TOP AID
HEALTHCARE, INC

AUTHORIZATION, AGREEMENT AND ACKNOWLEDGEMENT

I ACKNOWLEDGE that the Agency has notified, informed, and explained to me the following:

- ★ About the services
- ★ Non-Discrimination Policy
- ★ Notice of Privacy/Privacy ACT Statement
- ★ Client Bill of Rights and Responsibilities
- ★ Client Grievance
- ★ Advance Directives
- ★ Emergency plan
- ★ Discharge Policy
- ★ Abuse,Neglect and Exploitation and the State toll-free numbers to call.
- ★ HIPAA/Privacy Rights and Disclosure of Clinical Records
- ★ I participated in the development of the Plan of Care.

_____**I AUTHORIZE**_____ **I DO NOT AUTHORIZE** the Agency to release any medical information requested by representatives of local, state or federal agencies, accrediting bodies, Insurance companies or other organizations or entities as may be required by said representatives for payment of claims out of services provided which are due.

_____**I UNDERSTAND** that the Agency does not routinely perform drug testing on its employees but may do so at our discretion using urine samples.

_____**I AUTHORIZE**_____**I DO NOT AUTHORIZE** the Agency to use my image in the form of photograph in my chart/clinical records.

_____**I CERTIFY** that no AFC duplicative services are being provided to me. (ie. Home health, GAFC,PCA)

_____**I AM AWARE** that a Registered Nurse and a Care Manager will be supervising my care and if I have complaints regarding services rendered, I am to contact the RN or Care Manager in charge of my care of the Agency's office.

_____I have been informed of my rights and that I may file complaints about the Agency with the Massachusetts Home Health Hotline at 1800-462-5540 Mon-Fri from 8 A.M until 5 P.M. After hours/holiday calls will be answered by machine and responded to the next business day.

Clients Name:_____ **Date:**_____**Clients Signature:**_____