CONSENT FOR SERVICE/RELEASE OF RECORDS

I, _____, have been informed that Abounding Home Health Care, Inc, referred to in this consent as Agency, is licensed to provide home health services according to the Plan of Treatment established by the home health staff and the physician. I accept treatment from Agency. I can call the Agency 24 hours a day regarding my health care at **972-365-7433**. This is not an emergency line. Call 911 in an emergency. It is the policy of the Agency to protect all clinical records against loss, defacement, tampering and use by unauthorized persons. I authorize the agency to release medical information to my physician, the facility of my choice, payor source, or accrediting/regulatory/consulting organizations, as appropriate. I authorize the release of the Plan of Treatment and Discharge Summary upon my transfer to another health care facility.

FINANCIAL AUTHORIZATION

I authorize benefits to be made in my behalf.

Bill Medicare 100% - Medicare #: _____ Effective Date: Part A_____ Part B_____

All Medicare-covered services, including therapies and supplies, will be paid by Medicare. I understand I may be liable for payment of services provided by anyone other than Agency, while Agency is rendering services.

Bill Medicaid 100% - Medicaid #: _____ Effective Date: _____

Bill Primary Insurance: _____% Insurance Co: _____

Bill Secondary Insurance: _____% Insurance Co: _____

Bill patient: Co-payment _____ Payment of _____ ❑ Per Visit ❑ Per Hour

I am responsible to inform the Agency if I change to an HMO, Medicare Advantage/HMO; or if HMO refuses coverage, I am responsible for the home health charges incurred.

I will pay any service or supply charge not reimbursed by my insurance company on a monthly basis. I will pay all charges incurred on a monthly basis if I do not have insurance coverage. If a claim is denied for home health services which Agency has submitted on my behalf, I hereby elect not to appeal the denial myself, but I do hereby authorize Agency to resubmit the claim for me and represent me in any negotiations. I authorize the Agency to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

FREQUENCY/RIGHTS/HOTLINE/PROCEDURES

I understand that an RN will case manage all services. I understand the **frequency of services.** This frequency may change according to need.

Skilled Nursing: _____, Home Health Aide: _____,

PT Evaluation: _____, OT Evaluation: _____, SP Evaluation: _____, MSW Evaluation: _____, Other: _____

I have received a copy and an explanation of my **Bill of Rights , Patient Bill of Rights** and the **Rights of the Elderly,** as appropriate.

I have been notified of my right to voice a complaint. I may direct that complaint to the Agency Administrator or designee at **972-365-7433**. An investigation of the complaint will be initiated within 10 calendar days and resolved within 30 calendar days of receipt. I may also contact the Department of Aging and Disability Services, DADS' Consumer Rights and Services Division, PO Box 149030, Austin, TX 78714-9030, at **1-800-458-9858**. The line is open 24 hours a day. This includes a complaint regarding advance directives. Complaints regarding Utilization Review or HMO services can be made directly to Texas Department of Insurance Consumer Protections, PO Box 149091, Austin, TX 78714, at **1-800-252-3439**. This agency is CHAP accredited and any complaints regarding the agency may be directed to the CHAP hotline at **1-800-656-9656.**

I have received an information and Agency policy on **Advance Directives.** I have ❑ or have not ❑ signed a ❑ Living Will/Directive to Physician ❑ Out of Hospital DNR ❑ Medical Power of Attorney ❑ Declaration of Mental Health.

I am ❑ am not ❑ providing a copy for my record.

Medical Power of Attorney: _____ Phone: _____

I understand that it is my right and responsibility to be involved in my care and that I will be informed as to the nature and purpose of any technical procedure.

I have been informed what to do in an **emergency/natural disaster** and have received education on completing an emergency preparedness plan for myself and my family. I understand the importance of completing this plan and know that agency staff may assist in this process. I have been informed verbally and in writing regarding Agency policy on **abuse, neglect, and exploitation, agency drug testing and hazardous waste disposal in the home.**

I have been advised verbally and in writing the purpose and my rights pertaining to the collection of **OASIS** information and the **OASIS** Privacy Act.

HIPAA - I have received the Notice of Privacy Practices, which includes information about the "Red Flags Rule", and consent to the agency's use and/or disclosure of protected health information for payment, treatment and Agency's Health care operations.

_____ _____

Patient/Authorized Agent Signature (Relationship) If patient is unable to sign, state reason

_____ _____

Agency Representative Signature Date of Signatures