SHEPHERD HOME HEALTH CARE, INC. **PATIENT CONSENT**

- **Authorization to Release Information**

  I consent to the release of any information regarding my medical condition by any recognized health agency, institution or medical group/office in which I have been a patient, and I authorize the release and/or disclosure or any medical records or intonation by the preceding to **SHHC** and those involved in my care while admitted to **SHHC**. I understand my medical records may be revealed to federal and state accrediting bodies and by the Quality Management/Utilization Review Committees of **SHHC**.

  Information may **not** be released about____

  Information may **not** be released to____

- **Payment Request/Assignment of Benefits**

  I certify that all Medicare, HMO, Medi-Cal, or any other health care payment information given to **SHHC** is true and accurate and I authorize **SHHC** to request payment on my behalf. I authorize the release of any and all records that may be required to secure payment. I understand I must notify **SHHC** immediately of any changes in my medical coverage including Medicare and Medi-Cal. I also understand that if I change insurance coverage while under the care of **SHHC**, I will be responsible for any charges not covered as a result of the change in coverage.

- **Medicare Patients**

  I understand **SHHC** accepts all Medicare Part A and Part B as payment in full for all skilled nursing rehabilitation services and that 1 will be notified, in advance, if there are any charges for medical equipment and supplies.

- **Private Insurance, HMO, Self Pay, Share of Cost, Out Patient Part B**

  I am aware that 1 am responsible to for any non-covered costs, share of cost, or co-pay in consideration for the services I am to receive. All reasonable attempts will be made by SHHC to collect these payments. DME: 300% mark-up. Anticipated charges are:

  $150.00 Per visit/hour for RN/LVN. Therapy services (PT, OT, ST) $ 160.00. MSW $175.00 Per visit/hour. CHHA $120.00 Per visit/hour.

- **Proposed Services and Frequency of Visits**

  I have been actively involved in the planning of my care with **SHHC** and I understand that the following services and visits will be provided if approved by my doctor:

  Nursing _________________PT_________________ OT________________ MSW __________________CHHA______________________

- **Advance Directives**

  I have________ Have not _________completed an Advance Directive. I have a Durable Power of Attorney for Health Care____________

  A Living Will__________ A Do Not Resuscitate Directive_______________ Other (explain) ______________________________________.

  I do not know if I have any of the above ___________. I understand that I must provide a copy of any of these documents in order that my wishes may be followed regarding my health care. The name of my DPOA is: ____

- **OASIS Privacy Act Statement-Health Care Records confidentiality and retrieval**

  I have been instructed and given a written notice of the Privacy Act Statement on OASIS to advise me of my rights, principle purposes, routine uses and effect on me if I do not provide accurate information to complete OASIS. I have been given information on the confidentiality and the disclosure of my clinical records maintained by **SHHC**. I have been given information on how to retrieve and obtain a copy of my medical record maintained by **SHHC**.

- **Information on:** <u>My Care plan/Proposed visits/Services/DHS Hotline/Rights &Responsibilities/Safety Information/Emergency preparedness/Infection Control & Universal Precaution/911 Protocol/Pertinent Agency Policies and Procedures, and s/s to Report to MD</u> is given to me and/or my caregiver on the initial evaluation and on an ongoing basis as needed .1 have been instructed & I verbalized understanding of these information.

- **Consent To Photograph**

  <u>I consent / I do not consent</u> (circle one) to the appropriate part(s) of my body being photographed by the Agency personnel in order to provide supporting documentation of my medical condition. (I understand that any photographs taken will be placed in and remain part of my medical record)

- **health Insurance Portability and Accountability Act (HIPAA)**

  <u>Permission to Use and Disclose Your Health Information.</u> By signing this consent, you authorize us to use and/or disclose your health information for treatment, payment or health care operations. You have the right not to sign this consent. However, if you refuse to sign this consent, we have the right to refuse to treat you.

- **Your Rights With Respect to This Consent:**

  <u>Right to Review Notice of Privacy Practices.</u> You have the right to review a copy of our Notice of Privacy Practices before signing this consent. Our Notice of Privacy Practices details how we may use and disclose your health information. We may amend the Notice from time to time. A copy of our Notice of Privacy Practices is included in your Home Chart.

