Kaerbear's Healthcare LLC **Agreement to Establish Home Care Services**

Patient Name: _____ **Medical Identification #:** _____

Date _____

Consent for Medical Treatment I consent to examination and treatments by KAERBEAR'S HEALTHCARE, LLC including, but not limited to, any laboratory tests, blood samples, and intravenous medications ordered or prescribed by my physician. I have been informed of the nature, risks, possible alternative methods of treatment and possible complications involved in my treatment. I have also been informed of the expected benefits, risks involved, possible consequences, and the possibility of complications associated with my treatment. No warranty or guarantee has been made to me as to the results. I have had the opportunity to ask any questions I have regarding the treatments and home care services I intent to receive. All my questions have been answered in a satisfactory manner. I understand that the explanations that I have received are not exhaustive and that other more remote risks and consequences may arise. I also consent to accept the supervision of my care as dictated by federal and state law.

Acknowledgement of Policy Regarding Hiring of KAERBEAR'S HEALTHCARE, LLC Personnel

In the event a Client hires, directly or indirectly, an employee of KAERBEAR'S HEALTHCARE, LLC within ninety days (90) of the last date that said employee provided services to the Client, Client agrees to pay KAERBEAR'S HEALTHCARE, LLC liquidated damages equal to forty (40) hours of service by employee weekly (even though employee may not have worked forty (40) hours per week during the 90 days period) times thirteen (13) weeks. Such liquidated damages will apply to each employee so hired by the Client.

Medicare/Medicaid Information I certify that any information given to me in applying for payment under Title XVIII and/or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Health Care Finance Administration or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I request that payment of authorized benefits be made to KAERBEAR'S HEALTHCARE, LLC on my behalf. I understand that to receive Medicare covered home care services; I must meet the criteria as outlined under Medicare Coverage Information contained in the KAERBEAR'S HEALTHCARE, LLC Patient Handbook.

Permission to Photograph or Video Tape I hereby authorize KAERBEAR'S HEALTHCARE, LLC by this written release, to video tape or photograph me during the course of my treatment.

Release of Information I hereby authorize KAERBEAR'S HEALTHCARE, LLC by this written release, to view, furnish, obtain and receive information from the patient's medical record, including photographs or video taken of the patient, to any insurer, compensation carrier, health care facility, welfare agency, physician, or any health care provider for reasons of financial assistance or continuity of medical care. Regulatory and accrediting agencies also have my permission to review my medical records. Personal Health Information will be kept confidential and will not be disclosed except for legitimate purposes stated in the Federal privacy Act. Assessment information will be collected for quality and payment purposes.

Financial Agreement I certify that any information I provide in applying for services under the Title XVIII of the Social Security Act is true and correct. I authorize release of records required to act on request for payment. I request that payment for authorized benefits from Medicare, Medicaid, or other responsible payor be made on my behalf to KAERBEAR'S HEALTHCARE, LLC

For non insurance covered services, or insurance coverage with a designated co payment, I agree to promptly pay KAERBEAR'S HEALTHCARE, LLC as bills are presented to me, at KAERBEAR'S HEALTHCARE, LLC's prevailing rates. I understand that KAERBEAR'S HEALTHCARE, LLC. is required to adhere to all applicable wage and hour laws related to overtime and I agree to be billed accordingly. KAERBEAR'S HEALTHCARE, LLC is hereby authorized to a) investigate my credit history and employment status; b) obtain credit information from credit reporting agencies; c) make inquiries as to insurance coverage; and d) make such other inquiries as are reasonable and appropriate under the circumstances. I understand that all past balances shall bear interest at the rate of 1 1/2% per month, or such other maximum rate allowed. Should I fail to make payment in accordance with KAERBEAR'S HEALTHCARE, LLC terms and it becomes necessary to collect any outstanding balances through the judicial process or otherwise, I agree to pay costs of collection, including reasonable attorney fees. This agreement is binding upon my heirs, executors, administrators and equal representatives. My liability, if any, for payment is:

Services to be provided and client Liability for payment Check applicable services and have pt initial next to payer information

____ Medicare A ____ Medicare B ____Medicaid ____Private Insurance ____Self Pay ____ Medicaid waiver ____other (explain)

Type of service and rate that I am responsible for are: HHA____ Rate per visit/hr $____ Nurse RN/LPN_____ Rate per visit/hr $_____ Physical Therapy____ Rate per visit $_____ Occupational Therapy____Rate per visit $_____ Speech Therapy_____Rate per visit $_____ Social Services_____ Rate per visit $_____

CoPay_____ **Deductible**_____ **Health Insurance Claim Number**_____ **Other**_____

Frequency and Duration for each Discipline (write abbreviated discipline/ number of visits per week x number of weeks) (ex: RN 3x4)

1. 2. 3. 4. 5.

6.

Assignment of Benefits I authorize payment directly to KAERBEAR'S HEALTHCARE, LLC of any and all benefits due me from insurance polices covering KAERBEAR'S HEALTHCARE, LLC otherwise payable to me.

Financial Responsibility I understand that I am fully financially responsible to KAERBEAR'S HEALTHCARE, LLC for charges not paid by any third party payor. Payment will be made by check or money order.

Consultation I hereby give the agency personnel permission to discuss my care and medical history with: _____

Acknowledgment of Receipt of Instruction and Materials

I acknowledge that I have been given a copy of KAERBEAR'S HEALTHCARE, LLC's Patient Handbook. The following materials have been explained verbally and provided to me in written form.

__Patient Rights and Responsibilities __ Advance Directive Information __Notice of Privacy Practices __ OASIS Privacy Statement __ Agency Emergency Plan (verbal)

__ Agency Safety Book __ Abuse Reporting 800 number __ Complaints Process __ I received a copy of this agreement

Advanced Directives I understand that the Federal Self Determination Act of 1990 requires that I be made aware of my right to make healthcare decisions for myself. I understand that I may want to express my wishes in a document called an Advance Directive (Living Will/ Healthcare Surrogate Designation) so that my wishes may be known when I am unable to speak for myself.

I have a Living Will _____**Yes** _____**No** **I have a health care Surrogate Designation** _____**Yes** _____**No**

If yes to either question, you must provide a copy to agency for Kaerbear's Healthcare to honor your request.

_____ Relationship and Reason Patient is unable to sign_____

Patient or Legally Authorized Patient Representative Date

_____ _____

Witness (Employee) Date Print Employees name Date

A copy of this document is to be given to the patient and the original is to be retained in the patient's clinical record.

Agency Copy