ADMISSION SERVICE AGREEMENT
HOME HEALTH

Top Aid Healthcare, INC
51 Union St. Suite 204
Worcester, MA 01608
Phone: (508)-343-8555
Fax: (508)-519-0353

CONSENT FOR CARE/SERVICES

I hereby consent and authorize the organization, it's agents and associates to provide care and treatment to me in my home as prescribed by my physician and per program policy. I understand that I must always have an attending physician for the duration of this agreement, unless the organization determines otherwise. I have received an explanation of the services to be provided (including disciplines, proposed frequency of the visits and anticipated outcomes), my involvement with the plan of care, and how changes will be made if needed. I understand that I and/or my family/caregiver will be responsible for my care in the absence of the staff.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby consent to and authorize the organization to release information for the purposes of treatment, payment and health care operations. The exchange of information may occur between, but is not limited to, physicians, third party payers, other health care providers, and regulatory and/or accreditation reviewers.

☐ I have a legal representative _____; they receive a
(name/title if applicable)
written copy of the patient's Rights and Responsibilities, the Transfer and Discharge policy, the agency's Administrator's contact information for complaints, and OASIS privacy notice before home health services were provided.

☐ My selected representative is _____; they receive the
(name/title if applicable)
following written documents (by checking a box below you are indicating which documents you want them to receive)

☐ The patient's Rights and Responsibilities

☐ The agency's Transfer and Discharge policy

I understand they will receive a copy within 4 business days from the initial evaluation date.

LIABILITY FOR PAYMENT

I certify that all the information given by me to the organization is correct for requesting and applying for payment under Title XVIII (Medicare), Title XIX (Medicaid), of the Social Security Act and/or from any third-party payer. I understand and agree to pay deductibles, co-payments, spend downs and any amount due after payment of benefits on my behalf by all third-party payers.

I verify that ☐ I am ☐ I am not a participating member of an HMO (Health Maintenance Organization). If I enroll in one, I will immediately notify the organization.

I understand that services provided to me by this organization will be billed as follows:

☐ Medicare fee for service (Project 100% covered).

☐ Medicaid (Project 100% covered after meeting spend down and/or other requirements).

☐ Insurance (Coverage varies with individual policy). The patients' anticipated payment amounts per visit will be provided in writing when the insurance company informs the organization of the patient's financial liability. See organization's separate Visit Rate information. *When known at time of Admission:* Project _____% of charges to be covered after deductible met. (Specify amounts_____).

☐ Private Pay (See separate Private Pay Rate Sheet. Patient is responsible for the timely payment of all charges).

ASSIGNMENTS OF BENEFITS

I request that payment of authorized benefits be made on my behalf directly to the organization.

CONSOLIDATED BILLING - SUPPLIES (MEDICARE HOME HEALTH PATIENTS ONLY)

I understand that I will be informed which supplies are covered by Medicare while I am under a physician's home health plan of care. I understand that when the organization provides these types of supplies, I have no financial liability, but if I choose to obtain them or not to use the organization's vendor and/or brands, I will be responsible for the payment of that bill. I also understand when I am no longer an active patient under a Medicare home health plan of care that I am responsible for obtaining supplies and arranging for payment under Medicare Part B, if allowable.

ACKNOWLEDGMENT OF INFORMATION

I have received verbal and written information on the following:

- *Advanced directives.* In addition, I understand that the organization's policy is to respect individual choice and to avoid discrimination based on whether I have an Advance Directive or a Do Not Resuscitate (DNR) directive.
- *Patients' Rights and Responsibilities:* This also includes information about how to use the organization's complaint process and the state's toll-free hotline.
- *Statement of Patient Privacy Rights and Privacy Act Statement-Health Care Records:* (Medicare and Medicaid patients), and/or *Notice About Privacy* (Patients who do not have Medicare and Medicaid).
- *Basic Home safety*
- *Emergency Planning Related to a Disruption in Services.*
- *Infection Control.*
- *Agency's Transfer. Discharge Policy*

This Admission agreement is applicable to this admission to the organization. I understand what I have read and what was explained to me and agree to the terms and conditions as above. Additionally, I understand that either party may terminate this agreement for any reason and/or at any time.

_____
Signature

_____ _____ _____ _____
Admitting Clinician Date Patient or Authorized Representatives Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient's Signature _____ Date _____

Patient unable to sign because: _____

_____

Legal Representative Signature (if applicable) _____ Date _____

Admitting Clinical Signature _____ Date _____