SILVERTHORNE ADULT MEDICAL DAY PROGRAM

Participant Consent Form (HIPPA)

I authorize Silverthorne to share information with my physician, referring organization, regulatory and accrediting bodies, and others as needed to effectively provide for my care.

I further authorize Silverthorne Adult Day to provide services to me, to bill my insurance company or other payor for the services provided and to release information as required to receive payment for my services

The following family or significant other persons are also authorized by me to receive information about my care.

Name	Telephone	Relationship

Signature_____

Date_____

Lost and Found Policy

Neither Silverthorne nor its staff can be held responsible for any loss articles at the center, ie: rings, dentures, watches, while _____is in attendance. It is recommended that you do not bring or wear anything expensive to the center.

Signature_____