  <u>Right to Request Restrictions on Use/Disclosure.</u> You have the right to request that we restrict how we use and/or disclose your protected health information for the purpose of providing treatment, obtaining payment for our services, and/or conducting health care operations. Such requests must be made in writing. Please note that we are not *required* to agree to any restriction you may request. If, however, we decide to agree to a restriction you have requested, we must restrict our use and/or disclosure of your health information in the manner described in your request. To obtain a restriction request form, please contact ***Odette Nayrouz, Administrator, HIPAA Officer.***

  <u>Right to Revoke Consent.</u> You have the right to revoke this consent at any time. Your revocation of this consent must be in writing, If you wish to revoke this consent, please contact ***Odette Nayrouz, Administrator, HIPAA Officer*** to obtain a revocation form. Note that your revocation of this consent will not be effective for disclosures we have already made in reliance on your prior consent. We also have the right to refuse to provide further treatment if you revoke this consent.

  <u>Effective Period.</u> This consent is effective unless and until you revoke it in writing.

  I hereby authorize ***SHHC*** to use and/or disclose my health information for treatment, payment, or health care operations.

  Computerized Note: I have been informed that **SHHC** Have some or all of my Medical Information recorded digitally on computers. I understand that all Medical Records will be kept confidential.

<u>I have been give written and verbal information, and the Agency's Policies and Procedures regarding all items in this consent and I verbalize understanding of them.</u>

<u>Patient /Legal Representative Consent /Acknowledgement</u>

My/our signature below serves to attest and certify to the following: that — a) this documents consists of two pages: b) I/we have received written copies of all the Information and material relevant to all the matters contained in page 1 and page 2 hereof; c) that all such information and material covered page 1 and page 2 hereof have been fully explained to me/us to my/our satisfaction; and, d) I/we verbalized and demonstrated understanding of all such information and material covered by page 1 and page 2 hereof.

Signature of Patient or Legal Representative: ____Date:__________________________

SHHC Representative/staff: ____Date:__________________________

<u>Grant of Authority to Legal Representative</u>

I certify that I have authorized the person(s) named below to sign for me for all services rendered by **SHHC** and other patient health record requiring my signature:

____

Additional Approved Signature **Relationship**

____

Additional Approved Signature **Relationship**

Patient Name ____ **MR#**_________________________

SHEPHERD HOME HEALTH CARE, INC. PATIENT CONSENT

PATIENTS RIGHTS

SHEPHERD HOME HEALTH CARE, INC. will be referred to as **SHHC**.
As a patient you have the Right to be informed of your rights. **SHHC** must protect and promote the exercise of these rights.

- **SHHC** must provide you with written notice of these **Rights** including the **OASIS Statement of Patient Privacy Rights** and **The Privacy Act Statement** and **Notice of Privacy Practices** in advance of furnishing care or during the initial evaluation procedure.
- You have the Right to be treated with consideration, respect and full recognition of dignity and individuality, be given appropriate and professional home health services without discrimination against your race, religion, gender, age, creed, marital or political status, sexual orientation, diagnosis or source of your payment, be assured the personnel who provide care arc qualified through education and experience to carry out the services which they are responsible.
- You have the Right to receive services appropriate to your needs, and to be informed of the nature and purpose of all skilled and non-skilled services, technical procedures that will be performed, including information about the potential benefits and burdens as well as when and who will perform the procedures, and expect the Home Care Organization to provide safe, professional care at the level of intensity needed. You have the Right to receive reasonable continuity of care.
- You have the Right to have staff communicate in a language or form you can reasonably be expected to understand, and which possible, the organization assists with or may provide special devices, interpreters or other aids to facilitate communication.
- You have a Right to exercise your Rights as a patient of **SHHC**.
- Your family or guardian may exercise your Rights in the event you are unable.
- You have the Right to have your property treated with respect and your health information to be kept confidential.
- You have the Right to voice grievances regarding treatment or care that is (or fails to be) furnished or regarding the lack of respect for your property by anyone on behalf of **SHHC**. You will not be subjected to discrimination or reprisal for doing so. You have the right to DHS hotline number as provided below. You may call them 24 hours a day without reprisal from the Agency.
- **SHHC** must investigate any complaints made by you, your family, or your guardian regarding the grievances mentioned above or any grievances and
- **SHHC** must document the existence and the outcome of the complaint. You have the right to be free of abuse and neglect.
- You have a right to be informed, in advance, of the care to be furnished.
- **SHHC** must advise you, in advance, of the disciplines that will furnish the care and of the frequency of the proposed visits
- **SHHC** must advise you, in advance, of any change in the plan of care before the change is made.
- You have a Right to participate in the planning of your care.
- You have the Right to refuse treatment and be advised of the consequence of your action. You have the right to refuse any experimental treatment and/or participate in research unless you give documented voluntary consent.
- **SHHC** must inform you and provide you with written information in advance, about the policy on Advance Directives and include a description of the California State law. **SHHC** will provide the information during the evaluation visit.
- You have the Right to have your medical records, that are maintained by **SHHC**, remain confidential. You have the right to refuse or approve in writing the release of your medical record to any individual outside the agency.
- **SHHC** must advise you of their policy and procedure regarding disclosure of medical records. You or your Legal Representative have the right to obtain a copy of your medical record by giving **SHHC** 3 days advance notice.
- You have the Right to be advised, before care is initiated, of the extent to which payment for **SHHC** services may be expected from Medicare or other sources, and the extent to which payment may be required from you.
  Before initiating care, **SHHC** must inform you verbally or in writing of:
  - The charges for the services and Medical equipments (DME) that will not be covered by Medicare.
  - The charges for the services and the Medical equipments (DME) that you may have to pay.
- You have the Right to be advised verbally and in writing of any changes in the information regarding payment within 30 days from the date **SHHC** becomes aware of such changes.
- **SHHC** Corporate Office is open Monday through Friday 09:00 AM to 05:30 PM (except on major Holidays)

