Consent Form — *Amatus Health Care LLC*

Consent for Service / Release of Records

I, _____, have been informed that Amatus Health Care LLC 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 Amatus Health Care LLC. I can call the Agency 24 hours a day regarding my health care at 972-249-4999. 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, payer source, or accrediting/regulatory/consulting organizations, as appropriate. I authorize the release of the Plan of Treatment, Transfer Summary or 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 _____

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 Amatus Health Care LLC has submitted on my behalf, I hereby elect not to appeal the denial myself, but I do hereby authorize Amatus Health Care LLC 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.

Discipline	Cost per Visit	Insurance Payment	Patient Payment
SN			
PT			
OT			
SLP			
MSW			
hha			

Frequency / Rights / Hotline / Procedures

I understand that a Registered Nurse will supervise all nursing services. Home Health Aide services will be supervised by a Registered Nurse or a Therapist, as appropriate. A Physical Therapist or Occupational Therapist will supervise therapists for each specific therapy discipline. A Masters Social Worker will supervise all social services. A Clinical Manager will supervise all services. I understand the frequency of services. This frequency may change according to need. Skilled Nursing: _____, Home Health Aide: _____, MSW Evaluation:_____, PT Evaluation:_____, OT Evaluation:_____, SP Evaluation: _____.

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

I have received ☐ Patient Information & Emergency / Disaster Preparedness Plan ☐ Responsibilities of Patient and Agency During a Disaster ☐Emergency Preparedness tips and resources ☐Emergency Preparedness was discussed. I have been informed on what to do in an ☐ emergency/natural disaster.

I have been informed verbally and in writing regarding Agency policy on ☐ abuse, neglect and exploitation, ☐ agency drug testing policy, including testing method, and ☐ hazardous waste disposal in the home. I have received: ☐ discharge & transfer policy, ☐Non-Discriminatory Policy, ☐Medicare Homebound Eligibility Criteria / Admission Criteria, ☐ Medication Safety, Fall Prevention and Safety in the Home / Sharps and Waste Disposal, ☐Oxygen, Equipment and Fire Safety (if applicable) ☐Weapons and Threatening Situation /Terms for Immediate Discharge, ☐ Infection Control, & ☐ clinical manager contact information for asking questions about services. I understand and agree that I meet requirements for homebound status. I further agree to notify Agency if I no longer meet requirements for homebound status.

❑I do not wish to select a patient representative to be involved in the coordination of care activities.

❑ I have selected _____Phone: _____ as my patient representative. ❑ Patient representative received a copy of the patient rights, discharge and transfer policy; or ❑ Patient representative was not available; will receive information **within 4 business days of today's visit.**

❑ I authorize the release of medical records related to services beginning on _____ to _____ at _____ (healthcare provider) _____(city), _____(state) to Amatus Health Care LLC.

You have the right to request that the Agency communicate with you in a certain way.

❑ I authorize Amatus Health Care LLC to release of information to: ❑spouse: _____

❑ children: _____; ❑ other: _____.

The release of information will remain in effect until terminated by me in writing.

If you are unable to contact me, you may:

❑ Leave a detailed message on voicemail ❑ Leave a message asking me to return your call

I have received Agency policy and information sheet on **Advance Directives** including Out of Hospital DNR.

❑ I do not have an advance directive.

❑ I have an advance directive for: ❑Living Will/Directive to Physician ❑Out of Hospital DNR ❑Medical Power of Attorney

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

Name of Medical POA: _____ Phone #: _____

I have been notified of my right to voice a complaint and may direct that complaint to the Texas Health and Human Services Commission, Consumer Rights and Services, PO Box 149030, Austin, TX 78714-9030, at 1-800-458-9858. The line is open 24 hours/day, 365 days/year. This includes a complaint regarding advance directives. Complaints regarding Utilization Review or HMO services can be made directly to TX Dept. of Insurance at 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. The CHAP Hotline is available 24 hours/day, 365 days/year.

I may also direct a **complaint** to the Amatus Health Care LLC Administrator or designee _____ at 972-249-4999. The investigation of the complaint will be initiated within 10 calendar days and resolved within 30 calendar days of receipt.

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 understand the Agency will not be able to provide medications.

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.

Telehealth:

❑ I acknowledge and understand that the agency may provide services to me via telehealth, in relation to the COVID-19 Pandemic, and I agree to receive services in this manner as necessary and appropriate. I acknowledge that all aspects of telehealth contact have been explained to me and/or my representative, including the principles of technology as they apply to patient privacy, and I understand that telehealth visits are not substitutes for planned visits, but are used by the agency as a supplement to on-site visits, and that telehealth will be used in an effort to minimize exposure.

