items brought into the Facility.

- Please do not bring highly expensive items or items that are irreplaceable.
- Properly label all belongings. Clothing can be labeled by the Laundry Department.
- Items, including but not limited to eyeglasses, dentures and hearing aides should be insured by family members. A.G. Rhodes is not responsible for lost items.

Personal Items:

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**Privacy Act Statement-Health Care Records (7/14/2005)**

*This form is not a consent form to release or use health care information pertaining to you.*

**1. Authority for collection of information including social security number (SSN).**

Sections 1819(f), 1919(f), 1819(b)(3)(A), 1919(b)(3)(A) and 1864 of the Social Security Act.

**2. Principal purposes for which information is intended to be used.**

This form provides you the advice required by the Privacy Act of 1974. The personal information will facilitate tracking of changes in your health and functional status over time for the purposes of evaluating and assuring the quality of care provided by nursing homes that participate in Medicare or Medicaid.

**3. Routine uses.**

The primary use of this information is to aid the administration of the survey and certification of Medicare/Medicaid long-term care facilities and to improve the effectiveness and quality of care given in those facilities. This system will also support regulatory, reimbursement, policy, and research functions. This system will collect the minimum amount of personal data needed to accomplish its stated purpose.

The information collected will be entered into the Long-Term Care Minimum Data Set (LTC MDS) system of records, System No. 09-70-1517. Information from this system may be disclosed, under specific circumstances (routine uses), which include: To the Census Bureau and to: (1) Agency contractors, or consultants who have been engaged by the Agency to assist in accomplishment of a CMS function, (2) another Federal or State agency, agency of State government, an agency established by State law, or its fiscal agent to administer a Federal health program or a Federal/State Medicaid program and to contribute to the accuracy of reimbursement made for such programs, (3) to Quality Improvement Organizations (QIOs) to perform Title XI or Title XVIII functions, (4) to insurance companies, underwriters, third party administrators (TPA), employers, self-insurers, group health plans, health maintenance organizations (HMO) and other groups providing protection against medical expenses to verify eligibility for coverage or to coordinate benefits with the Medicare program, (5) an individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, or restoration of health, or payment related projects, (6) to a member of Congress or congressional staff member in response to an inquiry from a constituent, (7) to the Department of Justice, (8) to a CMS contractor that assists in the administration of a CMS-administered health benefits program or to a grantee of a CMS-administered grant program, (9) to another Federal agency or to an instrumentality of any governmental jurisdiction that administers, or that has the authority to investigate potential fraud or abuse in a health benefits program funded in whole or in part by Federal funds to prevent, deter, and detect fraud and abuse in those programs, (10) to a national accrediting organizations, but only for those facilities that these accredit and that participate in the Medicare program.

**4. Whether disclosure is mandatory or voluntary, and effect on individual of not providing information.**

For Nursing Home residents residing in a certified Medicare/Medicaid nursing facility the requested information is mandatory because of the need to assess the effectiveness and quality of care given in certified facilities and to assess the appropriateness of provided services. If the requested information is not furnished the determination of the beneficiary services and resultant reimbursement may not be possible.

Your signature on page 26 (Acknowledgement of Receipt of Notice) of this document merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

## Resident Federal and State Rights

As a Resident of this Facility, you have the following rights:

### Exercise of Rights:

You have the right to exercise your rights as a Resident of the Facility and as a citizen or resident of the United States. Your rights, benefits and privileges as a citizen include, but are not limited to the following:

- The right to vote. If you are eligible to vote, you shall have the right to vote in primary, special and general elections and in referenda. The Facility shall permit and reasonably assist you to obtain voter registration forms and applications for absentee ballots and to comply with other requirements, which are prerequisites for voting.
- The right to free exercise of religion as well as freedom from imposition of religious beliefs or practices.
- The right to associate, meet and communicate privately with persons of your choice.
- The right to participate, inside and outside the Facility, in social family, religious, and community group activities.
- You have the right to be free of interference, coercion, discrimination or reprisal from the Facility in exercising your rights.
- If you are adjudged incompetent under the laws of this State by a court of competent jurisdiction, your rights will be exercised by the person appointed under State law to act on your behalf.

