iMatter Adult Day Center

We Make Aging Fun!

New Client Application

3427 West Woolbright Road
Boynton Beach, FL 33436
P: 561-777-7492 F: 561-777-7494

iMatter Adult Day Center New Client Registration

LAST NAME OF PARTICIPANT	FIRST	MI	SOC. SEC. NUMBER

ADDRESS	CITY & STATE	ZIP

DATE OF BIRTH	AGE	SEX M F	MARITAL STATUS M S P W D	OCCUPATION

HOME PHONE	WORK PHONE ( )	❑ RETIRED OR ❑ EMPLOYED	YEARS

RACE ❑ White ❑ Black ❑ Native American ❑ Asian/Pacific ❑ Other

ETHNICITY ❑ Hispanic ❑ Caribbean Islander ❑ Other	PRIMARY LANGUAGE

REFERRED BY :	ADDRESS/CITY/STATE/ZIP	TELEPHONE(S)

INSURANCE COMPANY INFORMATION

❑MEDICARE NO ❑ MEDICAID NO. ❑ HMO NO. / NAME _____ Copy attached ❑ Yes ❑ No	SUPPLEMENTAL INSURANCE	GROUP NO.

ADDRESS				ADDRESS			
CITY	ST	ZIP CODE	TELEPHONE ( )	CITY	ST	ZIP CODE	TELEPHONE

PHYSICIANS INFORMATION

PRIMARY DR.'S NAME	ADDRESS/CITY/STATE/ZIP	TELEPHONE(S)	FAX (S)
SPECIALIST'S NAME	ADDRESS/CITY/STATE/ZIP	TELEPHONE(S)	FAX (S) ( )

IN CASE OF EMERGENCY NOTIFY

NAME	RELATIONSHIP	ADDRESS/CITY/STATE/ZIP	TELEPHONE(S)
NAME	RELATIONSHIP	ADDRESS/CITY/STATE/ZIP	TELEPHONE(S)

RESPONSIBLE PARTY

LAST NAME	FIRST	MI	Start Date: ____/____/____ Inactive Date: ____/____/____ Restart Date: ____/____/____ End Date: ____/____/____ Reason: _____

ADDRESS/CITY/STATE/ZIP		
HOME PHONE / CELL PHONE	WORK PHONE	EMAIL

RELATIONSHIP TO CLIENT:

Do you have: Wanderer Prevention Program ❑ Yes ❑No Health Care Surrogate ❑ Yes ❑No
Durable Power of Attorney ❑ Yes ❑No Living Will ❑ Yes ❑No

FINANCIAL AGREEMENT

Daily Rate for Adult Daycare Program = $80.00 per day min of 2 days, 1 day = $85
All clients will be charged biweekly prior to services rendered.

Non-Refundable Program Fee of $250. (These Non-Refundable fees are paid prior to attendance).
Veterans Program Fee $175 (Must show proof)

I understand and agree that the **Non-Refundable program fee** in the amount of $250 may be due prior to attendance to reserve my space in the program. Further, I will not be provided a refund for the Non-Refundable Fees for any reason or under any circumstances, including if the Client leaves prior to attendance. **Initials:** _____

A. Program Fee

The minimum attendance requirement for all clients is two days. Upon attendance the client will be responsible for paying for days the client intends on participating. You will be charged biweekly based on those number of days.

B. Long Term Care Policies Program Fee

Above requirements are still applied and once the LTC has been approved, it is up to the caregiver to submit claim and policy information to the Administrator. The Administrator will send monthly statements to the LTC company and the caregiver will be reimbursed directly. iMatter does not receive any money from the LTC company. The only exception will be if the client has Humana LTC. See Administrator for details.

***If services are cancelled, you will be refunded 20 business days from the day you give notification that the client will no longer be attending. If the client becomes a Medicaid client after paying privately and is owed a refund, it will be refunded once the first payment from the Medicaid provider is received.**

Ancillary Charges:

- Transportation $15-$50 based on distance
- Recurring assistance with activities of daily living (i.e. eating, toileting) $10.00 in addition to daily rate
- Coaching sessions for family caregivers, help with Medicaid/Placement $100.00-$250.00
- Early drop-off/Late pick-up $25

Guarantor Initials: _____
Updated: 3/23/2023

C. FINANCIAL AGREEMENT

1. Guarantor Information

I _____, as the guarantor for this account, agree to pay all charges incurred by the named Client while attending at iMatter Adult Day Center. Further, I understand that should this account be referred to an agency or attorney for collection that I will be responsible for all collection costs, attorney fees and court costs.