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 Agency's Health care operations.

❑ I authorize the use or disclosure of Protected Health Information for future research.

❑ I do not authorize the use or disclosure of Protected Health Information for future research.

❑ I authorize the Agency to send treatment communications concerning alternatives or health related products or services where the Agency receives financial remuneration from a third party in exchange for making communications. I have a right to opt out of receiving such communications at any time.

❑ I do not authorize the Agency to send treatment communications concerning alternatives or health related products or services where the Agency receives financial remuneration from a third party in exchange for making communications.

If Applicable:

❑ Not Applicable

❑ I authorize the Agency to send communications for fundraising purposes. I understand I may opt out of receiving such communications at any time.

❑ I do not authorize the Agency to send communications for fundraising purposes. I understand I may opt back in at any time. The Agency **will not condition treatment or payment on an individual's choice with respect to receiving fundraising communications.**

_____ _____

Patient/Authorized Agent Signature (Relationship) Date

_____ _____ _____

Agency Representative Signature Date/Time Reason patient is unable to sign

Beneficiary Elected Transfer / Right of Choice Statement

Patient name: _____ Date:_____

Discovery efforts:

☐ HIQH Query /Customer Service indicates Patient under an established home health plan of care

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I, _____, choose to transfer to

Amatus Health Care, LLC

From:

_____

(Initial home health agency).

Effective transfer date _____.

I understand the initial home health agency will no longer receive Medicare Payment on my behalf and will no longer provide Medicare covered services to me after the effective date of transfer.

I request that my records be released to the receiving agency to ensure continuity of care.

_____

Patient/Beneficiary Signature Date

For Agency Use Only

Coordination of Transfer:

☐ Phone call to _____ (initial home health agency) for coordination of transfer on _____

Contact person: _____

☐ Beneficiary Elected Transfer/Right of Choice form sent /faxed to Initial agency on _____

_____

Amatus Health Care, LLC
5 Day Discharge Notice

To: _____
(Patient's Complete Name)

You will be discharged from home health services on _____. The reason for this discharge is _____.

If you should have any problems or questions following your discharge, please contact your physician.

It has been a pleasure caring for you and if you have any questions or concerns that we might address, please don't hesitate to contact us at_____.

Notified: _____
(Date)

By: _____
(Agency Representative)

Patient Signature: _____
(Needed if hand delivered)

Copy sent/faxed to physician ☐ Yes ☐ N/A Date: _____

_____
(Physician's Name and Number)

☐ Phone call date: _____ Patient/SO acknowledges awareness of discharge.

Discharge Instructions given:

☐Counseled to continue medical follow-up with their physician

☐Counseled to call agency for further home care needs

☐Other: _____

Staff Signature: _____ Date: _____ Time: _____

Patient Information & Emergency / Disaster Preparedness Plan

Amatus Health Care, LLC **(972) 249-4999**

IN EMERGENCY: CALL 911 OR APPROPRIATE EMERGENCY ACCESS

Patient Name: _____ DOB: _____ Phone: _____

Physical Address: _____ City: _____ Zip: _____

Your Physician: _____ Phone: _____

Pharmacy: _____ Phone: _____

DME Company: _____ Phone: _____

Do you have transportation to evacuate? [ ] Yes [ ] No Number of others evacuating with you: # _____

By Whom? _____ Relationship: _____ Phone: _____

Emergency contact: Name: _____ Relationship: _____ Phone: _____

Do you have pets or service animal? [ ] Yes [ ] No Number of pets evacuating with you: _____ Carriers available? [ ] Yes [ ] No

Do you have special needs? [ ] None [ ] Life support equipment: _____**; [ ] Transportable**

[ ] Battery operated [ ] Electrical Condition of equipment: _____

[ ] Special dietary needs: _____ **[ ] Communication challenges:** _____

[ ] Language barriers: Primary language: _____ **[ ] Intellectual disabilities:** _____

[ ] Mobility issues: [ ] Bedfast [ ] Chairfast [ ] Wheelchair needed [ ] Cane needed [ ] Needs assistance for ambulation/transfers

[ ] Special procedures/medical care needed: _____

[ ] Special adaptive equipment: _____

Other entities involved in care: _____ **Phone:** _____

_____ **Phone:** _____

_____ **Phone:** _____

Coordination of Care with: _____ **Regarding:** _____ **Spoke to:** _____

Coordination of Care with: _____ **Regarding:** _____ **Spoke to:** _____

Registered with 211 [ ] Yes [ ] No **[ ] Assisted with 211/STEAR Registration [ ] Assistance with registration declined**

Emergency

If the Patient's condition changes significantly or for medical emergencies such as chest pain, difficulty in breathing, paralysis, bleeding, or injury from falls, please call 911, or your appropriate emergency access for immediate attention. The agency does not operate as an emergency service; therefore, valuable time may be lost by contacting the agency.