### Notice of Rights and Services:

- You have the right to be informed prior to or upon admission and during your stay both orally and in writing in a language you understand of your rights and all rules and regulations governing your conduct and responsibilities during your stay in the Facility.
- You have the right, upon written request and 48 hour notice, to inspect and purchase photocopies of all records pertaining to you.
- You have the right to be fully informed in language you understand of your total health status including, but not limited to, your medical condition.
- You have the right to refuse treatment and to refuse to participate in experimental research.
- You have the right to be informed in writing at the time of admission to the Facility, or when you become eligible for Medicaid, of items and services that are included in nursing Facility services under the Medicaid program in this State and for which you may not be charged. You also have the right to be informed of those other items and services that the Facility offers and for which you may be charged, the amount of charges, and to be informed when charges are made to items and services paid for and not paid for by the Medicaid program of this State.
- You have the right to be informed before or at the time of admission and periodically during your stay of services available in the Facility and of charges for those services including any charges for services not covered under the Medicare program or by the Facility's per diem rate. You have a right to be informed in writing of any changes in rates or the services that the rates cover at least 30 days in advance of the effective date of change.
- You have the right of access to the written policies and procedures of the Facility during ordinary business hours.
- You have the right to file a complaint with the State Survey and Certification Agency concerning abuses, neglect and misappropriation of your property in the Facility.
- You have the right to be informed of the name, specialty, address and telephone number of the Physician responsible for your care.

- Except in a medical emergency or if you have been adjudged incompetent, you have the right to be consulted with immediately whenever:
  - You are involved in an accident which results in injury.
  - A significant change occurs in your physical, mental, or psychosocial status.
  - There is a need to alter treatment significantly.
  - A decision is made to transfer or discharge you from the Facility.
  - A change in your room or roommate assignment occurs.
  - There is a change to your rights under Federal or State laws or regulations.
  - You also have the right to have your Attending Physician notified of the above and to have your legal representative or interested family member notified within 24 hours of the above.
  - You have a right to be notified prior to or at the time of a suspension of a right or rights due to a medical contraindication, of such suspension, its duration and your legal right to meet with legal counsel, the ombudsman, members of your family, your guardian or others of your choice.

#### Work:

- You have the right to refuse to perform services for the Facility. You have the right to perform services for the Facility if you choose to do so and agree to the work arrangement described in the plan of care.

#### Contributions:

- You have the right not to be coerced by any means into giving contributions.

#### Resident Funds:

- You have the right to manage your financial affairs and the Facility may not require that you deposit your personal funds with the Facility. A description of the manner of protecting personal funds is contained in the Management of Personal Funds Agreement, which is incorporated into this document.

#### Free Choice:

- You have the right to choose a personal Attending Physician.
- You have the right to be fully informed in advance about care and treatment and of any changes in the care and treatment that may affect your well-being and to participate in planning care and treatment or changes in care and treatment, unless you have been adjudged incompetent or found to be incapacitated under State laws.
- You have a right to refuse medical treatment, dietary restrictions and medications unless such refusal would be harmful to the health or safety of others, as documented in your medical records by your Physician. If such refusal apparently would be seriously harmful to your health or safety, the Facility shall either refer you to a hospital or notify a responsible family member or, if such a family member is not readily available, the Department of Family and Children Services of the County.
- You have the right to select the Pharmacy or Pharmacist of your choice for those pharmaceutical supplies and services not provided by the Facility as a part of the basic rate.
- You have a right, if you request, to be informed of the identity, purpose and possible reactions to each drug to be administered.

#### Freedom from Discrimination:

- You have a right to be free from discrimination on the basis of your history or condition of mental or physical disease or disability, unless you would cause the Facility or any Resident to lose eligibility for any Federal or State Program of financial assistance or unless the Facility cannot provide adequate and appropriate care, treatment and services to you due to the disease or disability.

