



**THE CARE
GROUP**

Consent for Additional Services

PATIENT NAME: _____

DATE: _____

PATIENT RIGHTS AND RESPONSIBILITIES

I acknowledge that I have been given a copy of my rights and responsibilities (including OASIS rights), Human Resource Code, Chapter 102 relating to the Rights of the Elderly for those 60 years of age and older, if applicable and I understand them. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency. The State home health hot line number has been provided and explained to me. I have received notification that the agency may not retaliate against a person for filing a complaint, presenting a grievance, or providing in good faith information relating to home health services provided by the agency. I have received a copy of the agency policy on Abuse, Neglect & Exploitation and the agency policy on drug testing of employees. I have educated verbally and in writing regarding the proper procedure for disposing of sharps in the home.

AUTHORIZATION FOR TREATMENT

I hereby give my permission for authorized personnel of your agency to perform all necessary procedures and treatments as prescribed by my physician for the delivery of home health care. I understand that I may refuse treatment/plan of care or terminate services at any time and the agency may terminate their services to me as explained in my orientation hand book . I agree and consent to the home care plan and payment for the additional services as listed below:

Service	Frequency	Cost	Ins. Pays	You Pay	Service	Frequency	Cost	Ins. Pays	You Pay
Skilled Nursing		\$			Occupational Therapy		\$		
Medical Social Work		\$			Speech Therapy		\$		
Physical Therapy		\$							

I understand that I will be notified by the agency each time there are changes made in my plan of treatment. I also understand that it is my responsibility to notify the agency of **any** insurance changes I may have.

Patient's Signature

Responsible Person or Legal Guardian Signature

Witness Signature/Agency Representative

Printed Name & Relationship of Person above

Patient unable to sign due to: _____



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