2. THE GUARANTOR(S) FOR THIS ACCOUNT IS:

NAME(S): _____

ADDRESS: _____

CITY / STATE / ZIP: _____

PHONE/DAY:_____**PHONE/CELL:**_____

EMAIL: _____

D. Payment Options

Payments may be made by check or credit card. (Please circle method of Payment)

Visa MasterCard Discover AmEx Check

****If paying via check, must still put card on file-We will not charge unless payment isn't received****

In order to make credit card payments the following information must be completed

Credit Card #_____

Card Holder's Name: _____

Expiration date_____

V number: _____ **(last 3 digits in signature panel on back of card)**

Card Holder's Address that Credit Card Statement is mailed to:

_____

If card holder is other than guarantor, a signature is required

Guarantor Initials: _____

Card Holder Signature

I am completing the credit card information of this form and do hereby authorize iMatter Adult Day Center to charge my credit card for the amount noted in Items A-G above on every other Thursday of each month and upon cancellation of services for any outstanding balance. I hereby waive all protests to the credit card companies arising out of such automatic charging by iMatter Adult Day Center. I authorize iMatter Adult Day Center to correspond and receive information from Merchant Services and/or the cardholders issuing bank, as necessary in order to resolve errors or disputes. This authorization by me for iMatter Adult Day Center to charge my credit card on every other Thursday of each month shall remain in effect for one (1) year or until I notify iMatter, in writing, via certified mail, overnight delivery by FedEx, UPS or DHL, or Email with Email reply from iMatter, that I wish to end this automatic charging agreement and with sufficient notice (at least thirty [30] days), providing a reasonable amount of time to act on this request. My monthly credit card statement will serve as my receipt.

Guarantor Signature **Date**

E. Client Agreements

Release of Liability

I _____, understand that at iMatter, I will be attending an Adult Daycare community with individual autonomy and independence. While attending this Daycare I may be walking, riding public transportation, or driving my own vehicle. All of these activities will be undertaken at my own risk, and I agree to hold iMatter harmless from any and all incidents or accidents that may occur.

I _____, further understand that a safe is made available to me for my valuables, and iMatter will not accept liability for the theft of any personal items not placed in the safe during my stay.

Agreement to Do No Self-harm or Harm Others

I _____, agree that while attending iMatter I will do no harm to myself or others. I understand that iMatter is not liable for any harm I may do to myself or others during my stay.

Guarantor Initials: _____

I have read this agreement IN FULL prior to signing and understand the provisions contained therein.

Client Signature **Date**

Witness or Administrator's Signature **Date**

ATTENDANCE TERMINATION AGREEMENT

As a client of iMatter Adult Day Center, I _____ understand and agree to the **FINANCIAL AGREEMENT**. I acknowledge and agree that I may be subject to discharge (e.g., administrative, or of my own volition) resulting in cancellation of services. Similarly, in the event of discharge (cancellation of services), I understand and agree that iMatter Adult Day Center may, at its sole discretion, ask me to leave or have me removed from the facility premises. I will be permitted to take with me only my personal belongings. Once I have left the premises, I hereby agree that I will not return to the facility for any reason unless I receive permission by an authorized representative of iMatter Adult Day Center.

I hereby agree if for any reason, including but not limited to mental or physical incompetence, I am unable or unwilling to adhere to the terms set forth in this Agreement, local law enforcement officers may physically remove me from the facility. I understand and agree this is necessary for the health, safety and welfare of others in the iMatter Adult Day Center program.

I am mentally competent and am executing this Agreement knowingly, voluntarily and under no duress. I understand that this Agreement limits my rights as provided for under the law. I understand that there are alternative daycare programs available to me.