Privacy And Confidentiality:

- You have the right to personal privacy and confidentiality of your personal clinical records. Personal privacy includes privacy in accommodations, medical treatment, written and telephone communications, personal care, visits and meetings of family and resident groups, but this does not require the Facility to provide a private room. The Administrator of the Facility must make available at least one private place for visits during normal visitation hours, which shall be for at least 12 continuous hours per day.
- You have a right to privacy in your room or in your portion of the room. No member of the Staff may enter your room without making his/her presence known, except when you are asleep, in an emergency threatening your health or safety or as required by your Care Plan.
- You have a right to a private room and a personal sitter if you pay the difference between the Facility's charge for such a room and sitter and the amount reimbursed through Medicare or Medicaid.
- You have the right to refuse to accept correspondence, telephone calls or visitation by anyone.
- You have a right to respect and privacy in your medical, personal and bodily care program. Your case discussion, consultation, examination, treatment and care shall be confidential and shall be conducted in privacy. Those persons not directly involved in your care must have your permission to be present.
- You have the right to approve or refuse the release of personal and clinical records to any individual outside the Facility except: When you are transferred to another health care institution; or when record release is required by law or third-party payment contract.

Examination of Survey Results:

- You have the right, upon reasonable request, to examine the results of the most recent survey of the Facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the Facility.
- You have the right to receive information from agencies acting as client advocates and to be afforded the opportunity to contact these agencies.

Access to Facility/Visitation Rights:

You have the right and the Facility must provide immediate access to you by the following:

- Any representative of the Secretary.
- Any representative of the State.
- Your individual Physician.
- The State long-term care ombudsman.
- The agency responsible for the protection and advocacy system for developmentally disabled individuals.
- The agency responsible for the protection and advocacy system for mentally ill individuals.
- Immediate family or relatives, subject to your right to deny or withdraw consent at any time.
- Others, subject to your right to deny or withdraw consent at any time.
- You have a right and the Facility must provide reasonable access to you by any entity or individual that provides health, social, legal or other services to you, subject to your right to deny or withdraw consent at any time.

Telephone and Mail:

- You have the right to regular access to the private use of a telephone.
- You have the right to privacy in written communication, including the right to send and receive mail promptly that is unopened and to have access to stationary, postage and writing implements at your own expense. The Administrator shall provide that mail is received and mailed on regular postal delivery days.

Personal Property:

- You have the right to retain and use personal possessions including some furnishings, appropriate clothing and foods, in your immediate living quarters, as space permits, unless to do so would infringe upon the rights to health and safety of other residents.
- You have the right to request the Facility to provide a means of securing your property in your room or in any other secured part of the Facility so long as you have access to such property on weekdays and where the Facility policy allows, on weekends and holidays.

Married Couples:

- You have the right to share a room with your spouse if you live in the same Facility as your spouse and both you and your spouse consent to the arrangement.
- You have a right to private visits with your spouse.

Self-Administration of Drugs:

- You have the right to self-administration of drugs unless the Interdisciplinary Team has determined, for you individually, that this practice is unsafe.

Admission, Transfer And Discharge Rights:

- You have the right to remain in the Facility and not be transferred or discharged from the Facility unless:
- The transfer or discharge is necessary for your welfare and your needs cannot be met in the Facility.
- The transfer or discharge is appropriate because your health has improved sufficiently or you no longer need the services provided by the Facility.
- The safety or health of individuals in the Facility is endangered.
- You have failed, after reasonable and appropriate notices, to pay for (or to have paid under Medicare or Medicaid) your stay in the Facility.
- The Facility ceases to operate.
- You have the right, when transfer or discharge occurs for any reasons listed above, to have the reason for the transfer or discharge documented in your medical record and to have notice of the reason given to you and your family or legal representative.
- You have a right to be notified and to have your Attending Physician notified at least 30 days before any involuntary transfer, except a transfer pursuant to (2nd statement) above.
- You have a right to receive at least 15 days' notice prior to an involuntary intra-facility transfer.
- You have a right to be assisted by the Facility with sufficient preparation and orientation to ensure safe and orderly transfer or discharge from the Facility. The plan for such transfer or discharge shall be designed to mitigate the effects of transfer stress to you. Such plan shall include counseling regarding available community resources and informing the appropriate state of social service organization.
- You have a right to be transferred with your spouse, if you are married to another Resident in the Facility, if the Facility proposes to transfer involuntarily you or your spouse to another Facility at a similar level of care, pending availability of accommodations.
- You have a right to be discharged from a Facility after you give the Administrator or person in charge of the Facility notice of your desire to be discharged and the date of the expected departure.
- You have a right, if allowed by your health condition, to treatment and care, rehabilitative services and assistance by the Facility to prepare you to return to your home or other living situation less restrictive than the Facility. Upon request, you have a right to information regarding available resources and information regarding appropriate state or social service organizations.