Non-Emergency

For a non-emergency, the agency has a nurse "on-call" 24 hours per day, seven days per week. Your call will be forwarded to an answering service/machine during unscheduled business hours. Please leave your name, the name of the Patient, the telephone number and address, and a brief description of the problem. This message will be forwarded to the "on-call" nurse who will return your call within 30 minutes.

Natural Disaster

In the event of a natural or man-made disaster (e.g., to include tornadoes, hurricanes, winter storms, nuclear power plant disaster, floods, chemical toxicity, and fire, etc.) **the agency will prioritize visits according to the following: What category describes your special needs?**

[ ] **Class I** - Life threatening (or potential) requiring ongoing medical treatment to prevent a life threatening episode. Patient is unable to withstand any interruption in power supply. Patient is unable to evacuate/transport self. No readily available caregiver or caregiver is unable to provide needed care. Appropriate arrangements to transfer to an acute care facility will be made by the agency in collaboration with the local county or city authorities (fire department, police, and sheriff), the Patient/family and the physician.

[ ] **Class II** - Not immediately life threatening but Patient may suffer adverse effect without service (i.e. new insulin-dependent diabetic unable to self- inject insulin, IV medications, or sterile wound care with large amounts of drainage). Visits may be postponed 24-48 hours with minimal adverse effect. Patient is unable to transfer/transport self or no transportation available from caregiver. Appropriate arrangements may be made if necessary, to send Patient to a facility that can meet their needs. This will be done in collaboration with the Patient/family, physician, and local or city authorities.

[ ] **Class III** - Services may be postponed 48-72 hours without adverse effect on the Patient (i.e. new insulin-dependent diabetic able to self inject, cardiovascular and/or respiratory assessments, or sterile wound care to a wound with minimal to no drainage). Transportation is available from family, friends, volunteers or caregiver.

[ ] **Class IV** - Services may be postponed 72 hours or more without adverse effect on the Patient (i.e. routine catheter changes or postoperative with no open wound). Willing able caregiver is readily available or Patient independent in most ADL's. Transportation is available from family, friends, volunteers or caregiver.

Patient/caregiver has been instructed & provided written information on an individualized Emergency Preparedness Plan. Agency will notify State and local emergency preparedness officials of need for patient evacuation during a disaster due to patient medical condition or home environment.

_____

Agency Representative Signature Date

Amatus Health Care, LLC
Vital Signs Log, Blood Glucose Monitoring & Insulin Administration Log

Patient Name_____
Insulin Orders (date, medication information)
_____
_____
_____
_____

Physician Name _____
Physician Phone Number _____
Physician Notification Range (date, range)_____
_____
_____
_____

Date	Time	Temp	Pulse	Resp	B/P	FBS	Random BS	WT	O2 Sat	PT/ INR	Initials	Insulin Administration / Comments

_____ _____ _____
Employee Name/Title Initials Date

_____ _____ _____
Employee Name/Title Initials Date

_____ _____ _____
Employee Name/Title Initials Date

MEDICATION PROFILE — Amatus Health Care, LLC

PATIENT_____ PHARMACY_____
HEIGHT_____ WEIGHT_____ ADDRESS_____
PHYSICIAN _____ PHONE_____
ALLERGIES ☐ NKA ☐ YES, list environmental, food and drug sensitivities: _____

HAS PATIENT HAD ANY ADVERSE DRUG REACTIONS IN THE PAST? ☐ NO ☐ YES, list:_____

DATE	DRUG	Dose	Route	FREQ	(N) NEW /(C) CHANGE	CLASS	COMMENTS	D/C DATE	SIGNATURE
	OXYGEN		at _____ l/m via ☐ NC ☐ Mask ☐ Vent ☐ continuous ☐ PRN dyspnea ☐ at HS						

☐By my signature, I have reviewed the medications to identify any potential adverse effects and drug reactions including ineffective drug therapy, significant side effects, significant drug interactions, significant drug and food interactions, duplicate drug therapy, and non-compliance.

SIGNATURE/DATE	SIGNATURE/ DATE