Change in Condition:

A resident's physician, legal representative, if any, and other responsible persons designated in writing by the resident to be notified shall be notified promptly of any significant accident, incident or adverse change in resident's condition. Please list in order the name of the person you would like notified. **NOTE:** Our staff will contact the first person on the list that can be reached. It will then be up to that person to notify any others.

1. ____
Name Address Phone/Alt. Relationship

2. ____
Name Address Phone/Alt. Relationship

3. ____
Name Address Phone/Alt. Relationship

Change in Status:

A resident's legal representative, if any, and other persons designated in writing by the resident, shall be notified promptly if any significant **non-medical** change in the resident's status, including financial situation, plans for discharge or plans to transfer to another facility. **NOTE:** Again our staff will contact the first person on the list that can be reached. It will then be up to that person to notify any others.

1. ____
Name Address Phone/Alt. Relationship

2. ____
Name Address Phone/Alt. Relationship

3. ____
Name Address Phone/Alt. Relationship

Personal Effects:

Each resident of Willow Manor must sign a statement as to what he/she wishes to do with his/her personal effects. In the event of my death, injury, or accident resulting in my permanent release from the facility I request my personal effects to be released to:

____
Name Address Phone/Alt. Relationship

Consent:

A resident's consent is required to use and disclose the resident's protected health information to carry out treatment, payment activities and health care operations of this facility. Consent is also required to use and disclose resident information to persons involved in the resident's care under the Wisconsin patient confidentiality statute governing use and disclosure of patient health care records.

Purpose of consent: By signing this admission agreement you will consent to our use and disclosure of your patient health care records to carry out treatment, payment activities and health care operations as discussed in our Notice of Privacy Practices. This consent is effective until revoked by you. You may also consent to our use and disclosure of patient health care records for the purposes indicated below. Please place an **X** on the lines provided.

(a) ____ I consent to your listing my name and location in your facility directory and to display my name and or picture outside my room.
(b) ____ I consent to your disclosure of my patient health care records for disaster relief purposes as permitted by law.

You may use professional judgment and your experience with common practice to make reasonable inferences of m best interest in allowing a person acting on my behalf to pick up filled prescriptions, medical supplies, or other forms of protected health information.
Effect of Declining Consent: Obtaining consent for use and disclosure is a condition of your treatment by us. If you decide not to give consent we may decline to treat you.
Privacy Practice Notice: You have the right to read our Privacy Practices Notice before you decide whether to sign this agreement. We encourage you to read it carefully and completely before signing. We reserve the right to change our privacy practices. If we change our privacy practices we will issue a revised Notice to each resident.
Right to Revoke: You have the right to revoke this consent at any time by giving us a written notice of your revocation. The written notice must clearly state your intent to revoke, your signature, and the date.

YOU WILL BE PROVIDED WITH A COPY OF THIS SIGNED ADMISSION AGREEMENT WHICH INCLUDES YOUR CONSENT.

Signature of Resident or Resident's Legal Authorized Representative:

____ Date: ______________________________

Signature of Willow Manor Representative:

____ Date: ______________________________