- If you are transferred from the Facility to a hospital, other health care Facility or trial alternative living placement, you have the right to return to the Facility immediately upon discharge from the hospital or other health care Facility or upon termination of the trial living placement, provided that you have continued to pay the Facility or third-party payment is provided for the period of your absence. In cases of nonpayment to the Facility during the absence, you, upon request to return to the Facility from a hospital shall be admitted by the Facility to the first bed available after discharge from hospital.

#### Abuse:

- You have the right to be free from verbal, sexual, physical or mental abuse, corporal punishment or involuntary seclusion.

#### Participation in Resident And Family Groups:

- You have the right to organize and participate in resident groups in the Facility and your family has the right to meet in the Facility with the families of other residents in the Facility. The Facility may not compel your attendance at or participation in residents' council meetings.

#### Restraints/Isolation:

You have the right to be free from any actual or threatened isolation, physical restraints, psychoactive drugs, which are used for the purpose of discipline or convenience and are not required to treat your medical symptoms. Restraints may only be imposed:

- To ensure your physical safety or the physical safety of other residents.
- Only upon the written orders of a Physician. The orders must specify the duration and circumstances under which restraints are to be used, except in emergency circumstances.
- You have the right to be informed immediately of the need for the use of restraint restriction or isolation, the reasons for such use and the time the Physician has specified for such use.
- You have the right, if you are restrained or isolated, to be monitored by the staff at least every hour and relaxed and exercised at least every two hours, except during normal sleeping hours.

#### Quality Of Life:

You have the right to receive care from the Facility in a manner and in an environment that promotes, maintains or enhances your dignity and respect in full recognition of your individuality. You have the right to:

- Choose activities, schedules and health care consistent with your interests, assessments and plans of care.
- Interact with members of the community both inside and outside the nursing facility.
- Make choices about aspects of your life in the nursing facility that is significant to you.
- You have a right to rise and retire at times of your choice if you do not interfere with the right of others.
- You have a right to use tobacco and to consume alcoholic beverages if you do not interfere with the rights of others, subject to the Facility's policies and safety rules and applicable State law.
- You have the right to participate in social, religious and community activities that do not interfere with the rights of other residents in the Facility.

#### Accommodation of Needs:

- You have a right to reside and receive services in the Facility with reasonable accommodation of individual needs and preferences except when your health or safety or the health or safety of other residents would be endangered.
- You have the right to receive care, treatment and services which are adequate and appropriate and provided:
  - With reasonable care and skill.
  - In compliance with applicable laws and regulations.



- Without discrimination in the quality of a service based on the source of payment for the service.
- With respect for your personal dignity and privacy; and
- With the goal of your return home or to another environmental less restrictive than the Facility.