Client Signature **Date:**

Guarantor Signature **Date:**

Witness Signature **Date:**

Guarantor Initials: _____

Authorization for Release of Confidential Information

I understand that the use and disclosure of any protected health information pertaining to me is governed by the Health Insurance Portability and Accountability Act (HIPPA), as summarized in iMatter's Privacy Notice.

CLIENT'S NAME _____ _____ _____
LAST FIRST MI

ADDRESS _____ _____ _____ _____
CITY FL ZIP

DAY PHONE_____ ALT PHONE_____

I hereby authorize the release of any financial, medical, psychiatric and/or social information to:

iMatter Adult Day Center, LLC
3427 West Woolbright Road
Boynton Beach, FL 33436
P: 561-777-7492 F: 561-777-7494

TO:_____

IN REFERENCE TO: _____D.O.B_____ SSN_____

The company named above may release and disclose any financial, medical, psychiatric and/or social information, which we deem appropriate to third-party providers i.e. Client's internist, long-term care policy provider, of who have been referred to me pursuant to my request for their use in the performance of services for me and their evaluation and/or care management.

I understand that this authorization will expire as of _____.If left blank, the expiration shall occur when I discontinue services with the provider.

I have a right to revoke this authorization at any time and to obtain a copy of it for my records.

By signing below, I acknowledge that I have read and received a copy of

ATTENDEE_____ DATE_____

OR

LEGAL GUARD./POA_____ DATE_____

iMatter Adult Day Center, LLC
Telephone: 561-777-7492 Fax: 561-777-7494

TB/Communicable Disease Form

As a Florida licensed healthcare provider, I certify that this individual listed below is few and clear of tuberculosis in its communicable form and does not exhibit any signs and/or symptoms of other communicable diseases.

Patient Name_____ **DOB**_____

Last 4 of SSN_____

Date of Last PPD exam_____ **Results of Exam**_____

Date of Last Chest X-ray_____ **Results of Exam**_____

Printed Name of Physician_____

Physician Signature_____ **Date**_____

Mailing Address_____

Telephone #_____ **Fax #**_____

Disclaimer: iMatter Adult Day Center, LLC reserves the right to deny enrollment if this form is not completed to its entirety. This form must be completed within 45 days prior to enrollment.

Patient Name _____ **Last 4 of SSN**_____

Allergies:

Food_____

Medication(s)_____

Diet (Circle all that apply)

Normal	Low-Salt	Low-Carb	Vegan
Kosher	Diabetic	Vegetarian	Low-Fat

Dietary Restrictions (If applicable)_____

Mobility Restrictions_____

Can Aspirin be Given if and when needed? Yes _____ **No**_____

Vital Signs

B/P_____ P-AP_____ RP_____

I _____ certify that this patient is able to participate in most, if not all activities and programs at iMatter Adult Day Center.

Printed Name of Physician_____

Physician Signature_____ Date_____

Mailing Address_____

Telephone #_____ Fax #_____

Disclaimer: iMatter Adult Day Center, LLC reserves the right to deny enrollment if this form is not completed to its entirety. This form must be completed within 45 days prior to enrollment.

iMatter Adult Day Center

Client Acknowledgement

At iMatter Adult Day Center, we are committed to full transparency, all while ensuring that your loved one(s) have a rewarding experience. Below are a list of services that we provide:

Cognitive and Social Stimulation

Catered Breakfast, Lunch and snacks

Theme-Based Activities throughout the day

Music and Art Therapy

Licensed Professional and Clinical Staff

As needed transportation

In the event that any changes are made to the services provided or anything related to the business we will be sure to notify you.

By signing below I am acknowledging that I am fully aware of the services provided by iMatter in addition to knowing my loved ones rights as an attendee. I'm also aware of the policies and procedures and the Emergency Management Plan for iMatter Adult Day center

_____ _____

(Signature of Caregiver/POA/Guadian) **(Date)**

Getting to Know You

Full Name_____D.O.B._____

Country of Origin_____State of Origin_____

Spouse/Partners Name_____ Anniversary Date_____

Number of Children_____Number of Grandchildren_____Number of Siblings_____

Pets **Dogs Cats Other**_____Language(s) Spoken_____

Are You a Veteran? **Yes or No** If yes, what war(s) did you serve in_____

Former Career_____

Favorite Holiday(s)_____

Favorite Pastime_____

Hobbies_____

Favorite Food(s)_____

Favorite Genre(s) of Music_____

Things that Bring
Joy/Happiness_____
_____

Things that are
Upsetting/Triggers_____
_____

Additional Comments/Concerns

_____

_____

iMatter Adult Day Center recognizes the need to ensure the welfare and safety of all seniors taking part in any activity associated with our organization.

