March 19, 2021

AUBURN HILL
SENIOR LIVING

Hello Auburn Hill Residents, Families, and Team members and Happy Friday!

We are excited that private dining room visits and salon visits have been such a success! It has been nice to see your masked faces!

With that said, I know there have been questions about apartment visitation and a timeline. A. I have reached out to VDH for additional guidance and I am awaiting a response.

While we examine the possibilities and recommendations for apartment visitation, we will begin as a team to determine what that process would look like here at Auburn Hill. This will consist of a process with specific guidelines and some restrictions in place. Although I cannot commit to a timeline at this point, we all agree that it is important to explore possibilities of how we can move things forward for everyone.

In addition to this, we are working with Senior Well to establish when onsite services can begin here. As a reminder, Senior Well has the capability to offer podiatry, dental, optometry, and audiology services here. Everyone has signed the consents and elected to receive or decline services during the admissions process. Senior Well has since then developed new consent forms that they require. I have attached that for your review. Please return these to Auburn Hill once you have signed it. Please let us know if you have any questions about this.

We are all enjoying the socialization and the energy that has been brought back to the dining room for meals. As we continue to move forward, it will be important to start resuming to some “normalcy” of a daily routine. We felt that during the pandemic with so many restrictions that regardless of where meals were being served it was important to maintain a level of flexibility with meal service. As we grow and try to get back on track with our dining program, we will need to move towards meal delivery charges to the apartments. This will take effect on 4/1/21. Please let us know if you have any questions about this.

I remain hopeful that we might continue to see some more “wins” in our future. Residents, families, and team members continue to amaze me in their continued support, and commitment to Auburn Hill. It is truly amazing and so appreciated.

More good things to come on the horizon, as always, please let me know if you have any questions.

Thanks

Kelly Carter, Executive Director

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Complete care, because we care

Welcome to Auburn Hill Senior Living!

We are excited to introduce ourselves as a partner with Auburn Hill to provide on-site **Podiatry, Optometry, Dentistry, and Audiology** healthcare services to the residents.

In delivering health care, effective teamwork positively affects patient health outcomes.[1] Without initiating preventative care, diagnosis and treatment may be delayed and disease management further compromised. [2] SeniorWell is committed to delivering patient-centered preventative care to the people residing in communities across the country. We are excited by the possibility of providing care to your loved one, we care deeply about each of our patients, and are humbled by the opportunity.

In addition to providing **in-house care**, SeniorWell has the capability to manufacture and fabricate custom dentures, hearing aids, and eyeglasses for residents in need.

In order for you to take advantage of this on-site service we need the attached packet to be completed by the resident or their medically responsible party. Please complete the packet in its entirety and submit to the community so you are directly registered for our next visit. Alternative ways are to email the packet to consents@seniorwellgroup.com or as a last option, mail to SeniorWell at 2100 E. Lake Cook Rd, Suite 1000, Buffalo Grove, IL 60089.

We are looking forward to taking care of the residents at Auburn Hill and to help them live a long, active and healthy life by providing exceptional quality healthcare.

Thank you for the privilege of providing service to your senior.

Sincerely,
Tom
Thomas Nolan
Chief Operating Officer and Authorized Signatory

1.Babiker A, El Husseini M, Al Nemri A, et al. Health care professional development: Working as a team to improve patient care. Sudan J Paediatr. 2014;14(2):9-16. 2. Yu, S.W.Y., Hill, C., Ricks, M.L. et al. The scope and impact of mobile health clinics in United States: a literature review. Int J Equity Health 16, 178 (2017). https://doi.org/10.1186/s12939-017-0671-2

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Patient Agreements

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I hereby authorize the release of pertinent information required by my insurance company or other appropriate party pertaining to treatment rendered to me by **SeniorWell**. Furthermore, I authorize **SeniorWell** to obtain needed information from my personal physician, or insurance company to manage my care and bill for services rendered.

CONSENT TO TREATMENT

I hereby consent to the treatment as prescribed by my physician and/or provided by **SeniorWell** providers. I understand that I am ultimately responsible for charges related to my treatment. All accounts are due and payable upon receipt of the bill.