#### Grievances and Enforcement:

- You have the right to voice complaints and recommend changes in policies, procedures and services to the Administrator, his designee or the residents' council.
- You have the right to voice grievances with respect to treatment or care that is furnished or fails to be furnished without discrimination or reprisal for voicing the grievances. You have the right to prompt efforts by the Facility to resolve grievances you may have including those with respect to the behavior of other residents. You have the right to file a complaint with the state survey and Certification Agency concerning abuse, neglect, and misappropriation of your property in the Facility and non-compliance with the advance directives requirements.
- You have a right to file a grievance under the following procedure if you believe your State rights have been violated by the Facility.
- To initiate the grievance, you may submit an oral or written complaint to the Social Worker or his/her designee. The Administrator or his/her designee shall act to resolve the complaint or shall respond to the complaint within three business days, including in the response a description of the review and appeal rights.
- If you are not satisfied by the action taken by the Administrator or his/her designee, you shall submit an oral or written complaint to State or community ombudsman.
- If the ombudsman does not resolve the grievance to your satisfaction within ten days, you may submit the grievance to an impartial referee, jointly chosen by the Administrator or his/her designee and you, who will conduct a hearing.
- The referee's hearing shall be held at the Facility within 14 days after submission of the grievance to him/her, at a time convenient to the referee, you and the Administrator. You and the Administrator may review relevant records and documents, present evidence, call witnesses, cross-examine witness and make oral arguments. You also have a right to be represented at the hearing by any person of your choice. The referee may ask questions of any person, review relevant records and documents; call witnesses and receive other evidence as appropriate. The referee shall keep a record of the proceeding, which record may be a sound recording. Within 72 hours after the grievance review, the referee shall render a decision and shall give to you and to the Administrator a written statement of the decision and reasons therefore, which statement shall therefore, describe the appeal rights. Such a decision shall be reversed upon the binding parties unless reversed upon appeal.
- If the Ombudsman does not resolve the grievance to your satisfaction within ten days, you may submit the grievance to an impartial referee, jointly chosen by the administrator or his/her designee and you, who will conduct a hearing.
- The referee's hearing shall be held at the Facility within 14 days after your submission of the grievance to him/her at a time convenient to the referee, you, the administrator. You and the administrator may review relevant records and documents, present evidence, call witnesses, cross-examine witnesses and make oral arguments. You also have the right to be represented at the hearing by any person of your choice. The referee may ask questions of any person, review relevant records and documents, call witnesses and receive other evidence as appropriate. The referee shall keep a record of the proceeding, which record may be a sound recording. Within 72 hours after the grievance review, the referee shall render a decision and shall give to you and to the administrator a written statement of the decision and reasons therefore, which statement shall describe the appeal rights. Such decision shall be reversed upon the binding on the parties unless reversed upon appeal.

- You have a right to any document pertaining to you that is kept by the Facility in a central file of grievance documents.
- You have a right, if you believe your State rights have been violated, to an administration hearing under the Georgia Administration Procedure Act.
- You have a right, if your state rights have been violated, to cause of action against the Facility for damages and other relief, as the court having jurisdiction or the action deems proper.

### **Notice of Privacy Practices**

I understand that A.G. Rhodes Health & Rehab is a health care provider and may share my health information for treatment, payment and healthcare operations. I have been given a copy of the organization's Notice of Privacy Practices that describes how my health information is used and shared.

I understand that A.G. Rhodes has the right to change this notice at any time. I may obtain a current copy by contacting the Privacy Officer at 404-636-3512. My signature of receipt of Notice of Privacy Practices during the Admission process constitutes my acknowledgement that I have been provided with a copy of the Notice of Privacy Practices.

This document describes the type of information we gather about you, with whom that information may be shared and the safeguards in place to protect it. You have the right to the confidentiality of your medical information and the right to approve or refuse the release of specific information except when law requires the release. If the practices described in this document meet your expectations, there is nothing you need to do.

If you prefer that information not be shared, we may honor your written request in certain circumstances described below. If you have any questions about this notice, please contact our Privacy Officer at the address below.

### **Who Will Follow This Notice**

This notice describes the practices of A.G. Rhodes regarding the use of your medical information and that of:

- Any health care professional authorized to enter information into your chart or medical record.
- All departments and areas of the A.G. Rhodes communities you may visit.
- Any member of our volunteer group we allow to help you while you are at A.G. Rhodes.
- All employees, staff and other personnel who may need access to your information.
- All entities, sites and locations of The A.G. Rhodes Homes follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or health care purposes described in this notice.

### **Our Pledge Regarding Medical Information**

We understand that medical information about you and your health is personal. Protecting medical information about you is important. We create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the A.G. Rhodes organization, whether made by health care professionals or other personnel.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Keep private all medical information that identifies you.
- Give you this notice of our legal duties and privacy practices with respect to your medical information.
- Follow the terms of the notice that is currently in effect.

## How We May Use and Disclose Medical Information About You

The following categories describe different ways that we may use and disclose medical information.

**For Treatment:** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, training doctors or other health care professionals who are involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different health care professionals also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside of the A.G. Rhodes organization who may be involved in your medical care after you leave A.G. Rhodes or that provide services that are part of your care.

**For Payment:** We may use and disclose medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. For example, your insurance may need to know about treatment you received so they will pay us or reimburse you for the surgery. We may also use and disclose medical information about you to obtain prior approval or to determine whether your insurance will cover the treatment.

