CONSENT / AGREEMENT / AUTHORIZATION / ACKNOWLEDGEMENT

PATIENT NAME (Last, First, MI): _____ **MR#** _____

Referral Source and Date: _____ **SOC**: _____

CONSENT TO RECEIVE SERVICES: I, _____, hereby consent and authorize Noble Man Care Services _____ (Agency Name), its agents, and associates to provide care and treatment to me in my home as prescribed by my physician and per agency policy. I understand that I must have an authorized provider (MD, NP, PA) for the duration of this agreement. I have received an explanation of the services to be provided (including disciplines, proposed frequency of visits, and anticipated outcomes). I understand that I and/or my caregiver will participate in developing the Plan of Care. I recognize that I have the right to refuse treatment or terminate services at any time by notifying the agency office. **I believe my services to be:**

_____

AUTHORIZATION FOR PAYMENT TO PROVIDER: I certify that information given by me in applying for payment under title XVIII or title XIX of the Social Security Act (SSA), or other third-party payor, or coverage, is correct. I authorize any holder of medical or other information about me to be released to the SSA or its intermediaries, or other third-party payers any information needed for this or other related claims. I request that payment, as authorized, be made on my behalf to the agency. This authorization and request shall apply to the certification period starting _____, 20 _____ until the order is discontinued by my physician.

CHARGE FOR SERVICES: Your initial services from the agency will include the following services, initial frequency of visits, and the charges for services that may not be covered by Medicare, Medicaid or any other federally funded or federal aid program known to the agency.

Payer for services: _____

Service	Frequency & Duration	Charge Per Visit	Payor source liability	Patient Liability	Service	Frequency & Duration	Charge Per Visit	Payor source liability	Patient Liability
Skilled Nursing					Occupational Therapy				
Physical Therapy					Medical Social Worker				
Home Health Aide					Speech-language pathologist				

_____ _____ _____

Patient or Authorized Agent Signature **Relationship to Patient** **Date**

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Liability for Payment: I understand and agree to pay deductibles, co-payments, spend downs and any amount due after payment of benefits on my behalf by any and all third-party payers.

I verify that ☐ I am ☐ I am not a participating member of an HMO (Health Maintenance Organization). If I enroll in one, I will immediately notify the organization.

I understand that services provided to me by this organization will be billed as follows:

- ☐ Medicare fee for service (Project 100% covered).
- ☐ Medicaid (Project 100% covered after meeting spend down and/or other requirements.)
- ☐ Insurance (Coverage varies with individual policy. The patient's anticipated payment amounts per visit will be provided in writing when the insurance company informs the organization of the patient's financial liability. See the organization's separate Visit Rate information. When known at the time of Admission: Project _____% of charges to be covered after deductible met. **(Specify amounts** _____).
- ☐ Private Pay (See separate Private Pay Rate Sheet. Patient is responsible for the timely payment of all charges.)

Confidentiality: It is our policy to protect all clinical records against loss, defacement, tampering, and use by unauthorized person(s). All patient-identifiable information in the clinical record, including OASIS data, remains confidential and is not released to the public. OASIS data will be electronically transmitted to the state. The patient's written consent is required for the release of medical information to persons not otherwise authorized by law (federal and state) to receive this information. Authorized persons who may review the clinical record include surveyors, physicians, Centers for Medicare, and Medicaid Services (CMS), and external and internal auditing personnel.

Assignment of Benefits: I request that payment of authorized benefits be made on my behalf directly to the organization. In consideration of any services rendered, I hereby assign and transfer, to the agency, any benefits payable to, or for my benefit under, the rules and regulations prescribed by Medicare. I agree to cooperate, aid, and assist the agency in the process of billing Medicare for these services. I certify that no other home health agency is currently providing home healthcare and understand that misrepresentation of this fact shall cause me to be liable financially for care rendered by the agency. If home health services were provided by another home health agency in the past, I have requested discharge from those services, before my start of care date with this agency.

