

ANCILLARY SERVICES CONSENT FORM

I hereby consent to have the following ancillary services completed by licensed professionals in each discipline. These services may not be covered by my insurance; I understand I may be responsible for part of or the entire financial obligation.

I also understand that no services will be performed without approval of my Primary Care Physician and without reviewing the financial cost with me.

(Mark the services you consent to):

Service	Yes	No
Dental Hygiene • (cleaning/screening)		
Dentist • (Exam, Interventions, Dentures)		
Podiatry • (Care & Treatment of Feet/Toes)		
Audiologist (Hearing) • Testing/Hearing Aides, etc.		
Ophthalmologist (Vision) • Vision Screening, Corrective Lenses, etc.		
Beauty Shop Services • Only As Requested		
Beauty Shop Services • Routine Scheduled Appointment		
Frequency: _____		

The resident will be reminded of appointments. Does the responsible party wish to be notified of these routine appointments? _____

Special Instructions: _____

I hereby consent to have all removable appliances (oral, hearing, vision, personal hygiene) appliances clearly identified and marked in a permanent manner with my name. This shall apply, but not necessarily be limited to, toothbrushes, hearing amplifiers, and glasses.

Yes _____

No _____

(The Resident or Legal Representative may revoke these consents in writing at any time)

Resident/Legal Representative Signature

Date

Facility Representative Signature

Date

Resident Name: _____

MR #: _____