Directions to our Health & Aging Center
The Christ Hospital Health & Aging Center is located at the former site of the Oakley drive-in, just inside Carespring’s Indianspring Transitional Care Center.

**I-71 North or Southbound**
Take the Red Bank Road exit (one-way off exit) and follow Red Bank Road to the Madison Road intersection.
Turn right on Madison Road.
Turn left at the first light into Madison Circle at Babson Place.
At the second drive, turn left again.
Take another left turn at The Plaza @ Madison Circle. The Health & Aging Center is directly inside the double-doors to the left.

**I-75 North or Southbound**
Take the Norwood Lateral East to the Ridge Road exit. At the light, take a right onto Ridge Road.
Follow that to the Madison Road intersection. Turn left at the light.
Turn right into Madison Circle at Babson Place.
At the second drive, turn left.
Take another left turn at The Plaza @ Madison Circle. The Health & Aging Center is directly inside the double-doors to the left.

**Columbia Parkway East or Westbound**
Take Columbia Parkway to the Red Bank Road exit. Turn right off the exit.
Follow Red Bank Road to the Madison Road intersection. Take a left on Madison Road.
Turn left at the first light into Madison Circle at Babson Place.
At the second drive, turn left.
Take another left turn at The Plaza @ Madison Circle. The Health & Aging Center is directly inside the double-doors to the left.
Welcome to The Christ Hospital Center for Health and Aging. We are pleased that you have entrusted us with your geriatric specific care needs.

Your appointment will last approximately two hours. We suggest all involved caregivers or family member are in attendance. The assessment is very detailed and at times lengthy, so we highly recommend small children to not accompany you the day of your visit.

Please sign the enclosed Release of Information form and complete the Intake Assessment form and return them to our office as soon as possible. Use the enclosed envelope or fax to (513) 272-0015. Additionally, please bring the following to your appointment:

- All of your medications in their dispensed bottles (both prescription and over the counter)
- Insurance card(s)
- Picture ID, if available

Please arrive about 15 minutes before your scheduled appointment time to complete registration. The Christ Hospital Center for Health and Aging is covered by most insurance plans and we are a Medicare provider. You may receive two separate bills for the services at The Center for Health and Aging: The Christ Hospital Medical Associates bills for the physician/provider services.

Please see the enclosed directions. If special assistance is required, such as a wheelchair, please let our staff know prior to your visit. Feel free to call us with questions or concerns at (513) 272-8444. We look forward to your visit.

Sincerely,

The Center for Health and Aging Staff
The Christ Hospital Health & Aging Center Geriatric Assessment Intake Form

Patient Title (Miss, Mrs., Mr.):______ Name:_______________________________________Date:__________

Address:__________________________________________________________________________________

City, State, Zip:_____________________________________________________________________________

Home Phone ____________________Cell Phone:_____________________

Date of Birth: ____________________Age: __________________________

Marital Status:____________________ Soc. Sec.#:________________________Language:_________________

Educational level:__________________

Occupation:  ☐ Retired  ☐ Work Part time____________________  ☐ Work Full time________________

Caregiver Name:___________________________ Relationship:________________________________

Home phone:_________________ Cell phone: __________________Work phone:_________________

Caregiver Name:___________________ Relationship:________________________________________

Home phone:__________________ Cell phone:_________________ Work phone:___________

Person completing this form:_______________________________Relationship:__________________

Reason for Referral to The Christ Hospital Health & Aging Center

☐ Medical Assessment  ☐ Medication Review/Management  ☐ Mobility Evaluation

☐ Memory Evaluation  ☐ Caregiver Stress  ☐ Mood Concerns

☐ Behavior Issues  ☐ Multiple Medical Problems  ☐ Other

☐ Risk assessment/protective concerns

Comments:

List All Specialists Currently Involved:

☐ Cardiology/Heart

Name:      Name:      Name:

☐ GI / Stomach

Name:      Name:      Name:

☐ Neurology /Head

Name:      Name:      Name:

☐ Orthopedic/Bone

Name:      Name:      Name:

☐ Rheumatology/Arthritis

Name:      Name:      Name:

☐ Podiatry /Feet

Name:      Name:      Name:

☐ Psychiatry/Mental Health

Name:      Name:      Name:

☐ Pain

Name:      Name:      Name:

☐ Other

Name:      Name:      Name:

☐ Audiology

Name:      Name:      Name:

☐ Hearing Aids

☐ Yes ☐ No
How did you hear about us?