PATIENT FINANCIAL RESPONSIBILTY FORM

I acknowledge that I have received the Patient Financial Responsibility Form by **SeniorWell.**

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the Notice of Privacy Practices by **SeniorWell**.

ASSIGNMENT OF BENEFITS

I hereby assign all medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment check(s) directly to **SeniorWell** for medical services rendered to myself. I understand I am responsible for any balance not covered by my insurance plan(s) for services rendered.

NO SHOWS AND CANCELLED APPOINTMENTS

I acknowledge that I am responsible for contacting **SeniorWell** should I need to cancel or reschedule my appointment. I must provide notification with **at least 48 hour notice** to **SeniorWell**. I acknowledge that I will be charged a $25 fee for No Shows or notices provided within 48 hours of my scheduled appointment.

_____

Print Name

_____ _____

Signature **Date**

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information),or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to review and obtain copies of your health information with limited exceptions. If you request copies for personal usage, there is a $25.00 fee per incident. If you are requesting medical records for a provider, please complete the SeniorWell Medical Records request and we will fax records directly to the Physician Office at no charge to you.

Amendment: You have the right to request that we amend your health information with written request. Your request will be reviewed by our Medical team prior to any changes occurring.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, you disagree with a decision made about access to your health information, in response to a request made to amend/restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, please submit concerns to us using the contact information listed at the end of this Notice. You also may submit a written concern to the U.S. Department of Health and Human Services and will provide you with the address with the U.S. Department of Health and Human Services to file your complaint upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. A Privacy Officer has been designated. The Privacy Officer can be contacted by simply contacting SeniorWell and ask to speak to the SeniorWell Privacy Officer.

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PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

_____

Print Patient's Name Date

I,_____, acknowledge that I
(Print Patient's Name)

Have received a copy of this office's Notice OF PRIVACY PRACTICES.

I,_____, consent to the use and disclosure of
(Print Patient's Name)

my personal health information by your office for Treatment, Billing/Payment and Health care Operations as outlined in the **NOTICE OF PRIVACY PRACTICES.**

_____ _____

Signature **Date**

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PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing SeniorWell as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibility

- The patient (or patient's responsible party) is ultimately responsible for the payment of his/her treatment and care.
- We are pleased to assist you by billing for our contracted insurers however, the patient is required to provide us with accurate and updated information about their insurance. The ***patient will be responsible*** for any charges incurred if the information provided is inaccurate.
- Patients are responsible for the payment of co-pays, co-insurance, deductibles and all other procedures or treatments not covered by their insurance plan. Any payments received by SeniorWell may be applied to any unpaid bill(s) for which the patient is liable. All balances assigned as patient responsibility may be subject to collection efforts after 90 days, as well as credit reporting.
- Patients may incur and are responsible for the payment of additional charges. These charges may include, but are not limited to:
  - Charge for returned checks.
  - Charge for the copying and distribution of patient medical records.
  - Any costs associated with collection of patient balances.

Patient Authorization

- By my signature below, I hereby authorize SeniorWell to release medical and other information acquired during my examination to the necessary insurance companies, third-party payors, and/or other physician or healthcare entities required to participate in my care.
- By my signature below, I hereby authorize assignment of financial benefits directly to SeniorWell and any associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment. I understand that account balances not paid by my insurance company within 90 days are the patient's/my responsibility.
- By my signature below, I acknowledge and understand that it is ultimately my responsibility and obligation to be aware of my insurance's requirements, coverages, deductibles, and payments.
- By my signature below, I authorize SeniorWell personnel to communicate with me (the patient) or my legal guarantor/power of attorney (POA) by mail, answering machine message, voicemail, and/or email according to the information I have provided in my patient registration information.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

_____ _____

Signature of Patient or Legal Guarantor/POA **Date**

_____ _____

Print Name of Patient or Legal Guarantor/POA **Date**

Waiver of Authorization: I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and/or to submit claims to insurance at my discretion.

_____ _____

Signature of Patient or Legal Guarantor/POA **Date**

_____ _____

Print Name of Patient or Legal Guarantor/POA **Date**