TOP AID
HEALTHCARE, INC
...We never stop caring!

ADVANCE DIRECTIVE ACKNOWLEDGEMENT
HIPAA/PRIVACY RIGHT ACKNOWLEDGEMENT

Client's Name:_____ Medicaid #:_____

I_____, acknowledge that the Agency has provided me with Information which that.
I may accept or reject any medical treatment, including any particular care specified:

- Living Will or Hospital Do Not Resuscitate (DNR)
- Statutory Power of Attorney for Health Care Decisions
- Advance Directives in Massachusetts
- HIPAA /Home Care Privacy Rights also understand that it is my responsibility to ask questions about the information provided by the Agency. The Agency offered to provide a copy of the state's illustrative forms under state law if I request. I have also been advised to consult with my physician, lawyer, timely, clergy, social worker or other qualified personnel for additional information on consulting with a lawyer should I need assistance in changing the forms to reflect my treatment wishes or in executing a living will, statutory Power of Attorney for health care decisions.

I understand that this Agency will honor the advance directives and is willing and able to provide any procedure specified on the advance directives.

I understand that the fact that I have or have not signed a Living Will or Statutory Power of Attorney for Home care decisions does not affect the medical treatment and services to be provided by the Agency. I understand that it is the Agency's written policy to fully comply through its healthcare providers with the terms of a patient's Living Wilf, Statutory Power of Attorney for healthcare decisions to the fullest extent permitted by state Statutory Power of Attorney and l-healthcare decisions to the fullest extent permitted by state law.

I have been given an explanation and acknowledge receipt of the **HIPAA PRIVACY RIGHTS**. I understand that I may contact the Agency at any time regarding questions or concerns.

PLEASE CHECK THE FOLLOWING
___I Have___I have not signed a Living Will
___I Have___I have not signed a Statutory Power of Attorney for Il
___If I have the above documents, I will provide the Agency with copies of its records.

HIPAA PRIVACY RIGHTS
Patients have the right to give adequate notice concerning the use/disclosure of their PI Il on the first date of service delivery or as soon as possible after an emergency.
The Privacy Rule grants patients new right over their PHI, including the following:

1. Receive a Privacy Notice at the tune of the first delivery of service.
2. Restrict use and disclosure, although the covered entity is not required to agree.
3. Have PI Il communicated to them by alternate means and at alternate locations to protect confidentiality?
4. Inspect, correct and amend PHI and obtain copies, with some exceptions.
5. Request a history of non-routine disclosures for six years prior to the request, and
6. Contact designated persons regarding any privacy concerns or breach of privacy within the Facility or at HHS

Signature:_____ **Date:**_____
Representative:_____ **Date:**_____

(Signed on behalf of client when authorized to the extent permitted by state law)
Witness:_____ **Date:**_____

Federal law requires that this agency provide the above information.