Freudenthal HOME HEALTH

AGENCY CONDITIONS AND CONSENT FOR ADMISSION

I hereby provide consent for Freudenthal Home Health ("Agency") to deliver such care and treatment as is ordered by my physician. I understand the Agency will oversee the service ordered and I may refuse or terminate services at any time and the Agency may terminate services to me as explained during this admission visit.

PATIENT RIGHTS & RESPONSIBILITIES

I have been given information about my rights and responsibilities as a patient and understand I have the right to make medical decisions, to participate in my plan of care. I acknowledge that my plan of care, including service type, frequency and potential outcomes have been discussed with me and/or my caregiver.

SN_____ **PT**_____ **OT**_____ **ST**_____ **Aide**_____ **SW**_____

As a Medicare patient, I acknowledge that if I do not have a face-to-face encounter with a physician or certain non-physician practitioner within 90 days prior to or within 30 days of my start of home health care for a matter related to my need for home health services, that I am not eligible for Medicare payment of my home health services. Furthermore, I understand that my home health service may be discontinued if this required physician encounter does not occur.

RELEASE OF INFORMATION

I hereby authorize the agency to disclose to or receive from hospitals, physicians or other parties involved in my care all medical records and information pertinent to my care. I give permission for photographs to be taken if needed to document my care. I also give permission for the Agency's accrediting and regulatory bodies to review my medical record.

ADVANCE DIRECTIVES

I have received information regarding Advance Directives.

I understand that I may accept or reject any medical treatment. It is the policy of the Agency to fully comply with the terms of any Living Will, or Durable Power of Attorney for Health Care decisions, and whether or not I have executed any Advance Directives, it will have no affect on the service provided to me and:

- I have signed an Advance Directive: ❑ **No** ❑ **Yes**
- If yes, is it a: **Living Will** – ❑ **No** ❑ **Yes** **OR** **Power of Attorney for Health Care** – ❑ **No** ❑ **Yes**
- I have provided a copy to the Agency: ❑ **No** ❑ **Yes** – If No, arrangements have been made to obtain copy: ❑ **No** ❑ **Yes**
- New Advance Directive to be completed: ❑ **No** ❑ **Yes**

AUTHORIZATION FOR PAYMENT

I hereby authorize the agency to submit a claim for payment for any services I have received by the Agency and am directing the carrier providing my health benefit coverage to pay the Agency directly for these services, but not to exceed the charges for services rendered. I acknowledge that it is my responsibility to contact the Agency immediately if my health benefit coverage changes.

Primary Payor: _____ Policy #:_____ Group #:_____

Secondary Payor: _____ Policy #:_____ Group #:_____

My benefit carrier has informed the Agency I am responsible for $_____ deductible and _____% of charges not to exceed $_____ per visit plus customary charges for medications or medical supplies provided by the Agency. If at any time of the billing my carrier determines that this information is incorrect, I understand I may be financially responsible in whole or in part for billed charges as would be determined by my insurance carrier.

I certify the information I provide in applying for payment under Title XVIII or XIX of the Social Security Act is correct. I request payment of authorized benefits from Medicare, Medicaid, or other responsible payer to be made on my behalf to Freudenthal Home Health.

❑ I have received a copy of the Agency's Privacy Notice.

ACKNOWLEDGMENT OF CONSENT

I hereby certify that I have read and understand the Conditions and Consent for Admission and I sign voluntarily:

Printed name of Patient or Legal Representative:_____ Date: _____

Signature of Patient or Legal Representative:_____ Date: _____

Signature of Witness: _____ Date: _____

Freudenthal HOME HEALTH

MEDICARE SECONDARY PAYOR QUESTIONNAIRE

❑ No Is the patient under 65? ❑ Yes

Eligible for Medicare base on disability? ❑ Yes ❑ No

Eligible for Medicare solely due to ESRD? Dialysis began on:_____ ❑ Yes ❑ No

❑ No Is the patient covered by an HMO? ❑ Yes

Date enrolled:_____ Date disenrolled:_____ Name of HMO: _____

❑ No Is the patient or the patient's spouse employed? ❑ Yes

Covered by a Group Health Plan? ❑ Yes ❑ No

Name of employer:_____

If covered by spouse's employer, spouse's DOB: _____

Has patient signed up for new insurance within the past 3 months? ❑ Yes ❑ No

Document insurance information below.

❑ No Is the patient covered by Black Lung? ❑ Yes

❑ No Is the patient covered by a government program or research grant? ❑ Yes

❑ No Is the patient covered by VA? ❑ Yes

Does the patient elect to take Medicare coverage instead of VA? ❑ Yes ❑ No

❑ No Is the patient covered by Worker's Compensation? ❑ Yes

Document insurance information below.

❑ No Was the illness/injury due to a **NON**-work related accident? ❑ Yes

Date of accident/injury:_____ Type of injury: _____

Was it reported? ❑ Yes ❑ No

❑ No Is no-fault insurance available? ❑ Yes

If yes, name/address of no-fault insurer(s) and no-fault policy owner:

_____

_____

❑ No Is liability insurance available? ❑ Yes

If yes, name/address of liability insurer(s) and responsible party:

_____

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