Home Health & Hospice of Montana

ADMISSION CONSENT

PATIENT NAME: _____ **PATIENT ID:** _____

PATIENT RIGHTS AND RESPONSIBILITIES: I acknowledge verbal explanation and written receipt of my rights and responsibilities as a patient (including OASIS rights, agency administrator's name and contact information, agency discharge, transfer and referral policy and how to contact local resources) and I understand them. The state home health hotline number, its purpose, and its hours of operation have been provided and explained to me. I acknowledge that I have chosen Home Health and Hospice of Montana to provide home health care. No employee of this agency has coerced my decision in selecting a home health agency.

CONSENT FOR TREATMENT: I hereby give my permission for authorized personnel of HHOM to perform all necessary assessments, procedures and treatments as prescribed by my physician for the delivery of home health care. I understand that HHOM will supervise services provided. I may refuse treatment or terminate services at any time. 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 in advance each time there is a change made to my plan of care. The initial service(s) and visit frequencies are as follows:

Nursing: _____ **Home Health Aide:** _____ **Social Worker:** _____ **Occupational Therapy:** _____

Speech Therapy: _____ **Physical Therapy:** _____ **Other:** _____

CONTINGENCY PLAN: I understand and agree that HHOM will be held harmless by myself/heirs/assigns for any and all incidents that occur during instances or extended periods in which HHOM is unable to provide services (see page 24, Emergency Preparedness Plan).

RELEASE OF INFORMATION: I acknowledge receipt of the Notice of Privacy Practices (pages 19-20) and have been given opportunities to ask questions and voice concerns. I understand that HHOM may use or disclose protected health information (PHI) about me to carry out treatment, payment or health care operations; and that the agency may release information to or receive information from insurance companies, health plans, Medicare, Medicaid or any other person or entity that may be responsible for paying or processing for payment any portion of my bill for services; any person or entity affiliated with or representing for purposes of administration, billing and quality and risk management; any hospital, nursing home, or other health care facility to which I may be/have been admitted; any assisted living or personal care facility of which I am a resident; any physician providing my care; family members and other caregivers who are part of my plan of care; licensing and accrediting bodies; and other health care providers in order to initiate treatment.
I agree that the agency may share my PHI with emergency officials or others involved in my care to assist in disaster relief efforts. ☐ Yes ☐ No

AUTHORIZATION FOR PAYMENT: I certify that the information given by me in applying for payment under Title XVIII 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 HHOM.
If I have Medicare Part A benefits, I understand that Medicare payments will be accepted as payment in full and I have no financial liability, unless I have been a) notified in writing that service(s) will not be covered by Medicare and b) wish to receive the care or service. I understand that while I am under HHOM's plan of care, they will coordinate all my therapy needs and medical supplies. 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.
If I have other insurance, I may be responsible for the co-payment and any charges that my insurance will not cover. I understand that I am responsible for all amounts not paid by my insurance, or if I do not have the insurance coverage for the services provided.
Home Health services are voluntarily requested and authorized by the undersigned or the authorized patient representative and are to be provided by HHOM. A one-hour minimum charge applies for any service. Time after one hour will be billed in 15-minute increments. Frequency and duration of service are subject to the Patient's Plan of Care. The following holidays will be billed at time and one half rate: New Year's Day, Memorial Day, July 4th, Labor Day, Thanksgiving Day and Christmas Day. A mileage rate (current IRS rate) will be added for services provided outside the immediate area.

Payment Source: ☐ **Medicare** ☐ **Workers' Compensation** ☐ **Medicaid** ☐ **Private Pay** ☐ **Private Insurance** ☐ **Co-Pay**

HIRING PROHIBITION: HHOM or the patient has the right to terminate services any time in writing by regular U.S. Mail. For a period of 90 days after termination of HHOM services, the patient will not hire or otherwise employ any employee of HHOM who rendered services on his/her behalf. If he/she does so, he/she will pay HHOM the sum of $1,500 as liquidated damages per employee hired, payable upon written request by HHOM.

CONSENT TO PHOTOGRAPH: I hereby give my consent to HHOM to take pictures of myself and treatments being performed, and consent to the release of those photographs for use in advertisement or public education regarding home health services or to insurance providers to document my medical condition.

ADVANCE DIRECTIVES: I have been made aware of my right to make health care decisions for myself in accordance with state law and 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 Declaration (Living Will).** ☐ **No** ☐ **Yes** *(If yes, provide a copy to the agency.)*
2. **I have made a Montana Appointment of Agent.** ☐ **No** ☐ **Yes** *(If yes, write the name and phone number of the person named agent.)* _____
3. **I have a Provider Orders for Life-Sustaining Treatment (POLST) form.** ☐ **No** ☐ **Yes** *(If yes, provide a copy to the agency.)*

☐ Advance Directive ☐ Available Services ☐ Home Health Eligibility ☐ Emergency Planning/Evacuation ☐ Transfer/Discharge Policy

By signing this consent, I acknowledge receipt of the orientation manual and confirm my understanding and agreement with its contents. I understand a copy of this consent shall be as valid as the original and shall remain in effect until I am discharged from HHOM. I also understand that I may revoke this consent in writing at any time.

Patient Signature	Date/Time	Responsible Person, Legal Representative or Legal Guardian Signature
Agency Representative Signature/Title	Date/Time	Printed Name and Relationship of Person Above

☐ *Patient unable to sign due to:* _____