CONSENTS AND RELEASES

PATIENT NAME____

I hereby request admission for home health care services and consent to such care and services as are ordered by my physician through the home health care agency. I have been informed verbally of, and have received copies of the documents listed below:

___✓___PATIENT RIGHTS AND RESPONSIBILITIES
___✓___EMERGENCY PREPAREDNESS PLAN/ SAFETY PRECAUTIONS
___✓___HOME SAFETY MEASURES
___✓___CONSENTS AND RELEASES
___✓___ADVANCE DIRECTIVES ACKNOWLEDGEMENT
___✓___SCHEDULE OF FEES, VISIT SCHEDULE, TREATMENTS & EDUCATION PLAN
___✓___NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
I consent to the release of information by any physician, hospital, extended care facility or home health agency of which I have been a patient and I authorize such physician, hospital, extended care facility or home health agency to disclose all or part of my medical record, including information on infectious diseases, to a representative of the Agency.

I consent to the release of information (verbal, fax or photocopies) and/or disclosure of all or any part of my clinical record by the Agency, to any physician, hospital, or other entity of which I am or have been a patient. I further consent to the release of any information necessary to public safety organizations (Fire, Police, etc.).

I consent to the release of information (verbal, fax, or photocopies) and/or disclosure of all or any part of my clinical record by the Agency, to be reviewed by authorized representatives of Medicare, Medicaid, Medicare Intermediary, and/or my private insurance company, or other outside review organizations, for use in determining my home health care benefits.

ASSIGNMENT OF INSURANCE BENEFITS
I hereby authorize payment for services and supplies provided by the Agency, to be made directly to the Agency (Provider).

CONSENT FOR HOME VISIT
I hereby permit state/federal and/or outside survey personnel to visit me at my home to ensure that the federal requirements are met and to assist in evaluating the effectiveness and quality of home health services which I am receiving. I understand that consent for this visit is voluntary and that the visit will only be performed with my permission. I also understand that refusal to permit a home visit will have no effect on the level and nature of Medicare benefits to which I am entitled.

I have read and/or have had this form read to me and understand my rights concerning consents and releases. I fully understand that I am financially responsible for any and all deductibles and co-insurance, and any amount not covered by my insurance. I also understand that these consent and releases can be revoked by me at any time.

PATIENT SIGNATURE ____ DATE___________