TOLSTOY FOUNDATION REHABILITATION & NURSING CENTER

cc: Resident/Family
Social Services
Business Office

ADMISSION AGREEMENT

NAME: _____ **ADM DATE:** _____

I understand that my continued stay at Tolstoy Foundation Rehabilitation & Nursing Center (TFRNC) is periodically assessed. Should nursing care no longer be indicated, discharge to a level of care not provided by TFRNC will be affected in a timely fashion.

I understand that should I finance my stay at TFRNC privately, I will be billed for all pharmaceuticals directly by MEDWIZ Rx, the facility's contracted pharmacy. Should I have any supplemental insurance that will cover the purchasing of prescription drugs, in part or in full, I am ultimately responsible for submitting this information to MEDWIZ Rx.

I understand that my attending physician will visit whenever my medical condition warrants attention and will be paid either directly or through third party coverage. The frequency of visits shall be no less often than once every thirty (30) days for the first ninety (90) days after admission, and at least once every sixty (60) days thereafter.

I understand that if (or when) my physician or alternate is not available; the Medical Director will arrange for another physician to visit for the next scheduled visit or immediately when required by my physical condition. I also understand that the Medical Director will arrange for another physician to visit me within 72 hours if my attending physician is delinquent in examining me as scheduled.

I understand that all personal mail is delivered directly to me. I request the business office to assist me by reviewing all mail arriving in business-like envelopes with the TFRNC address prior to giving it to me, and assist me in understanding and coping with any important matters which may arise from its contents.

I understand that my Social Security check and all other pension checks shall be mailed directly from the PAYOR to my new address here at TFRNC, with the provision that I will be considered as long-term placement and have Medicaid. I also understand that personal funds, allowed me each month, shall be paid to my personal funds account on a timely basis or paid to my fiduciary designate whom I shall so name.

Signed: _____ Date: _____

I understand that Dr. _____, attending physician to my _____ has found him/her to be unable to handle his/her personal finances. I will assume the responsibility for his/her personal needs to the limit of his/her personal funds.

_____ _____

Date Signature-Relationship

"Federal and state laws prohibit discrimination based on race, sex, handicap, disability; color, creed, blindness; religion, national origin; source of payment; marital status; age; sexual preference and retention and care of Residents."

Submit:

Revised: April 2021