



Carelink Health Care Services, LLC New Admission Packet

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Patient Name: Constance Dowling

MR# 5132005599-1

CONSENT & VERIFICATION OF RECEIPT OF INFORMATION

I hereby consent to admission and to care. I acknowledge and consent to the following:

I understand my care is based on a treatment plan and/or ordered by my physician per agency policy. I have participated in the development of, and am in agreement with, the treatment plan outlined. My treatment plan as well as my initial days and hours of service may change as my care needs change. I will be informed if my care plan or services days/hours change.

I understand that this is the initial plan and I will be notified by the agency each time there are changes made in my plan of care.

I understand that the agency will provide supervision for all services rendered to me.

I understand that I have the right to refuse care or treatment at any time.

I have read, understand and received a copy of:

- Welcome Letter / Hours of Operation
- Client Rights, Responsibilities and Grievance Procedure
- HIPAA Notification of Privacy Rights
- Abuse, Neglect, Exploitation Policy and Drug Testing Policy
- Advance Directive Information
- Infection Control Guidelines and Sharps Disposal
- Emergency Procedures / Disaster Plan / Emergency Numbers
- Reimbursement for Services Rendered
- Fee Schedule per discipline
- Consent & Verification of Receipt of Information

Disciplines Proposed to Provide Care and Frequency (Circle those that apply and enter the frequency)

HHa _____, SN _____, PT _____, OT _____, ST _____, SW _____, RD _____

Total Estimated Cost of Care: _____

HIPAA: We honor all rights of patient privacy and HIPAA Guidelines. I hereby authorize Carelink Health Care Services, LLC to provide my health care information to the following person(s):

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Release of Information: I hereby authorize your agency to release to or receive from hospitals, physicians, third party payers, Joint Commission, and/or other agencies involved in my care all medical records and information pertinent to my care. I hereby give permission for the review of my medical record by the agency's accrediting and/or other regulatory bodies.

Authorization for Payment: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits from Insurance, Workers Compensation, Medicaid, or other responsible payer sources be made in my behalf to the above named HCSF. I understand that I am responsible for all amounts not paid by my insurance. If I am a private pay patient, I agree to pay for all services rendered by the agency.

Advanced Directives: I understand that the Advance Directive Act of 1999 requires that I be made aware of my right to make healthcare decisions for myself. I understand that I may express wishes in a document called an Advanced Directive so that my wishes may be known when I am unable to speak for myself.

I have made a Directive to Physician (Living Will):	Yes	No
I have made a Medical Power of Attorney:	Yes	No
To: _____	Phone: _____	
I have made an Out of Hospital DNR:	Yes	No
I have made a Declaration of Mental Health:	Yes	No
Location of the above COPIES if Yes _____		

Patient Signature: _____ Printed: _____

Legal Guardian: _____ Printed: _____

Relationship to Patient: _____

Agency Staff: _____ Printed: _____

Date: _____