Administrator: Odette Nayrouz
5455 Wilshire Blvd. Suite 705
Los Angeles, CA 90036
Phone (323) 932-8851-Fax (323) 932-8983
You may Contact the nurse on call 24 hours a day at Phone: (323) 932-8851

PATIENT'S RESPONSIBILITIES

As a patient you have the Responsibility to:

- Remain under a doctor's care while receiving services from **SHHC**.
- Provide the agency with complete and accurate health and OASIS information.
- Sign the required consents prior to care being given or received.
- Provide a safe environment for **SHHC** staff members
- Treat **SHHC** personnel with respect and consideration.
- Notify' S **SHHC** HHC when you cannot keep appointments.
- Comply with plan of treatment while under care of **SHHC** and understand that non-compliance may result in discharge from **SHHC**.
- Participate in the planning of your care.
- Provide **SHHC** with a copy of advance directives if applicable.
- Provide the evaluating staff with Outcome and Assessment Information Set (OASIS) as mandated by Medicare and consent that the agency transmits OASIS data to CMS. (A copy of **OASIS Statement of Patient Privacy Rights** and **The Privacy Act Statement** is given to me prior to my admission.
- Medicare patients must have a face to face encounter with physician 90 days prior to their Start of Care up to 30 days after the Start of Care in order to be eligible for Medicare Home Health benefits.

PATIENT CONSENT/CERTIFICATION

- **Request For Initial Assessment/Admission/Consent for Treatment**
  I hereby request and agree to initial assessment and if I am eligible for admission to **SHHC**. I consent for approved personnel from the Home Health Agency to perform all necessary procedures and treatments ordered by my physician for my home health care. I realize my care is directed and monitored by my doctor who is neither an employee nor an agent of **SHHC** and that **SHHC** is not liable for any act or omission when following the instructions of the doctor.
- **Client's Rights and Responsibilities**
  I understand my Rights and Responsibilities. I have received a written notice of my Rights and Responsibilities and the **OASIS Statement of Patient Privacy Rights** and **The Privacy Act Statement** and **Notice of Privacy Practices** before care was furnished by the staff of **SHHC**.
- **Advance Directives/Resuscitation**
  I am aware that if I do not have, or fail to produce or provide a properly executed copy of an advance directive, SHHC will be obligated to perform cardiac resuscitation and call paramedics if my condition indicates a need for such intervention.
- **Registering of Complaints**
- **Problem/Complaints-Hot line**

I have been given information and instruction on **SHHC** complaint procedure and resolution. As a patient I understand I have the right to make a complaint to the State Department of Public Health, Licensing and Certification Division without being subject to discrimination or reprisal.
The **Hot line number is: 1-(800) 228-1019,** 24 hours/7day or by Fax: (213) 351-0768 or in writing to:
County of Los Angeles —Department of Public Health, Health Facilities Inspection Division Operations 600 Commonwealth Avenue, Room 903, Los Angeles, CA 90005
To **file a complaint with The Joint Commission or** For concerns regarding patient care and safety in our organization, that the organization has not addressed please call the administrator at **(909) 464-2273** the concern cannot be resolved through the organization, you may contact The Joint Commission directly by writing to: Office of Quality Monitoring, The Joint Commission : One Renaissance Boulevard , Oakbrook Terrace, IL 60181 or call: **(800) 994-6610** or
email at complaint@jointcommission.org.