ADMISSION CONSENT AND CONTRACT FOR SERVICES

Patient Name _____ ***Date***_____

PATIENT RIGHTS AND RESPONSIBILITIES

I acknowledge that I have been made aware of my rights and responsibilities as a home health client. I have been given a copy of the Client's Rights and Responsibilities and acknowledge receipt of information regarding my federal and state-regulated rights and how to file a grievance. The Agency's drug testing policy, the policy on abuse, neglect and exploitation and the Emergency Preparedness Plan have also been shared with me. I acknowledge that I have not been solicited or coerced to this agency and realize I can choose any agency to care for my child's home health needs. I can call the Agency 24 hours a day regarding my child's health care at **(972) 905-3413**. This is not an emergency line. I will call 9-1-1 in the case of an emergency. It is the policy of the agency to protect all clinical records against loss, defacement, tampering, and use by unauthorized persons. I authorize this Agency to release medical information to my child's physician, the facility of my choice, payer source, or regulatory organizations, as needed. I authorize the release of the Plan of Care and Discharge Summary upon my transfer to another health care facility, if needed.

AUTHORIZATION FOR TREATMENT AND ACKNOWLEDGMENT OF PLAN OF CARE

I acknowledge that my child will be receiving the following services:

ı Licensed Home Health

I give my permission for authorized personnel of Agency to perform all necessary procedures and treatments as prescribed by my physician for the delivery of home health care services. I understand that I may refuse treatment or terminate services at any time and Agency may terminate services to me as explained in my Clients' Rights and Responsibilities.

I acknowledge that the Plan of Care will be fully explained to me and that I will understand the plan. I understand that the frequency and duration of each service noted is based on the initial assessment of my child's needs but can change depending on physician orders received by Agency and authorization by my insurer. I understand that if I require therapy services, the frequency and duration of services will be determined, with my input, after evaluation by that discipline. I understand that I will be notified each time my Plan of Care changes and will be given the opportunity for input. The proposed Frequency and Duration of services is as follows:

PT_____**OT**_____

RELEASE OF INFORMATION

I acknowledge the receipt of the Notice of Privacy Rights, in compliance with the Health Insurance Portability and Accountability Act of 1996. I acknowledge that my personal health information will be released when related to treatment, operations and payment for the services provided by the Agency. The Notice of Privacy Rights details circumstances under which any personal Protected Health Information may be released. I authorize the Agency to release to, or receive from, hospitals, physicians, hospices, home health agencies and other healthcare entities involved in my care all medical records and information pertinent to my care, including but not limited to: the Plan of Care, history and physical, recent laboratory tests, diagnostic tests, a summary of the care provided and any information regarding any Advance Directives I may have.

I acknowledge that I may revoke this consent for release of information at any time; however, any revocation applies to future occurrences only. Without revocation, this consent shall remain effective for a period of time not to exceed two years after my discharge from home health services.

EMPLOYEE ALCOHOL/DRUG TESTING

Employees are not subjected to alcohol/drug testing prior to employment with this agency. However, the Agency prohibits use of alcohol or drugs during work hours or if it affects work performance or the safety of its clients in any way.

ABUSE NEGLECT OR EXPLOITATION

The Agency does not employ any staff with any previously recorded incidents of abuse, neglect, or exploitation. I have read and understand the policy (see Patient Education Booklet) relating to reporting of abuse, neglect or exploitation of clients. Agency employees are required by law to report any incidences of suspected abuse, neglect, or exploitation to legal authorities and/or Agency administrator.

ADVANCE DIRECTIVES

I understand that the Federal Patient Self-Determination Act of 1990 requires that I be made aware of my right to make healthcare decisions for myself. I understand that I may express my wishes in a document called an Advance Directive (Directive to Physicians / Medical Power of Attorney / Do Not Resuscitate Order [DNR] / Declaration of Mental Health) so that my wishes may be known when I am unable to speak for myself. I agree to provide a copy or to share the contents of any Advance Directives with my home health care providers.

