L&C CONSENT FORM

Agency 24 Hour Number:

CONSENT FOR SERVICE/RELEASE OF RECORDS

I, _____, have been informed that the above named Agency, referred to in this consent as the Agency, is my primary home health agency and is licensed to provide home health services according to the Plan of Care established by the home health staff and authorized by the physician. I accept treatment from the Agency. I can call the Agency 24 hours a day regarding my health care at the above referenced phone number. This is not an emergency line. I understand I should 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 Care and Discharge Summary upon my transfer to another health care facility.

FINANCIAL AUTHORIZATION

I authorize benefits to be made on 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 the Agency, while the Agency is rendering services.

Bill HMO/MCO:_____% HMO/MCO:_____

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 for informing the Agency if I change to an HMO, Medicare Advantage/HMO or MCO. I understand I am responsible for the home health charges incurred for failure to notify the Agency of the change or if the HMO/MCO refuses coverage.

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 for home health services which the Agency has submitted on my behalf is denied, I hereby elect not to appeal the denial myself, but I do hereby authorize the 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 supervise 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 Patient/Client Rights and Responsibilities and the Rights of the Elderly, as appropriate.

I have received a copy and an explanation of the Agency's transfer and discharge policies.

I have been informed of my rights in a language and manner that I understand.

I have received and understand the contact information including the names, addresses, and telephone numbers of the Agency Administrator, Supervising Nurse, and Clinical Manager(s) as applicable, and Federal and State funded entities that serve the area where I reside.

I have been notified of my right to voice a complaint to the Agency Administrator or designee at the above referenced phone number. An investigation of the complaint will be initiated within 10 calendar days and resolved within 30 calendar days of receipt. I may also contact Texas Health and Human Services, HHS, Consumer Rights and Services Division, Mail Code E249, PO Box 149030, Austin, TX 78714-9030, or by calling 1-800-458-9858. The line is open 24 hours a day. This includes a complaint regarding advance directives. For any complaints regarding discrimination, I understand that I may contact the Office of Civil Rights within 180 days of when the situation occurred. The complaint must be filed in writing by mail, fax, e-mail, or via the OCR Complaint Portal.

Complaints regarding any health insurance services can be mailed to MC 1111A, Consumer Protection, Texas Department of Insurance, PO Box 149091, Austin, TX 78714, or by calling the Consumer Help Line at 1-800-252-3439, online at http://www.tdi.texas.gov/consumer/complfrm.html, or by email to ConsumerProtection@tdi.texas.gov.

When a managed care organization (MCO) member wants to file a complaint, he or she must first contact the MCO, following procedures specified in the MCO's member handbook. If the member is not satisfied with the outcome of the MCO complaint process, he or she sends a written request to HHSC to investigate the complaint. The request is sent to: Texas Health and Human Services Commission, Managed Care Operations – STAR+PLUS, Mail Code H320, P. O. Box 13247, Austin, TX 78711.

My legally authorized representative and I have been informed verbally and in writing regarding the Agency's policies on abuse, neglect, and exploitation (ANE) and how to report complaints and allegations of ANE; my legally appointed representative or I may report complaints and allegations of abuse neglect or exploitation by calling the Abuse Hotline, 24 hours a day, 7 days a week, toll-free 1-800-252-5400 from anywhere in the US , or reporting on the secure internet website at https://www.txabusehotline.org.

I have received the 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 of how to register with 2-1-1.

I have been informed verbally and in writing regarding the Agency's policies on drug testing; as well as information about hazardous waste disposal in the home.

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

HIPAA - I have received the Notice of Privacy Practices and consent to the Agency's use and/or disclosure of protected health information for payment, treatment and the Agency's health care operations.

_____	_____	_____
Patient/Client Signature	Relationship	Date
_____	_____	_____
Authorized Representative Signature (if applicable)	Relationship	Date
_____	_____	_____
Agency Representative Signature	Reason patient/client is unable to sign	Date