<table>
<thead>
<tr>
<th>Type</th>
<th>Name</th>
<th>Assisted</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician:</td>
<td></td>
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<tr>
<td>Community Agency:</td>
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<td>Relative:</td>
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<td>Friend:</td>
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<td>Media:</td>
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<td>Other:</td>
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</table>

Living Arrangements:

- [ ] Alone in own home with assistance [ ] Yes Name __________________________ [ ] No
- [ ] Alone in apartment with assistance [ ] Yes Name __________________________ [ ] No
- [ ] With family/companion/friend
- [ ] Skilled Nursing Facility
- [ ] Residential Care Facility
- [ ] Senior Housing
- [ ] Nursing Home
- [ ] Other

Family Physician: __________________________ Telephone: __________________________

Address: __________________________ Fax #: __________________________

Date last seen: __________________________

Family doctor aware of referral? [ ] Yes [ ] No If no, why? __________________________

Family doctor agreed to referral? [ ] Yes [ ] No If no, why? __________________________

Have you been in the Hospital or Emergency Room Recently? [ ] Yes [ ] No

Date(s): __________________________

Reason(s): __________________________

Please list your medical problems as you know them:

1. __________________________
2. __________________________
3. __________________________
4. __________________________
5. __________________________
6. __________________________
7. __________________________
8. __________________________
9. __________________________
Please list your current medications (include over the counter and supplements):

<table>
<thead>
<tr>
<th>Name</th>
<th>Dosage</th>
<th>How often?</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
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<td>2.</td>
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<td>15.</td>
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</table>

Pharmacy Name & Phone #

Professional or Community Services Involved

<table>
<thead>
<tr>
<th>Council on Aging</th>
<th>CASS (Cincinnati Area Senior Services)</th>
<th>Alzheimer’s Association</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meals on Wheels</td>
<td>Home Health Care Agency</td>
<td>Other</td>
</tr>
<tr>
<td>Name:____________</td>
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<tr>
<td>□ Nursing</td>
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<tr>
<td>□ Homemaking</td>
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<tr>
<td>□ Personal Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Therapy: PT/OT/Sp eech</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
AUTHORIZATION FOR RELEASE OF PATIENT PROTECTED HEALTH INFORMATION
R-7162 Rev. 02/13

TO BE USED: 1) When patient or patient’s legal representative requests use or disclosure of PHI; 2) for request by or to an entity unless exceptions apply; 3) for use and disclosure of PHI for research (when patient has not signed a research informed consent that includes authorization or researcher has not received a waiver by the I.R.B. or privacy board); and 4) when no other exceptions apply.

Protected Health Information ("PHI") under HIPAA is defined as information that is received from, or created or received on behalf of The Christ Hospital Health & Aging Center and is information about an individual which relates to past, present or future physical or mental health or condition of an individual; the provision of health care to an Individual; or the past, present or future payment for the provision of health care to an individual; and that identifies the individual, or there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased. The following components of a patient’s Information also are considered PHI: a) names; b) street address, city, county, precinct, zip code; c) dates directly Related to a patient, including birth date, admission date, discharge date, and date of death; d) telephone numbers, fax numbers, and electronic mail addresses; e) Social Security numbers; f) medical record numbers; g) health plan beneficiary numbers; h) account numbers; i) certificate/license numbers; j) vehicle identifiers and serial numbers, including license plate numbers; k) device identifiers and serial numbers; l) Web Universal Resource Locators (URLs); m) biometric identifiers, including finger an voice prints; n) full face photographic images and any comparable; and o) any other unique identifying number, characteristic, or code.

PATIENT INFORMATION

Name ______________________________________________________________________________________________________
First  Middle Last Name

Address ____________________________________________________________________________________________________
City  State Zip

Date of Birth ________________________ Social Security No. ______________________ Phone No. ____________________

COPIES SENT FROM/TO

Agency/Hospital FROM TO: (Address where you would like your copies to be sent)
Name of Person The Christ Hospital Health & Aging Center
Street Address 4900 Babson Place Suite 600
City, State, Zip Cincinnati, OH 45227

PROTECTED HEALTH INFORMATION TO BE USED OR DISCLOSED

Check box to indicate PHI that may be used or disclosed. On the line provided, please indicate the dates of service for each service type. The following are not the only types of service. Please indicate any additional service types that are not listed under “other”.

☐ Inpatient ________________________________________________________________________________
☐ Emergency Department __________________________________________________________________
☐ Physical Therapy _________________________________________________________________________
☐ Same Day Surgery ________________________________________________________________________
☐ Outpatient _______________________________________________________________________________
☐ Other ___________________________________________________________________________________

TheChristHospital.com
AUTHORIZATION FOR RELEASE OF PATIENT PROTECTED HEALTH INFORMATION

The following does not constitute every document in a medical record. If you wish to receive a copy of the entire medical record please mark “entire” Referring Physician, Please send records for the past 12 months of the below marked items:

- [ ] History & Physical
- [ ] Lab Reports
- [ ] Progress Notes
- [ ] X-Ray Reports
- [ ] Specialist Notes or Consultation Notes
- [ ] Diagnostic Images
- [ ] Immunization Records
- [ ] Emergency Treatment
- [ ] Medication List
- [ ] In Patient Hospital Records
- [ ] Entire Medical Record (this will include every page in the Medical record, i.e., Nursing Notes, Consent Forms, any and all reports, etc.)

