FREEDOM HOME HEALTHCARE

Consent to Treatment

Patient's Name: ____ Date: ________________________________

Address: ____ Apt #____________________________________

City: _______________________________ State:___________________________Zip:____________DOB:_____________

Social Security Number: ____ Insurance: _____________________________

I, ____ hereby authorized the staff of FREEDOM HOME HEALTHCARE to provide treatment as deemed necessary in consultation with my primary care physician. I understand the treatment may include nursing assessment, diagnosis, evaluation, testing, home health aide, medication training, rehabilitation, and/or therapeutic activities.

I realize that written and computerized information will be kept on me and that evaluation data will be requested from me periodically, to ascertain my progress. I have also been informed that my information will be kept confidential and will not be released without my written consent, except in the case of extreme emergency or where mandated by law. I have been informed that I have the right to stop treatment at any time and to refuse any medication that may be prescribed. I understand that I am entitled to a full explanation of the potential risks associated with any of my current medications as provided in the Physician's Desk Reference. This explanation will be made available to me at my request. The Physician's Desk Reference provides detailed descriptions of medications, along with known side effects and appropriate warnings.

I have been offered a copy of this Consent to Treatment form and I (check one)

☐ Accept ☐ Refuse

I authorize payment in lieu of services rendered to me by MedNet Health Care System of Philadelphia. Further, I authorize the release of any medical information required to process claims submitted by **FREEDOM HOME HEALTHCARE**. I also understand that I am financially responsible for any charges not covered by this authorization up to the limit of liability to **FREEDOM HOME HEALTHCARE**. This authorization is made freely and voluntarily.

Patient's signature: ____________________________Date: ______________________________

Parent or Guardian: ____________________________Relationship: ________________________

Witness' Name:_____________________________ Witness' Signature:_________________

Date:___________

FREEDOM HOME HEALTHCARE

Patient Name______________________________________ Date: _______________________________________
Medicare/Medicaid #_________________________________Effective Date: PartA:__________PartB:__________

Instructions- This form is used to confirm your understanding and agreement with this service.
Your signature below indicates your understanding and approval.

PATIENT RIGHTS AND RESPONSIBILITIES

I acknowledge that I have been made aware of my rights & responsibilities as a patient (including OASIS rights) and I understand them. The State home care hot line number has been provided and explained to me. I certify that I was involved with planning my care and was offered a copy of such plan.

AUTHORIZATION FOR TREATMENT

I hereby give my permission for authorized personnel of FREEDOM HOME HEALTHCARE to perform all necessary procedures and treatments as prescribed by my physician for the delivery of home health care. I understand that I may refuse treatment or terminate services at any time and the agency may terminate their services to me as explained in my orientation. Services to be provided on the initial plan of care are: ☐SN ☐ PT ☐OT ☐ST ☐MSW ☐HHA ☐_______________

RELEASE OF INFORMATION

I hereby authorize your agency to release or receive from hospitals, physicians, or other agencies involved in my care all medical records and information pertinent to my care. This may include making disclosures to my family members, your personal representatives, or other persons identified by me who are involved in my care. I hereby give permission for the review of my medical record by the agencies accrediting and/other regulatory bodies.

AUTHORIZATION FOR PAYMENT

I certify that the information given by me in applying for payment under Title XVlll of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits from Medicare/Medicaid, or other responsible payer be made in my behalf to FREEDOM HOME HEALTHCARE, a certified home health agency. I understand that I am responsible for all amounts not paid by my insurance. If covered under Medicare Part A, I understand that the agency accepts the current Medicare reimbursement as payment in full for covered home health services. Expected payer source(s) for my home care services are: ☐Medicare ☐Medicaid ☐ other____________________ the rates or charges for services paid w/private funds☐ N/A ☐other______________

INSURANCE INFORMATION: NAME: ____-
*TELEPHONE*___________________________________
*Health insurance claim #*___________________________________*Group #*________________________________*Effective Date:* ______________________________
*Mailing address:*____--____

CONSENT TO BE PHOTOGRAPHED

I hereby authorize FREEDOM HOME HEALTHCARE to take pictures of myself and treatment being done and authorize release of those photographs for use in advertisement or public education regarding home health services or to insurance providers to document my medical condition.

OTHER MEDICARE SERVICES / SUPPLIES

I understand that while I am under Freedom Home Healthcare's plan of care, the agency will coordinate all medically necessary therapy services and medical supplies for me. Should 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 their cost.

ADVANCE DIRECTIVES

I understand that the Federal Patient Self Determination Act of 1990 requires that I be made aware of my rights to make health care decisions for myself. I understand that I may express my wishes in a document called an Advance Directive (Living Will/Durable Power of Attorney for Health Care) so that my wishes may be known when I am unable to speak for myself. The agency cannot honor your advance directive if you do not provide us with a copy:

(1.) I have made a Living Will ☐ Yes ☐ No Copy of Living Will obtained: ☐ Yes ☐ No
(2.) If answer is "No" (check one box): ☐ Document unavailable ☐ Patient refused to provide a copy ☐ Observed original in home, patient refused copy
(3.) I have a designated a Health Care Surrogate: ☐ Yes ☐ No (if "yes" write name & phone of the surrogate):

Name____ Phone____

____ ____
PATIENT'S SIGNATURE **RESPONSIBLE PERSON / LEGAL GUARDIAN SIGNATURE**

____ ____
WITNESS SIGNATURE/AGENCY REPRESENTATIVE **PRINTED NAME & RELATIONSHIP OF PERSON ABOVE**

_______________________________________ ☐ ____
DATE **PATIENT UNABLE TO SIGN DUE TO**