Acknowledgement of Information: I have received a copy of the Patient Handbook from the agency which explains to me the services under Medicare and Health Benefit including routine intermittent visits. I have also received verbal and written information in the handbook on the following:

- **Advanced Directives** information regarding this topic and a copy of the agency policy on respecting my rights under the Patient Self Determination Act of 1990 and state law. In addition, I understand that the organization's policy is to respect individual choice and to avoid discrimination based on whether or not you have an Advance Directive or a Do Not Resuscitate (DNR) directive.

_____	_____	_____
Patient or Authorized Agent Signature	**Relationship to Patient**	**Date**

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PATIENT NAME (Last, First, MI): _____ MR# _____

- **Patients' Rights and Responsibilities**. This also includes information about how to use the organization's complaint process and the state's toll-free hotline.
- **Statement of Patient Privacy Rights and Privacy Act Statement-Health Care Records** for Medicare and Medicaid patients, and/or Notice about Privacy for patients who do not have Medicare and Medicaid.
- **Receipt of Notice of Privacy Practices/HIPAA and OASIS Privacy Notice**
- **Basic Home Safety.**
- **Emergency Planning** for disaster planning and information related to disruption in service in the event of a disaster.
- **Infection Control & Hand-Washing Techniques and Disposal of Biomedical waste**
- **Discharge & Transfer Policy.**
- **Contact information for Federally funded and state-funded entities that serve my local area.**
- **Emergency contact information.**
- **Non-discrimination policies.**
- **Abuse, Neglect, and Exploitation** which lists the abuse & state hotline numbers.
- **Medication profile with signs and symptoms of toxicity or allergic reaction.**
- **Access to information in a language and manner I understand.**
- **Contact information for the Administrator and the Clinical Manager.**

I UNDERSTAND that the agency will notify me, and my representative (if any), in writing and orally, as soon as possible, in advance of the next home health visit, of charges not covered by Medicare or other sources.

I REALIZE that the agency reserves the right to substitute employees at its discretion and to make supervisory visits of staff as required. Every effort will be made to provide a caregiver; however, the agency cannot guarantee scheduling. The agency staff may not be present in my house, at all times, and I, my caregiver, or legal guardian will assume responsibility for my care when agency staff is not present.

I UNDERSTAND The agency makes an effort to provide uninterrupted services; however, sometimes interruptions are unavoidable due to inclement weather or natural disasters. During the interruption of essential services, I agree to provide or arrange for backup care. If I cannot provide care, I understand that the agency may assist in arranging for transfer to an appropriate emergency facility.

I UNDERSTAND that, in the event of an emergency, during which the agency cannot meet my needs, the agency can transfer me to another agency that can provide the care I require.

I HAVE BEEN INFORMED of my rights and that I may file complaints about the agency, with the Home Health Hotline during regular business hours. The agency is available after-hours/ holiday 24/7 365 days per year.

_____	_____	_____
Patient or Authorized Agent Signature	**Relationship to Patient**	**Date**

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I UNDERSTAND that the agency does not routinely perform drug testing on its employees. If they choose to do so, it will be at their discretion.

I UNDERSTAND that If I choose to hire a current agency employee (or former employee who has rendered services for me in the past 12 months) The agency will charge a fee of 30% of full-time (2080) hours at the employee's bill rate. After 12 months, the fee is 15%. After 18 months it is 12% and after 24 months it is 10%.

I UNDERSTAND that the agency is the employer of the home care worker and is responsible for all state and federal regulations regarding employment. The agency conducts a background check on all employees, including fingerprinting, and reference checks. The agency is responsible for payment of wages, withholding of payroll taxes, payment of unemployment insurance, worker's compensation, and time off. The supervisor is responsible for the supervision of the employee, assignment of duties, and oversight of care provided. All disciplinary action is handled by the agency.

I HAVE BEEN INFORMED of the agency's policies for resuscitation, medical emergencies, and accessing 911 services (EMS).

RELEASE OF RECORDS I understand the agency policy regarding confidentiality and release of records prohibits access to my records by persons other than personnel involved in care. I, therefore, give written consent for the release of medical records to health care providers in my treatment care.

