



Admission Service Agreement & Consents

INSTRUCTIONS- This form is used to acknowledge receipt of our Orientation Guide and to confirm your understanding and agreement with its contents. Your signature indicates your full understanding and approval.

AUTHORIZATION FOR CARE AND SERVICES

I hereby consent for authorized personnel to perform all necessary procedures, injections, infusions and treatments as prescribed by my physician for the delivery of home health care. If I am hospitalized while I am an active patient, I choose FOCUS HOME HEALTHCARE as my post hospitalization provider of home care services. Further, I authorize qualified FOCUS'S staff to visit me while hospitalized and authorize access my medical records to effectively coordinate my ongoing home health care needs upon discharge back to my home. I understand that I may refuse treatment and/or terminate services at any time. I further understand that the Agency may terminate services as described in my patient orientation guide. All of my questions have been answered satisfactorily. Proposed services to be provided:

SN _____ PT _____ OT _____ ST _____ MSW _____ AIDE _____

PATIENTS RIGHTS AND RESPONSIBILITIES - RELEASE OF INFORMATION

I hereby consent to and authorize the organization to disclose and release information contained in my clinical record to the health care providers involved in my care, third party payers, utilization review and professional standards review organizations, regulatory review entities and-any other organizations and companies that may/will assist me to meet my health care needs.

I have received a copy of my Rights and Responsibilities as a patient of FOCUS HOME HEALTHCARE and fully understand them, including information about the how to use the organization's complaint process and the state toll free hotlines. I am aware of my right to choose my home health care provider and by signing this consent I attest that I have exercised this right I Have had the opportunity to participate in the development of my plan of care. I have received and understand the information about my various privacy rights.

AUTHORIZATION FOR PAYMENT

I certify that the information provided by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits from Medicare, Medicaid or other responsible payers be made FOCUS HOME HEALTH CARE. I understand that I am responsible for all amounts not paid by my insurance company. If covered under Medicare Part A, I understand that FOCUS HOME HEALTHCARE, accepts the current Medicare reimbursement rates as payment in full for covered home health services. The expected payer source for my home health services is Medicare Part A unless another payer source is identified below. I understand that the charges per visit (which is not the amount reimbursed by Medicare) for services are: Nursing-\$125, Therapy-\$140, Medical Social Workers-\$160 and Home Health Aides-\$70 Expected payer source, if other than Medicare: _____.

OTHER MEDICARE SERVICES/SUPPLIES - CONSENT TO PHOTOGRAPH

I understand that while I am a patient of FOCUS HOME HEALTHCARE'S, the home health agency will coordinate all medically necessary therapy services and non-durable medical supplies for me. Should I choose to arrange for these services on my own, I understand that Medicare will not reimburse me or my supplier and I will be held responsible for their cost.

I hereby authorize the agency to take pictures of myself and treatment being done to me and authorize the release of those photographs for use in education regarding home health services or to insurance providers.

ADVANCE DIRECTIVES

I have received written information and an explanation regarding advanced directives and understand that it is the policy of FOCUS HOME HEALTHCARE to respect individual choice and to avoid discrimination based on whether or not I have an advance directive.

I DO I DO NOT have an advance directive. I DID I DID NOT provide copy to your staff.

I DO I DO NOT have a health care surrogate. If yes, provide name and phone: _____

X _____
Signature: PATIENT LEGAL GUARDIAN / RESPONSIBLE PARTY _____ DATE SIGNED

Printed Name and Relationship of Person Above (if other than Patient)

Agency Representative/Witness Signature

PATIENT NAME: _____

PATIENT ID# _____