Admission Consent Checklist

This form is used to acknowledge receipt of the Patient Orientation Booklet, and to confirm your understanding and agreement with its contents. Your signature on page 2 indicates your consent and understanding.

Client Name: ______________________________ SOC Date: ___ / ___ / ___

Consent for Treatment: I, __________________________ (Printed Name) voluntarily request and authorize Envision Home Health to carry out all treatment deemed necessary or beneficial per the judgment and medical order of my physician. I have been informed of my right to choose my home health care provider, and I verify Envision Home Health is my agency of choice.

Authorization for Release of Information: I authorize to release to Envision Home Health, third party payers, physicians or other health care providers/facilities, the Social Security Administration, the Health Care Financing Administration, fiscal intermediaries or regulatory/accrediting bodies any party involved in the coordination of my home health services copies of my medical records, reports or information necessary to complete my health care needs for continuing and coordinating my plan of treatment or related to my care for quality assurance or accreditation purposes. I acknowledge this information may be shared at any time during my home health episode.

Patient Designated Representative: ________________ **Contact Information** ____________

I authorize Envision Home Health to release confidential health information on my behalf to the following:

#1 ____________________ #2____________________ #3 ____________________

Authorized Representative for Signature: I authorize the following person(s) to act on my behalf in the act of signing documents related to services and disclosures that are necessary during my period of service.

#1 ____________________ #2____________________ #3 ____________________

Assignment of Benefits: I authorize and direct the named insurer(s) to pay Envision Home Health, as Third Party Claimants, any and all basic, major medical, extended coverage, trust fund benefits, indemnity benefits, automobile medical or no fault insurance, and liability benefits normally due to me as their interests appear. I permit a copy of this authorization to be used in place of the original by all as necessary. I understand that it is my responsibility to notify Envision Home Health if I have any benefit changes. I understand that I am financially responsible to Envision Home Health for charges not paid by any third party payor within the limits of the agency and credit policy. I understand and agree to make payment upon the receipt of an invoice. I have been informed of charges incurred for services rendered.

Name of Primary Payor: ______________________________ **ID#** ________________

Name of Secondary Payor: ____________________________ **ID#** ________________

Acknowledgement of Financial Responsibility

Services Provided	Usual & Customary Rate (per visit)	Amount Covered by Payor	Client Financial Responsibility	Visits Authorized / Anticipated Frequency
Skilled Nursing Services	$134.42			

Client Signature: ______________________________ Date: ____________________

Client Representative: ___________________________ Date: ____________________

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Physical Therapy	$146.95			
Occupational Therapy	$147.95			
Speech Therapy	$159.71			
Social Services	$215.47			
Home Health Aide	$60.87			

Medicare and Medicaid: I understand that benefit patients will not receive a bill for any service, unless it pertains to a service or supply with a co-payment, as Envision Home Health will accept assignment for services provided. **I have been informed that I will receive a Notice of Medicare Provider Non-Coverage no later than 48 hours prior to the determined date that services may no longer be covered under the Medicare benefit for home health.** I understand that it is my right to contact the **(QIO) Quality Improvement Organization** to appeal this decision and will avoid financial liability of services end no later than the date indicated on the notice. I understand that if services continue and my appeal is denied, I will be the sole responsible party for payment at the agency's usual and customary rates provided above.

Verification of Medicare as Primary or Secondary

1. Is the illness or injury due to any kind of accident other than a fall at home? ❑ Yes ❑ No
2. Do you have coverage through the VA, the Department of Labor's Black Lung Program or some other federal or state agency program? ❑ Yes ❑ No
3. Are you 65 or above and employed at the time of this service? ❑ Yes ❑ No
4. Do you have a spouse who is employed at the time of this service? ❑ Yes ❑ No
5. Are you under 65 years of age, entitled to Medicare solely because of End Stage Renal Disease (ESRD), and in the first 12 months of retirement? ❑ Yes ❑ No
6. Are you under 65 years of age and entitled to Medicare solely because of Disability? ❑ Yes ❑ No

Acknowledgment of OASIS Data Collection and Transmission: I am aware of the purpose of OASIS data collection. I agree to answer OASIS questions to the best of my knowledge and allow Envision Home Health to transmit this information to the State and Health Care Financing Administration.

Unanticipated Interruption of Services: I understand that services provided by Envision Home Health are on an intermittent basis and do not included emergent care. I understand that when interruption of services is unavoidable, including by not limited to inclement weather or other natural disasters, it is my responsibility to arrange for personal assistance. If I am unable to arrange such assistance, I authorize Envision Home Health to arrange a transfer to an emergent care facility on my behalf. Emergent Care Facility of Choice: ________________________

Assignment of Primary Caregiver: I have been informed that the services provided by Envision Home Health are intermittent services, and do not include custodial care. I have chosen the following person as my primary caregiver in the event that I am unable to fully participate in my home health plan of care:

Primary Caregiver Name / Relationship: ___________________________________ Phone: ________________

Advanced Directives: I understand that the Federal Patient Self-Determination Act of 1990 requires that I am informed of my right to make healthcare decisions for myself. I understand that I may express my wishes in a document, formally known as and Advanced Directive, so that my wishes may be known when I am unable to speak for myself. I understand the Envision Home Health cannot follow my Advanced Directive without a copy of these documents in my medical record. I have received information about Advanced Directives a my admission visit and I acknowledge that the admitting

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Client Representative: ____ Date: ______________________________

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clinician has requested a copy of the following Advanced Directives:
❑ Living Will ❑ Durable Power of Attorney ❑ DNR ❑ Other ______________________________

A copy of this document is: ❑ Attached ❑ Will be Given Later ❑ I Refuse to Provide a Copy

❑ I DO NOT have an advanced directive at this time, but understand that I may obtain assistance in regards to executing an Advanced Directive upon my request.

Special Services: I understand that if I need hospitalization or other special services not provided by Envision Home Health, I or my legal representative must make arrangements for these services. Envision Home Health should in no way be responsible for failure to provide the same and is hereby released from any liability arising from the fact that I am not provided with such additional services.

I acknowledge receipt of the following information through written and verbal education :
 Orientation Booklet Patient Bill of Rights Advanced Directives Universal Precautions / Infection Control
 HIPAA / Notice of Privacy Practices & Policy for Breach of Protected Health Information Statement of Privacy – OASIS
 Policies regarding Non-Discrimination SAFEY: Home, Medication, Oxygen; Emergency Planning, Fall Prevention

Envision Representative / Witness: ____

Client Signature: ______________________________________ Date: ______________________

Client Representative: _________________________________ Date: ______________________