I AUTHORIZE the agency to release any medical information requested by representatives of local, state, or federal agencies, accrediting bodies, insurance companies, or other organizations or entities as may be required for payment of claims to the agency that are due**.**

ADVANCED DIRECTIVE: I certify that I have read and received a copy of the Client Rights and Advance Directives information specific to the state and that I am the consumer, or am acting on the consumer's behalf, to accept their terms.

- ☐ I have prepared an advance directive regarding my healthcare and will provide a copy to the agency.
- ☐ I have not prepared an advance directive and do not wish to at this time regarding my health care.
- ☐ I have not prepared an advance directive but wish to make an advance directive at this time.

Permission to Photograph: Photography may be needed to assist in the patient's care. For example, the nurse may need a picture of a wound or rash to assist the physician in the treatment plan. Permission is hereby granted to allow photography for medical care.

☐ **I do OR ☐ I do NOT allow photography**.

_____	_____	_____
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This **Admission Agreement** applies to admission into this agency, and I authorize the Medicare Benefit and/or services to begin. I have read the information and listened to what was explained to me and agree to the terms and conditions above and understand my right to make my healthcare decisions.

I agree to provide information regarding the physical, emotional, and psycho-social information on an ongoing basis to ensure optimal care and have participated in the development of the plan of care. I understand the reason for the services and agree with the plan of care.

I recognize that I have the right to refuse treatment or terminate services at any time by notifying the agency's office. Also, the agency may terminate service by notifying me of termination and reason without penalty.

SIGNATURES:

_____	_____	_____
Patient or Authorized Agent Signature	**Relationship to Patient**	**Date**
_____	_____	_____
Agency Representative Signature	**Title**	**Date**

☐ ***Patient unable to sign due to cognitive impairment or disease process.***

RELEASE OF MEDICAL INFORMATION

Noble Man Care Services

PLEASE COMPLETE FORM IN ENTIRETY. Items that are not checked or left blank are assumed non-applicable or not authorize for release. This release is not valid unless signed and dated by the patient or the legal representative. This release may be revoked at any time by the patient or legal representative.

I hereby authorize the disclosure of my individual healthcare record to Noble Man Care Services Home Health Agency for the purpose of physician review, for providing supporting documentation of my Hospice diagnosis, and for the coordination of my healthcare. I have received information regarding HIPPA and The Privacy Act and understand my rights regarding my healthcare record. This for is valid for one year from date of signature.

PATIENT NAME: _____

ADDRESS _____CITY_____STATE_____

SS#:_____ DATE OF BIRTH:_____

_____

INFORMATION REQUESTED: ***Please check all that apply***

☐ Physician Order	☐ Lab results	☐ Therapy Notes	☐ Dietary notes/swallowing studies
☐ History & Physical	☐ Radiology Reports	☐ Pathology Reports	☐ Hospice certification/re-certification
☐ Physician Progress Notes	☐ Cardiac Diagnostics	☐ Nuclear Scan Reports	☐ Hospice Plan of Care
☐ Physician Consults	☐ Lung Function Tests	☐ Medication Profile	☐ Face to Face Visit

☐ **OTHER:_____**

I am requesting the following healthcare records for period ____/____/_____ to Present

List facilities/physicians information is requested from: 1._____

2. _____ 3. _____

RESTRICTION OF DISCLOSED MEDICAL INFORMATION

☐ **I DO NOT HAVE ANY RESTRICTIONS ON MY INFORMATION**

☐ **I REQUEST THE FOLLOWING USE/RESTRICTIONS OF MY HEALTHCARE RECORD:** (Specific treatments and dates of treatments that may not be disclosed**)**

_____

_____

☐ **I REQUEST THAT NO INFORMATION REGARDING MY HEALTHCARE BE RELEASED TO THE FOLLOWING PERSON(S):**

_____

_____

PATIENT/LEGAL REPRESENTATIVE SIGNATURE: _____ DATE:_____

Home Health REPRESENTATIVE SIGNATURE: _____ DATE:_____