**For Health Care Purposes:** We may use and disclose medical information about you for health care purposes. This is necessary to make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also disclose information to doctors, nurses, technicians, training doctors, medical students and other personnel for review and learning purposes. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

**Appointment Reminders:** We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care.

**Treatment Alternatives:** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**Health-Related Benefits and Services:** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

**A.G. Rhodes Directory:** We may include certain limited information about you in the directory while you are a patient at A.G. Rhodes. This information will include your name and location in A.G. Rhodes. Unless submitted in writing, additional information may also be given when requested by name. Such information includes, but is not limited to, your location in A.G. Rhodes, general condition (e.g., fair, stable, etc.) and religious affiliation. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name. This is so your family, friends and clergy can visit you in A.G. Rhodes and generally know how you are doing.

**Individuals Involved in Your Care or Payment for Your Care:** We may release medical information about you to a friend or family member who has your authorization, prior or otherwise, or the authorization from your Durable Healthcare Power of Attorney or Legal Guardian. We may also release information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

**Research:** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' needs for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the A.G. Rhodes organization. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care while at A.G. Rhodes.

**As Required By Law:** We will disclose medical information about you when required to do so by federal, state or local law.

**To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

**Fundraising Activities:** We may use medical information about you in an effort to raise money for the A.G. Rhodes communities or foundation and its operations. We may disclose medical information to a foundation related to A.G. Rhodes so that the foundation may raise funding for the A.G. Rhodes communities. We would only release contact information, such as your name, address and phone number. A.G. Rhodes will obtain separate authorization from the individual to use the Resident's health condition for fundraising activities. If you do not want The A.G. Rhodes Homes to contact you for fundraising efforts, you must notify our Privacy Officer in writing at A.G. Rhodes Health & Rehab, 2801 Buford Hwy. NE, Ste. 500, Atlanta, GA 30329.

### Special Situations

**Organ and Tissue Donation:** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

**Military and Veterans:** If you are a member of the armed forces, we may release medical information about you as required by military command authorities.

**Workers' Compensation:** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks:** We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability.
- To report births and deaths.
- To report child abuse or neglect.
- To report reactions to medications or problems with products.
- To notify people of recalls of products they may be using.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.

**Health Oversight Activities:** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

**Lawsuits and Disputes:** We may disclose medical information about you in response to a subpoena, discovery request or other lawful order from a court.

**Law Enforcement:** We may release medical information if asked to do so by a law enforcement official as part of law enforcement activities; in investigations of criminal conduct or of victims of crime; in response to court orders; in emergency circumstances; or when required to do so by law.

**Coroners, Medical Examiners and Funeral Directors:** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

**Protective Services for the President, National Security and Intelligence Activities:** We may release medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations, or for intelligence, counterintelligence and other national security activities authorized by law.

**Your Rights Regarding Medical Information About You Right to Inspect and Copy:** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to our Privacy Officer at the address below. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain, very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by A.G. Rhodes will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

**Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to our Privacy Officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment.
- Is not part of the medical information kept by the A.G. Rhodes organization.
- Is not part of the information that you would be permitted to inspect and copy.
- Is accurate and complete.

**Right to an Accounting of Disclosures:** You have the right to request an “accounting of disclosures”. This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Your request must state a time period that may be no

longer than six years and may not include dates before April 14, 2003. Your written request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must make your request in writing to our Privacy Officer at the address below. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

**Right to Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to our Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

**Right to a Paper Copy of This Notice:** You have the right to a paper copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please request one in writing from our Privacy Officer at the address below.

### **Changes to This Notice**

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facilities. The posted notice will contain on the first page, in the top right-hand corner, the effective date.

### **Other Uses of Medical Information**

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

### **Comments or Complaints**

If you believe your privacy rights have been violated, you may file a complaint with the A.G. Rhodes organizations. To file a complaint, contact our Privacy Officer at the address and phone number below. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

### **Privacy Officer**

A.G. Rhodes Health & Rehab  
2801 Buford Hwy. NE, Suite 500, Atlanta, GA 30329  
(404) 636-3512

### **Additional Information Available**

If you have any questions concerning any of this material, would like standard forms or complete policies and procedures, please contact the Social Services Director.