WellsBrooke
CERTIFIED HOME HEALTH CARE

# Home Care Consent and Admission Service Agreement

**Patient Name:**_____ **MR#**_____

*Instructions: This form is used to acknowledge receipt of our Patient Admission Booklet and confirm your understanding and agreement with its contents. Your signature on the following page indicates your approval.*

## Consent for Care and Service

I authorize WellsBrooke Certified Home Health Care to provide home health treatment as ordered by my physician. I understand that I have the right to make decisions concerning my medical care, including the right to accept or refuse medical or surgical treatment. I understand that I and/or my family/caregiver will receive instructions to assist with my care and that I am responsible for my care in the absence of WellsBrooke Certified Home Health Care staff in my place of residence.

## Patient Right and Responsibilities

My signature acknowledges that I have received the statement of rights and responsibilities and it has been explained to me. The Ohio Home Health Hotline number has been provided and explained to me.

As a Medicare patient, I acknowledge that I received information about Medicare's requirement for a face-to-face encounter with a physician or certain non-physician practitioners for matters related to my need for home health services within 90 days prior to or 30 days after my start of home health care. I understand that if, for any reason, I do not have a Medicare qualifying encounter within this time frame, that I am not eligible for Medicare payment of my home health services. Furthermore, I understand that my home health services may be discontinued if this required physician encounter does not occur.

## Grievance Procedure

I have received information about the WellsBrooke Certified Home Health Care Grievance Procedure and it was explained to me to my satisfaction.

## Release of Information

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act, or under a policy of insurance, is correct. I authorize WellsBrooke Certified Home Health Care or any other holder of medical or other information about the above named patient, to release or receive such information to any government agency or insurance company to whom application has been made for payment for services rendered to the above patient; to any physicians, hospitals, other healthcare providers or facilities, institutions or agencies providing treatment to the patient or providing continuity of care, to quality reviewers and accrediting bodies.

## Initial Services and Frequency

I have received the WellsBrooke Certified Home Health Care brochure. I have been informed of the nature and frequency of visits I will receive, and I have participated in the planning of my care.

SN:_____ PT:_____ OT:_____ SLP:_____ MSW:_____ Hha:_____

## Assignment of Benefits

I authorize payment directly to WellsBrooke Certified Home Health Care for any benefits owed in respect to my examination or treatment. I agree to pay any charges not covered by insurance benefit plans and where payment is prohibited by law. In circumstances when services or supplies I opt to receive will not be covered by Medicare, as will be explained to me through Advance Beneficiary Notice, I am aware of my full financial obligation to WellsBrooke Certified Home Health Care, should I choose to receive them.

Medicare Insurance pays for **100%.** Other insurance:_____% or ☐ N/A

For a Medicare patient, payment liability is **0% or $0.00** per visit.

Payment liability for other insurance:_____% or $_____ per visit.

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## (continued)

### Emergency Instructions

My signature below acknowledges that I have established and understand my emergency instructions.

### Acknowledgment of the Privacy Notice

I have received a copy of the Notice of Privacy Practices. I hereby authorize disclosure of my Personal Health Information to the following individual(s):

_____

### Receipt of Oasis Privacy Act Statement

I have received information about the Home Health Agency OASIS Statement of Patient Privacy Rights, including a toll free contact number.

### Safety and Infection Control

I have received information about basic home safety, contacting the organization, emergency/disaster planning related to a disruption in service and infection control practices as appropriate to my care in the home. I understand that staff may provide ongoing instructions on these areas as needed.

### Advance Directives

I acknowledge the receipt of a copy of my patient's rights and all rules and regulations governing patient conduct. I have also received information regarding advance directives.

I have previously signed an advance directive prior to this admission. ☐ Yes ☐ No

If yes, the name and phone number of the patient advocate authorized to make medical decisions on my behalf is:

Name: _____ Phone: _____

☐ Copy of Advance Directive Provided.

☐ Copy of Advance Directive not provided. Reason: _____

I have a DNR order?: ☐ Yes ☐ No

If yes, a copy of the order singed by the patient and physician **MUST** be on file.

### Consent to Photograph

I, the undersigned, authorize photographs to be taken by an authorized representative of WellsBrooke Certified Home Health Care. These photographs will be used as documentation for patient care and will be come part of the patient's medical record. Photographs will not contain identifiable images of the patient

**Signature of Patient or Representative** **Relationship** **Date**

**Printed Name of Patient or Representative** **Signature of Witness and Date**