HOME HEALTH CARE SOLUTIONS, LLC.

CONSENT FOR TREATMENT & AUTHORIZATION OF BENEFITS

PATIENT NAME ____ MR# _______________ SOC ________________

MEDICARE HEALTH INSURANCE		PRIVATE HEALTH INSURANCE	
NAME OF BENEFICIARY:		❒ BC / BS ❒ Other Insurance ____________________	
CLAIM NUMBER:	SEX:	SUBSCRIBER NAME:	
IS ENTITLED TO:	EFFECTIVE DATE:	CONTRACT NO:	
❒ Hospital (Part A)	A: ____________	GROUP NUMBER:	SERVICE CODE:
❒ Medical (Part B)	B: ____________		

MEDICAID RECIPIENT ID	RECIPIENT NAME	DOB	Medical Assistance Authorization / / Thru / /

I realize that these services are intermittent in nature and that they will be performed in accordance with my physician's written orders. I authorize **HOME HEALTH CARE SOLUTIONS, LLC.** to provide home health services. I request that payment of authorized benefits from Medicare, Medicaid or other insurers be made in my behalf to HOME HEALTH CARE SOLUTIONS, LLC (HHCS) and authorize release of all records to act upon this request. I certify that the above information given by me in applying for payment is correct. If I have other insurance, I am responsible for all deductibles, co-payments and any other charges my insurance does not cover. I authorize my insurance company to pay HHCS directly for services rendered. If payment of authorized benefits is made directly to me by my Insurer, I agree to endorse and forward check to HHCS for all services rendered by HHCS. Rates per visit: RN: $190, PT: $190, OT: $190, SLP: $190, MSW: $190, HHA: $140. I understand that each Clinician will determine the frequency of my treatment after the evaluation and will inform me of the frequency and duration of the services. I have been notified of the charges and that I will receive the following services;

RN___________ PT______________ OT_____________ SLP______________ HHA_____________ MSW__________

_______ As a beneficiary, we expect that Medicare, Medicaid, or your health insurance will cover the charges for our service at 100%.	________ CO-PAY Information: Your insurance requires a subscriber to pay a portion of our services. A prior authorization from you was received to bill the co-pay directly to you.

I permit HHCS to release information acquired in the course of my care to all healthcare professionals involved in my care, my insurance carrier(s), any state or federal regulatory bodies or their designees and any accrediting bodies. I also permit HHCS to release or share my health information with my following representative:

Patient Representative_______________________________________**Phone:**___________________

After services are completed, I give permission to HHCS to contact me monthly by phone for a period of 12 months to follow up on my condition.

I have a Medical Durable Power of Attorney and I have the right to inform the agency when changes are made.

Patient Advocate____ **Phone**___________________

I acknowledge receiving the Patient and Family Guide to Services which includes the agency's

-Notice of Privacy Practices including my privacy rights for the collection of OASIS

-Notice of Face-to-Face Encounter requirement and Transfer & Discharge Policy

-Written Patient's Bill of Rights and Responsibilities

This information has been explained to my satisfaction in my primary or preferred language by a representative of HHCS.

Signature of Patient ____ Date _____________

OR

Authorized Representative____ Date _____________

❒ Legal Guardian ❒ Spouse

Agency Representative ____ Date _____________