In accordance with our client protection policy we will not permit photographs, video or other images of clients to be taken without the consent of the caregivers and or participants. As your loved one will be taking part in different activities throughout the day, we would like to ask for your consent to take photographs/videos of the event or activity that may contain images of yourself and/or loved one. It is likely that these images may be used as

- a record of the activity or the event
- in a written evaluation report of the activity or event that will
- publicity material for further activities or events on leaflets/websites/magazines
- illustrations of the activities or events in published articles

iMatter Adult Day Center will take all steps to ensure these images are used solely for the purposes they are intended. If you become aware that these images are being used inappropriately you should inform iMatter Adult Day Center immediately.

I _____ (please circle one)**consent to/ do not consent to** iMatter Adult Day Center photographing or videoing

Signature:_____

Date:_____

NOTICE OF PRIVACY PRACTICES
Effective Date: September 13, 2010

THIS NOTICE DESCRIBES HOW MEDICAL 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.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. This notice takes effect on September 13, 2010 and will remain in effect until we replace it. We are required to abide by the terms of the notice currently in effect. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request and on our website.

You may request a copy of our Notice at any time.

PROTECTED HEALTH INFORMATION
Definition: Individually-identifiable health information regarding the patient. Examples include (but are not limited to): diagnosis, signs and symptoms of illness, name, address, birthdate.

USES AND DISCLOSURES OF HEALTH INFORMATION
We routinely use and disclose health information about you for treatment, payment and healthcare operations, for example:
Treatment. We may disclose your health information to your physician(s) and/or other healthcare provider(s) in order to coordinate treatment for you.
Payment. We may disclose your health information in order to obtain payment from your insurance carriers(s).
Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include data/information management and quality assessment and improvement activities, such as reviewing the competence of healthcare professionals or standards of care.
In addition to these routine uses and disclosures of your health information for treatment, payment or healthcare operations, we may also use and disclose your health information for the following purposes:
Your Authorization. You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
Notice of Privacy Practices - continued

To a Family Member or Friend. Under circumstances of serious concern about your health and wellbeing and/or your capacity to make rational decisions in the best interest of your health and wellbeing, we may disclose your health information to your personal representative, a family member, or another responsible person to the extent necessary to obtain assistance with your healthcare or with payment for your healthcare. We may use or disclose health information to notify, or assist in the notification of (including identifying or locating), a family member, your personal representative or another responsible person, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and experience in disclosing health information to only those individuals requiring it for your health and wellbeing. Under the circumstances described above, our priority would be to disclose relevant information only to the party/parties you have identified and for whom you have given written authorization. In addition, we would restrict disclosures in accordance with agreed upon restrictions.

As Required or Allowed by Law. We may disclose your health information if we are required or permitted to do so by law. Relevant circumstances include, but are not limited to, the following:
1. to comply with a court order;
2. to report suspected child abuse or neglect; 3. to report suspected elder abuse or neglect; 4.to prevent imminent harm to you or another person or persons, 5. to report an unsafe driver. We may be legally required to report certain health information in order to prevent or control disease or to protect public health and safety.

Appointment Reminders and Correspondence. We may communicate with you to provide you with appointment reminders and correspondence (using voicemail messages, postcards, letters and reports). Please let us know if you prefer that we contact you via a specified means or location regarding your appointments and correspondence. We will comply with your request if at all possible.

SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.

A patient has the right to a prompt and reasonable response to questions and requests.

A patient has the right to know who is providing medical services and who is responsible for his or her care.

A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

A patient has the right to know what rules and regulations apply to his or her conduct.

A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

A patient has the right to refuse any treatment, except as otherwise provided by law.

A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.

A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.

A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

A patient is responsible for following the treatment plan recommended by the health care provider.

A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.

A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.