Company Name

PATIENT SERVICE AGREEMENT

Date: _____ Time: _____

Patient: _____ ID#: _____

CONSENT TO TREAT

I hereby authorize this agency to render services as prescribed by my physician, or by any other physician who may be treating me, including all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the physician.

Initial _____

EMERGENCY MEDICAL SERVICES/TRANSFER

I understand that during the course of my therapy the need for emergency treatment and/or transfer to a hospital may become necessary and appropriate. I understand that the agency does not provide emergency medical care and therefore should the need for such treatment and/or transfer be deemed necessary and appropriate by my physician, agency staff will call 911. I consent to such emergency treatment and/or transfer to a hospital and I hereby indemnify the agency and its owners, staff and physician who may be in attendance from any loss resulting from such emergency treatment and/or transfer. I agree to assume full responsibility for all charges incurred for such treatment.

Initial _____

RELEASE OF PATIENT HEALTH INFORMATION

I authorize all physicians, hospitals, nursing homes, clinics and other health care providers to release medical information relevant to my care to the agency.

I hereby authorize the release of any medical information from my records to any licensed institutions, case management, accreditation and regulatory bodies and other health providers for the purpose of providing continuity of care. I place no limitations on history of illness or diagnostic/therapeutic, information including any treatment for substance abuse, psychiatric disorders, acquired immune deficiency syndrome.

Initial _____

INSURANCE BENEFITS

I hereby authorize my private insurance carrier to pay insurance benefits due to me directly to the agency and agree to release of medical information to my insurance carrier. If I should be required by my carrier, I also agree to be personally responsible for my deductible, co-insurance, or other co-payments.

Initial _____

ASSIGNMENTS OF BENEFITS

I authorize the agency to bill Medicare, Medicaid, or HMO for any services provided by the agency and authorize Medicare, Medicaid or HMO to make direct payment to the agency for said services. I understand that I am liable for payment for any services not covered by Medicare, Medicaid, and/or HMO.

Initial _____

NOTICE OF CHARGES

Episode: _____

Agency will provide the following services:

☐ SN ☐ Aide ☐ PT ☐ OT ☐ ST ☐ MSW Other: _____

Frequency of Services: _____

☐ Medicare Program, no charges expected

☐ Medicaid Program, responsible for $2.00 co-pay/visit with maximum of one co-pay per day

☐ Other insurance as per your contract with payer. You are responsible for any co-payment, deductible as stipulated by policy as well as for any non-covered services.

☐ Private Pay. You are responsible for all charges. Method of payment will be _____

☐ You will be billed at a rate of $_____ per _____ for services.

Initial _____

PATIENT SERVICE AGREEMENT

Date: _____ Time: _____

Patient: _____ ID#: _____

STATEMENT OF PATIENT RIGHTS AND RESPONSIBILITY AND ABUSE REGISTRY

Initial _____

I certify that I have read, understand and received a copy of the statement of Patients Rights and Responsibility which has been explained to me orally by a representative of the agency.

ADVANCED DIRECTIVES AND LIVING WILLS

I have received written information regarding my rights to make decisions concerning medical care, including the right to accept or refuse medical treatment and the right to formulate advance directives under state law.

I have a Living Will: ☐ Yes ☐ No

If yes, location of Living Will: _____

I have a "Patient Advocate/Proxy": ☐ Yes ☐ No

My Patient Advocate/Proxy is: _____

Name:_____

Address:_____

City, State, Zip: _____

Initial _____

Phone: _____

CERTIFICATION REGARDING HMO MEMBERSH

Initial _____

I hereby declare that at t pr nt I do not belong to an HMO. I will notify agency immediately should I se to e ll in HMO in the future. I agree to pay for all services rendered to me by agency s ul l t notify agency of my enrollment.

CONSENT FOR OASIS

Initial _____

I rstand that the agency is required to collect health care data on all patients admitted for and at this data is then transmitted to the Agency for Health Care Administration then to the CMS (Medicare Program). Agency personnel have discussed the OASIS ms and answered all my questions. I authorize the agency to release to CMS or its l information included in the OASIS form. I permit a copy of the authorization to be place of the original. I have been assured that all information will be kept in strictest co ence.

PHOTOGRAPHY PERMISSION

Initial _____

I understand and authorize photographs of myself to be taken and kept on file at the agency. These photographs will be used as deemed appropriate by the agency,

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the agency's Notice of Privacy Practices

OR

Initial _____

acknowledgment not signed because: _____

PERMISSION FOR SUPERVISORY VISITS: NOT SKILLED SERVICES

☐ N/A

Initial _____

I hereby give permission for agency to perform supervisory visits for aides, companions and/or homemakers as per agency policy and procedures.

PATIENT SERVICE AGREEMENT

Date: _____ Time: _____

Patient: _____ ID#: _____

AUTHORITY TO SIGN ON BEHALF OF PATIENT

Patient is unable to sign documents because:

_____

Name of person authorized to sign:

_____

Relative: _____

___ Guardianship (attach copy of order)

___ Other: (specify authority empowering signature)

Initial _____ _____

ONE AGENCY ONLY TO PROVIDE SERVICES

I have voluntarily chosen the agency as my sole provider for my home care services.

I am aware that Medicare will only pay for services to one agency during any period of time. I will not enter into any agreement for services with any other home care provider while receiving services by the agency. I will notify the home health agency if I choose to transfer to another provider. Failure to do so may result in me being responsible for any charges denied by my insurer to the agency due to the fact another agency was providing home care services simultaneously.

Initial _____

PATIENT HANDBOOK

I have received the Patient Handbook for the agency and it has been verbally explained to me by a representative of the agency. All of my questions/concerns have been addressed to my total satisfaction.

Initial _____

By my signature, I attest that I have read and received a copy of the Patient's Service Agreement and have had all questions and concerns addressed to my complete satisfaction. I am fully aware that I may contact the agency should any questions/concerns arise while I am a patient or thereafter.

_____ _____

Signature of Patient/Authorized Representative Date

_____ _____

Witness Date