ı I have a Directive to Physicians. Yes No

ı I have a Medical Power of Attorney. Yes No If yes, write the name & phone number of the person given power of attorney. _____

ı I have a DNR Order. Yes No If yes, is it an Out of Hospital DNR Order? Yes No

ı I have a Declaration of Mental Health. Yes No

EMERGENCY FORM

This Agency operates Monday-Friday, between 8 a.m. and 5 p.m. The administrator can be reached by calling **(972) 905-3413**.
However, in the case of a serious medical emergency or disaster, please call 911 as this agency is not an emergency service.
Physician Name/Phone Number: _____

Emergency Contact/Phone Number: _____

GRIEVANCE/COMPLAINT PROCEDURE

If you have any concerns, we would appreciate that you contact the Administrator of KidAbility, PLLC at 972-905-3413 to give us the opportunity to resolve your complaint or grievance. Your complaint will be investigated within 10 days of receipt. The entire process from receipt of complaint through resolution will not exceed 30 days. At any time you may address complaints to the Texas Department of Aging and Disabilities (DADS). DADS has a hotline number 800-458-9858 in which to receive complaints about the home health agency or for complaints concerning the implementation of Advance Directive requirements. The hotline number is answered from 8:00 am to 5:00 pm, Monday through Friday. After hours, holidays, and weekends, you may leave a message and a complaint intake specialist will return your call. You may also address a complaint in writing to: DADS Consumer Rights and Services Division, P.O. Box 149030, Austin, Texas 78714-09030. Complaints regarding Utilization Review or HMO Services can made directly to the Texas Department of Insurance at P.O. Box 149091, Austin, TX 78714 or 800-252-3439.

MEDICAID ASSIGNMENT OF BENEFITS TO MEDICAID OR INSURANCE CARRIER

ı I certify that the information given by me in applying for payment under Title XIX (Medicaid) of the Social Security Act or other federally or state funded programs is true and correct. I request that payment of authorized benefits from Medicaid or other responsible payor be made in my behalf and I assign the benefits payable for services to Agency. Should payment not be made, I will be responsible for services provided to me.

ı I authorize direct payment of insurance benefits due to me by my insurance company to Agency. In the event that my insurance carrier does not accept assignment of benefits, I understand that payments may be sent directly to me and that I am obligated to endorse and directly send such payments to Agency for payment of my bill.

PATIENT LIABILITY FOR PAYMENT

I have been informed of the extent to which payment may be expected from Medicaid/insurance carries, other federally funded program or other form of health insurance including a health maintenance organization (HMO) and any charges for which I am responsible. I understand that the payment estimates are preliminary and I will be notified of changes when Agency personnel receive more information regarding my benefits. I acknowledge that I am responsible for informing Agency personnel of changes in my eligibility, and that I will be liable for all charges should I fail to inform Agency of changes.

ı Medicaid for home health as long as eligibility maintained: 100%

ı Insurance: _____ % of _____; Patient: _____% plus _____.

ı Private Pay - Patient: 100% liable. See usual and customary charges below.

ı Other:_____

ı Incomplete information has been obtained from your payor source. You will be notified of your liability for payment as soon as information becomes available.

The above statement is provided as an estimate only. Otherwise the usual and customary charges for the services are as follows:

ı Occupational Therapy Evaluation $150 per visit ı Occupational Therapy Treatment-45 minute session $100 per visit

ı Physical Therapy Treatment $150 per visit ı Physical Therapy Treatment-45 minutes session $100 per visit

ı Other: _____

Should full payment not be made by third party payors, I understand that I will be responsible for payment of services rendered to me. The usual and customary charges may be negotiable. If I am liable for any portion of the payment, I agree to pay the amount due within ten (10) days of receipt of invoice. I understand that services can be terminated if payment is not received as agreed. In the event it becomes necessary to collect this amount, I agree to pay all collection and related costs, including reasonable attorney fees.

REGULATORY REQUIREMENTS

Discussed with patient and/or significant other; understanding verbalized; copies left in patient's home folder if applicable:

ı Patient/Client Rights and Responsibilities ı Patient Confidentiality/Privacy Notice ıPatient Liability for Payment

ı Emergency Instructions Given ı Hotline #, Hours, Purpose ı Grievance ı Abuse, Neglect/Exploitation

ı Information on Advance Directive/DNR ı POC Expected Outcomes, Barriers to Treatment

ı Disaster Plan & Resources

I, (print name) _____, am the legally authorized person to sign for the patient,

(print patient name) _____. This patient is a minor child.

_____

Patient/Authorized Agent Signature Date

_____Agency

Representative Signature Date