ADVANCED HOME CARE

HOME HEALTH ADMISSION CONSENT

PATIENT NAME:_____ **PATIENT ID:**_____ **DATE:**_____

INSTRUCTIONS: This form is used to acknowledge receipt of our Admission Booklet and confirm your understanding and agreement with its contents. Your initials on the bottom of this page and your signature on page 2 indicate your understanding and approval.

CONSENT TO PROVIDE CARE /EQUIPMENT

I give my permission for Advanced Home Care, Inc (AHC) staff to provide any or all of the following: equipment, medications, supplies and/or services. I understand that the agency will supervise services provided, I may refuse treatment or terminate services at any time, and the agency may terminate their services to me as explained in my orientation.

CONSENT TO RELEASE OR OBTAIN INFORMATION

I acknowledge that I have received the Notice of Privacy Practices and was given the opportunity to ask questions and voice concerns. I also hereby consent and give permission for AHC to access and release information contained in my medical record to health care providers involved in my care, third party payers, including Medicare/Medicaid and other insurance companies, utilization review and regulatory review agencies, family members and other caregivers who are part of my plan of care and any other organization/resource, etc. that may assist me in meeting my home care and/or health care needs. AHC is also authorized to contact me or a member of my care team, regarding services and/or products rendered, their availability, and any future needs.

Do not disclose any information about me or my care to the following people who are not involved in my care (please record name and relationship).

NAME:_____ RELATIONSHIP:_____
NAME:_____ RELATIONSHIP:_____
NAME:_____ RELATIONSHIP:_____

I certify that the information given by me in applying for payment and medical information is correct. I authorize any holder of medical or other information to release to the Social Security Administration or its Intermediaries or Carriers information needed for claims made for Medicare, Medicaid or other third party benefit payments.

I give my permission to the staff of AHC to record or film my care, treatment and services and allow the agency to use the photographs/recordings for their internal use, for documenting my medical condition or for insurance providers to document my condition for payment purposes.

PATIENT RIGHTS & RESPONSIBILITIES

I acknowledge receipt of the AHC admission booklet, which includes Patient Rights and Responsibilities (including OASIS and HIPAA) and I understand them. I have received the State Home Health hotline number, its purpose, hours of operation and address for submitting written complaints. I have also received information on how services are paid for, and how to contact AHC by telephone. I acknowledge that I have chosen this agency to provide home care and no employee of this company has solicited or coerced my decision in selecting AHC.

I understand that AHC is a joint venture of Moses Cone, CaroMont Health, High Point Regional, Novant Health, Mission Hospital, Community CarePartners, Haywood Regional, Vidant Health, Alamance Regional, Westcare Health System, Wellmont Health System, and Morehead Memorial that own and control it. I understand that I may choose other suppliers and that affiliate groups share financial gains.

I acknowledge that I have received the CMS Medicare DME POS Supplier Standards (as applicable).

EQUIPMENT AGREEMENT

I understand it is my responsibility to examine the equipment that I receive from AHC. The equipment provided by AHC, new and used, should be in good working order. I accept responsibility for the equipment and will return it to AHC in the same condition as received or assume responsibility for payment of neglected or abused equipment. I am aware that equipment shall remain the property of AHC unless full payment is made for its purchase.

I acknowledge that I have been provided with education on the care and safe operation of the equipment provided to me by AHC.

Initials _____

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OTHER MEDICARE SERVICES/SUPPLIES

I understand that while I am under the company's plan of care, the company will coordinate all medically necessary services and medical supplies for me. Should I arrange for these services or supplies on my own, I understand that Medicare will not reimburse me or my supplier and I will be responsible for their cost.

AUTHORIZATION FOR PAYMENT

I request that payment of authorized benefits be made directly to AHC on my behalf. I assign payment from authorized third party payers for all unpaid charges of services, supplies, equipment and/or medications furnished by AHC for whom they are authorized to bill. I understand that I am responsible for charges not covered by this assignment.

FINANCIAL RESPONSIBILITY

The amounts listed below reflect an ESTIMATION of your financial responsibility. The charges listed below are standard charges for the services listed. Your insurance company may not pay 100% of the charges. You will be informed as soon as possible, but no later than 30 days from the date that the company becomes aware of the change. It is your responsibility to notify AHC of ANY changes in insurance information during your course of treatment.

PLEASE BE AWARE THAT YOU WILL BE RESPONSIBLE FOR WHAT INSURANCE DOES NOT COVER.

SERVICE	ESTIMATED # OF VISITS	STANDARD CHARGE PER VISIT	YOUR CO-PAY PER VISIT
SKILLED NURSING		$150.00	
HOME HEALTH AIDE		$85.00	
PHYSICAL THERAPY		$175.00	
OCCUPATIONAL THERAPY		$175.00	
SPEECH THERAPY		$175.00	
MEDICAL SOCIAL WORK		$190.00	
DURABLE MEDICAL EQUIPMENT AND PHARMACY NOT INCLUDED			

If your insurance company requires co-pay or a deductible to be met, you will be required to pay these before your insurance begins payment on your home care charges.

ADVANCED DIRECTIVES

I understand that the Federal Patient Self-Determination Act of 1990 requires that I be made aware of my right to make healthcare decisions for myself. I understand that I may express my wishes in a document called Advanced Directives so that my wishes may be known when I am unable to speak for myself.

☐ **I do not have an Advance Directive**
Does patient have a surrogate health care decision-maker? ☐ No ☐ Yes: If yes, who is it?_____

☐ **I have an Advance Directive** (*Mark all the apply*) (*Please provide a copy to the agency*)
- ☐ Living Will
- ☐ Health Care Power of Attorney or Health Care Agent

If Yes, name & phone number of agent or power of attorney:_____
- ☐ Do not Resuscitate (DNR) order

By signing below, and initialing on page 1, I understand and agree with the contents of this consent form:

_____ _____
Patient Signature Date Responsible Person or Legal Guardian Signature Date

_____ _____
Witness Signature Date Printed Name & Relationship of Person Above

☐ PATIENT UNABLE TO SIGN DUE TO_____ *PXΦ*