Good Care
Home Health Services LLC.

885 N Powers Dr. Suite B Orlando, FL 32819
Phone: (407) 716-0219/407-668-4847, Fax: (407) 668-4953

GOODCAREHOMEHEALTHSVC@GMAIL.COM

Admission Consent

Patient Name:	DOB:	AGE:	Gender: MALE FEMALE
Insurance:	Insurance ID:	Location:	
MR#:	SOC:	Episode:	
Date:	Completed By:		

Organization Information

Instructions
This form is used to acknowledge receipt of Good Care Home Health orientation booklet and confirm your understanding and agreement with its contents. Your signature below indicates your approval.

Client Rights and Responsibilities

I acknowledge written and verbal receipt of my rights and responsibilities as a client (including OASIS rights) and I understand them. The state home health hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home healthcare. No employee of this agency has solicited or coerced my decision in selecting a home health agency.

Consent for Treatment

I hereby give my permission for authorized Home Care personnel, including students in approved programs, to perform any and all necessary procedures and treatments as prescribed by my physician for the delivery of home health care. I understand that the agency will supervise services provided, I may refuse treatment or terminate services at any time and the agency may terminate their services to me as explained in my orientation. I agree and consent to the home care plan and payment as outlined in this admission booklet. I understand that this is the initial plan of care. I will be notified by the agency in advance each time there is a change made to my plan of care. The initial service(s) and visit frequencies are as follows:

MSW	[] Evaluate & Treat	[] Refused/Not needed
OT	[] Evaluate & Treat	[] Refused/Not needed
ST	[] Evaluate & Treat	[] Refused/Not needed
PT	[] Evaluate & Treat	[] Refused/Not needed

Consent for Home Visits
I hereby give my permission for authorized Home Care personnel to schedule visits to my home upon a mutually agreeable schedule established by me and my home care provider(s). I consent to have health care review personnel and accrediting agency personnel visit my home in order to ensure that quality care is provided. I understand that I (or my family) have the right to refuse entry into my (our/their) home at any time. I understand that treatment will be provided over time, both before and after any readmittanee to an acute care hospital and in connection with any renewal of the plan of care prescribed by a physician.

Consent to Release and Request Information
I acknowledge receipt of the Notice of Privacy Practices and was given an opportunity to ask questions and voice concerns. I understand that the agency may use or disclose protected health information about me to carry out treatment, payment or health care operations. Unless specified below, I give my permission to Home Care to release

to or receive from hospitals, physicians, other health care providers and organizations, community agencies, third party payers, professional review agencies, regulatory review entities and accrediting agency personnel printed or facsimile information, including all medical records and information pertinent to my care and necessary to act on payment requests including, without limitation, medical records and information relating to HIV status and treatment, alcohol and substance treatment, sexually transmitted diseases and treatment and psychiatric care and treatment.
Confidentiality of information released or received, as a result of this consent will be strictly maintained. Information received shall not be further relayed in any way to any other person, organization or other entity without an additional written consent from me.

This consent shall remain effective from date of signature until my written revocation.

I authorize AIM Home Health to release my medical information to the following people:

Authorization for Payment

authorize release of all records required to act on this request. I request that payment of authorized benefits from Medicare, Medicaid or other responsible payor be made in my behalf to AIM Home Health (Please select correct insurance type below.)

I request that payment of authorized benefits ([]Medicare [] Medicaid []other insurance companies) be made on my behalf for Home Care services furnished to me. I authorize release of all records and information required to determine benefits. I understand that I may he responsible for and agree to pay deductibles, copayments and any amounts due after payment of benefits on my behalf by any and all third party payers. I understand that while I am under the agency plan of care, AIM Home Health will coordinate all medically necessary therapy services and medical supplies for me. If I arrange for these services or supplies on my own, I understand that Medicare will not reimburse me or my supplier and I will be responsible for the total cost. Co-pay: Deductable:

Homebound: I understand that I must also be homebound during the period of time that I receive home health services if I am a Medicare beneficiary or if my health provider requires the same.

Advance Directives

I understand that the Federal Patient Self-Determination Act of 1990 requires that I be made aware of my right to make health care decisions for myself. I understand that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak for myself.

1. I have made a Living Will. O.No O. Yes (If yes provide a copy to the agency)
2. I have made a Durable Power of Attorney for Health Care. O No 0 Yes (If yes, write the name and phone number of the person given power of attorney:)0 No O Yes
3. I have a Comfort One/DNR. Order. O No O Yes

Rights of Clients

Each home care client has the following rights (Section 13.5):

1. To receive services without regard to race, creed, color, gender, sexual orientation, age, disability or source of payment.
2. To receive safe, appropriate and high-quality care and services in a timely manner with consideration, dignity, respect and privacy.
3. To accept or refuse care and to be informed of the consequences of such action.
4. To be free from mental or physical abuse, physical punishment, neglect, damage to or theft of property or exploitation of any kind.
5. To have his or her property treated with respect.
6. To exercise his or her rights as a client of the home nursing care provider or home care provider agency. When the client is unable to exercise his or her rights, an agent or legal guardian may exercise the client rights.
7. To be informed, in advance, about the care to be furnished (and not to be furnished), the plan of care and of any changes in the care to be furnished before the change is made.