HMI Home Health Division
1025 Vermont Avenue, N.W., Suite 810
Washington, D.C. 20005
(202) 829-1111
(202) 829-9192 Fax

ADMISSION CONSENT

PATIENT NAME: _____ **DOB:** _____ **DATE:** _____

INSTRUCTIONS: This form is used to acknowledge receipt of our Orientation Booklet and confirm your understanding and agreement with its contents. Your signature below indicates 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 Health Hot Line number 1-800-492-6005 along with its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency. I have received information regarding the use and disclosure of my protected health information.

CONSENT FOR TREATMENT

I hereby give my permission for authorized personnel of your agency to perform all necessary procedures and treatments as prescribed by my physician. I understand the Agency will supervise any services provided to me and will communicate any changes, concerns or questions regarding my care with my physician. I understand that I may refuse treatment, all or part of the services prescribed without any negative repercussions or terminate services at anytime. The agency may also terminate their services to me as explained in my orientation. I agree and consent to the home care plan and payments outlined in this admission booklet. I understand that this is the initial plan of care. I will be notified by the agency in advance each time there is a change made to my plan of care. The initial service(s):

SN: _____ IVRN: _____ OT: _____ MSW: _____
MHRN: _____ PT: _____ ST: _____ HHA: _____

RELEASE OF INFORMATION

I acknowledge receipt of the Notice of Privacy Practices and was given an opportunity to ask question and voice concerns. I understand that the Agency may use or disclose protected health information about me to carry out treatment, payment or health care operations. I consent to the release of necessary medical information by any hospital, facility or home health agency in which I was a patient to HMI Home Health Agency and authorize HMI Home Health Agency to disclose all or part of my medical records to Hospital, Home Health Agency, Government Bodies, Medical Center, Accrediting Body, or Peer Review Organization as necessary to my care or to my insurance carrier(s) to process my claim. I understand that this consent may be revoked by me at any time. I understand my record will be treated confidentially.

AUTHORIZATION FOR PAYMENT

I certify that the information I have reported with regard to my insurance coverage is correct and that I am responsible for reporting any insurance changes immediately to the agency. I request that payment to authorized benefits from Medicare, Medicaid, or other responsible payor be made on my behalf to the above named agency. **The agency performs insurance checks and processes claims based upon our knowledge and understanding of how we expect your claim to be processed. This is provided as a service to you. I understand that I will ultimately be responsible for any remaining balance not covered by insurance. I understand that if I arrange for services/supplies on my own while under a home health Medicare Plan of Care, Medicare will not reimburse me or the supplier and I will be responsible for their costs.** I authorize the refund of overpayments of insurance benefits where my insurance coverage is subject to coordination of benefits bill.

HMI Home Health Agency will bill: _____ **HIC Claim No:** _____

□ Medicare on your behalf. I understand that Medicare (Part A or B) payment in full and I have no financial liability, unless I have been notified in writing that service(s) will not be covered by Medicare and wish to receive the care or service(s).

□ **Your Insurance Company**: We anticipate that your insurance will pay ____% of their usual and customary rates after you have met a yearly deductible of $ _____. Your insurance will pay 100% after you have met an out of pocket dollar amount of $ _____. The patient/guarantor will be responsible and billed for any difference between HMI Home Health Agency rates and the usual and customary rates as determined by his/her insurance carrier.

□ **You directly** for 100% of charges of services. All bills are due and payable upon receipt.

□ **Your insurance does not cover medical supplies**. You will be responsible for payment of all medical supplies we provide.

□ **At this time, the agency has been unable to verify benefits or obtain authorization for visits** from your insurance company. The undersigned agrees to pay any and all changes not covered by his/her insurance. *Financial information will be mailed directly to you. Once the benefits are verified, based on the pre-authorization received, we will bill your insurance company directly. If there is any co-payment involved, we will notify you.

Unless otherwise stated above, accounts 90 days delinquent shall bear interest at the rate of 18% annually, or a 1.5% on the balance and the end of each month. Should the account be referred to an attorney for collection, the undersigned agrees to pay reasonable collection cost, attorney's fee and court cost.

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 (Living Will/Durable Power of Attorney for Health Care) so that my wishes may be known when I am unable to speak for myself.

1. **I have made a living will □ Yes** (If yes, provide a copy to the agency) **□ No (information given regarding Advance Directives)**
2. **I have made a Durable Power of Attorney for Medical Care □ No □ Yes**
   (If yes, write the name & phone number of the person given power of attorney) _____
3. **I have a DNR (Do Not Resuscitate) Order □ No □ Yes** (information given on honoring advance directive and DNR status)

_____ _____
Date Patient's Signature Date Responsible Person or Legal Guardian Signature

_____ _____
Date Witness Signature/Agency Representative Printed Name & Relationship of Person Above