Please specify the reason for your request:

- [ ] Medical Care
- [ ] Geriatric Assessment
- [ ] Disability
- [ ] At My Request/Personal Reasons
- [ ] Other: ___________________________________________  ___________________________________________

Reason Patient is unable to sign: _________________________________________

Describe scope of authority to act for patient: _________________________________________

Provide guardianship, executor of estate, power of attorney papers

Witness Signature  Date/Time

I understand that if the person/entity that receives the above protected health information is not a health care provider / health plan covered by federal privacy regulation, the protected health information described above may be re-disclosed by such person / entity and will likely no longer be protected by the federal privacy regulations.

I understand that my legal representative may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. Written revocation must be sent to: ____________________________________________________________________________
________________________________________________________________________________________.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits, unless the treatment is for research purposes or unless the provision of treatment related solely to the disclosure of my PHI to a third party such as when requested by my employer.

I understand that I will be charged for requesting copies of my medical records and acknowledge that a Christ Hospital representative has discussed the pricing scheme with me.

EXPIRATION

This authorization will expire in 60 days unless otherwise specified (insert date or specific event)

- [ ] I hereby authorize the use of disclosure of my protected health information as described above. I authorize the hospital to release the protected health information concerning treatment, diagnosis, or testing of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric / psychological conditions, Acquired Immune Deficiency Syndrome (AIDS), and / or test for antibodies to the AIDS virus (HIV).
THE CHRIST HOSPITAL HEALTH & AGING CENTER
R-7230B Rev. 02/11

Today's Date: __________________________

Please print:

Patient's Legal Name: ____________________________________________________________________________

Last    First              Middle Initial

Date of birth: ___________________________   SS#: _____________________________________________

Do you have a Living Will:   Y    N Copy given to Primary Care Physician:   Y   N    In chart: (office use only)  Y       N

Is there a Healthcare Power of Attorney:   Y      N  Name:__________________________ Relationship:________________

May we release test results to your:

| Spouse | Y N | Name: _____________________________ |
| Parent | Y N | Name: _____________________________ |
| Child(ren) | Y N | Name: _____________________________ |
| Others | Y N | Name: _____________________________ |

May we discuss billing questions with your:

| Spouse | Y N | Name: _____________________________ |
| Parent | Y N | Name: _____________________________ |
| Child(ren) | Y N | Name: _____________________________ |
| Others | Y N | Name: _____________________________ |

May we leave messages/test results on your answering machine? Y N Phone #: (          )_______________________

May we call you at your place of employment? Yes No Phone #: (          )_______________________

The following may pick up my written prescriptions for controlled substances:

| Name: ___________________________________________ | Relationship: ________________________________ |
| Name: ___________________________________________ | Relationship: ________________________________ |
| Name: ___________________________________________ | Relationship: ________________________________ |

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)
We are legally required to provide you with a copy of our NOTICE OF PRIVACY PRACTICES the first time you receive care at TCHMA. If you are here for emergency medical treatment, you will be given a copy as soon as possible.

☐ I have received a copy of the Notice of Privacy Practices
☐ I have previously received a copy of the Notice of Privacy Practices
☐ I do not want a copy of the Notice of Privacy Practices

AUTORIZATION OF MEDICAL AND RELATED HOSPITAL SERVICES

1. CONSENT TO TREATMENT: I hereby consent to the administration of medical, nursing or other treatment, drug therapy and/or testing as considered necessary for my condition as directed by Dr. ____________ or assistants or designated as may be needed. I understand that The Christ Hospital is a teaching hospital and agree that interns, residents, fellows, nurses, medical students and other health personnel in training may participate with or assist my doctor(s) in the performance of medical, surgical or diagnostic procedures/treatment that my doctor(s) consider necessary.

2. RELEASE OF RECORDS: I authorize the release of medical records information (including, but not limited to information concerning drug related conditions, alcoholism, psychiatric conditions, HIV testing, AIDS diagnosis/related conditions) to insurance carriers, third-party payers or their representatives, and/or review organizations as deemed necessary to determine benefits entitlement and to process payment claims for health services provided. I also understand my records may be related to state, federal or other surveyors for accreditation and/or regulatory licensing purposes. I authorize the release of medical record information to the physician(s) or agency for my follow-up care, and/or to the healthcare facility to which I am transferred from The Christ Hospital. I also authorize release of my medical record information as required by law.

3. NOTICE: I understand that certain physicians providing services to me, including Radiologists and Pathologists are independent contractors not employed by the hospital, and that I will be billed by the individual physician for services rendered to me by these physicians.

4. FINANCIAL AGREEMENT: I hereby authorize the physicians of TCHMA as well as The Christ Hospital to submit a claim to my insurance carrier(s) or its intermediaries, to issue payment DIRECTLY to TCHMA and/or to The Christ Hospital on behalf of such rendered services. I understand that I am financially responsible to this TCHMA office and/or to The Christ Hospital for any balance not covered by my insurance carrier.

SIGNATURE OF PATIENT (if 18 years or older) OR LEGAL GUARDIAN IF PATIENT IS A MINOR

DATE