SUMMIT HOME CARE
170 Taylor Station Rd Ste 220
Phone: 614-866-8158 Fax: 614-866-8160

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HOME CARE

ADMISSION SERVICE AGREEMENT

Consent for care, Service(s), And Photography: I hereby give permission to Agency to provide care and treatment to me per program policy and as prescribed by my physician. I understand that the plan of care will be developed in consultation with me. My physician must agree with the plan of care, unless I am receiving only homemaker assistance. I understand that changes to the plan of care may be indicated. Those changes will be made in consultation with me, and that physician's orders are necessary to make changes. Instructions for my care have been explained to me. I am responsible for ensuring my needs are met when Agency is not present in my home. I agree to notify Agency, my physician and others providing care of any changes or problems. "I understand that I have the right to review assessment information (including OASIS data) and physician orders that the agency may complete to ensure accuracy. I consent to HCD associates taking photographs as indicated, including tracking wound healing and education. Agency has my permission to use said pictures as needed, including sharing this information with my physician. I accept no compensation or other remuneration for the use of such photographs.

Insurance Information and liability for payment

To the best of my knowledge, I am entitled to home care services through any and all of the following third payer sources:

[ ] Medicare #: ________________ [ ] Medicaid #: ________________ [ ] Passport

[ ] Waiver [ ] Senior Options [ ] Private Pay [ ] Other: ________________ HIC: ________________

I understand that I will be receiving the following service(s): [ ] SN [ ] PT [ ] PTA [ ] OT [ ] COTA [ ] HHA

The agency has informed me that the anticipated payer source for this care is: ________________;and that I will be responsible for 100% of anything not covered by insurance.

Assignment of Benefits: I request that payment of the authorized benefits on my behalf be made to the Agency. I understand that I will be responsible for any co- payments, deductibles, or any amounts due after payment of benefits on my behalf by any and all third party payers. I understand that I must keep the home health agency informed of any changes that occur that may jeopardize my qualifying for these or any other benefits I may be entitled to. Agency accepts assignment from Medicare, Medicaid, PASSPORT, and Senior Options as payment in full.

Receipt and review of client handbook: I certify that I have received and understand the information contained in the Patient Hand book. This handbook contains important information regarding my rights and responsibilities as a client, the Statement of Patient Privacy Rights, Notice about Privacy Act Statement - Health Care Records, the HIPPA Statement of Patient Privacy Rights, Nondiscrimination Policy, Section 504 Notice of Program Accessibility/ Translation Assistance, Information about Safety and Infection control, Advance Directives, Payment for Home Care Services, Grievance Procedure, the State Complaint Hotline Number, and payment rates for services.

Release of information: I give my permission to Summit Orthopedic Home Care to release to or receive from hospitals, physicians, other agencies including regulatory or accrediting agencies, and / or other persons involved in my care all medical records and information important to my care, including the presence or absence of communicable disease. I authorize agencies to release medical and other related information (unless I indicate otherwise in writing) to above and social/health care agencies, contracted agencies, case management agencies, laboratories, family members, and medical equipment/ supply vendors whose services may be required in conjunction with the services provided.

Advance Directives: I understand it is the policy of Summit Orthopedic Home Care to provide services to all persons without regard to whether they have executed any advance Directives. I understand that my decision regarding Advance Directives can be changed at any time. I will notify Summit Orthopedic Home Care, My physician(s), and my family should I wish to make changes. I would like to indicate the following at this time: _______ In the event of an emergency, I request the following Code Status: [ ] Full Code [ ] No Code [ ] other: __________

______ I have not and do not wish to execute Advance Directives at this time.

______ I have or would like to execute the following Advance Directives [ ] Living Will [ ] Durable Power of Attorney [ ] Do not Resuscitate Orders

[ ] Refusal of Specific Treatments, Services, and Medications [ ] Other: ________________

Certification: I understand the statements contained herein, and have received a copy of and an explanation of this agreement, I agree with the conditions. I am the patient or am duly authorized by the patient as the patient's general agent and can execute the above and accept its terms. I understand that this agreement can be revoked in writing at any time. This information has been provided to me prior to the provision of my care

Patient / Representative Signature ________________________________ Relationship to Patient: ____________ Date: ________

Witness Signature: ____________________________ Witness Name: ________________________ Date: ________