HOMECARE CONSENT TO TREAT and
Acknowledgement of Review and Receipt

Patient Name:_____________________________

Date of Birth:_____________________________

To Hospice & HomeCare of Reno County, I hereby give my **permission** for authorized personnel to perform all necessary procedures and treatments as prescribed by my physician for the delivery of home health care.

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Patient Signature and/or Authorized Legal Representative/Surrogate Decision Maker

☐ I acknowledge that I have received notification of the disciplines involved in providing care, treatment and services and how often I will be visited. I have been involved in the development of and have reviewed the **HomeCare Treatment Plan**.

☐ I acknowledge that a comprehensive review of my **medications** has occurred and I have been provided a written medication scheduled with instructions on administration.

☐ I further acknowledge that I have been made aware of my rights and responsibilities as a patient receiving care and understand these rights and responsibilities. I have been given a copy of the **Patient Rights and Responsibilities**, as well as **Advance Directive** information per Kansas Statutes and Federal requirements.

☐ I request _____ I decline _____to have a copy of my patient rights and responsibilities and agency discharge policy sent to my legal representative and/or surrogate decision maker______________________________.

☐ I acknowledge that the agency provided and reviewed with me my right and the procedure to voice **complaints and/or grievances**

☐ I acknowledge that the agency provided and reviewed with me procedures to follow if care, treatment or services are disrupted by a **natural disaster or emergency.**

☐ I acknowledge that the agency **discharge and transfer policies** have been reviewed with me.

☐ I acknowledge that I have been made aware of my Rights of Privacy in the use of OASIS data collection. I understand these rights. I have been given a copy of the **OASIS Notice of Patient Privacy Rights**.

☐ As required by the HIPAA Privacy Regulations I have received a copy of the **Notice of Privacy Practices.**

☐ I hereby give my permission for authorized personnel of the agency to use **photography** as deemed reasonable and necessary for the delivery and documentation of home health care. I understand the photos will become a part of the medical record.

☐ I further authorize the agency to release to or receive from hospitals, physicians, or other agencies involved in my care all **medical records** and information pertinent to my care.

☐ I certify the **information** given by me for payment under TITLE XVIII, TITLE XIX of the Social Security Act, other insurance policy or responsible payer is correct.

☐ I authorize **release of all records required for payment for services** rendered. I request that payment of authorized benefits from Medicare, Medicaid, or other responsible payer be made on my behalf to the named Certified Home Health Agency. I agree to pay for any services not covered by insurance.

_______ I acknowledge review of all of the statements listed above.

DATE_________________________ WITNESS____

(Form expires two years from date of signature)