Admission Agreement

A-Plus Home Care
1443 North 1200 West
Orem UT 84057
(801) 225-0990
fax (801) 225-4067

Patient Name ____ Date______________

CONSENT AGREEMENT

I certify that I have read the Client Consent Agreement (or have had it read to me), received a copy of the Rights & Responsibilities and understand them as they have been explained to me, and agree with the conditions, and am the client (or legal representative authorized to execute this agreement and accept its terms). I understand that this Agreement can be revoked at anytime. I certify that I have given reliable information regarding medical benefits.

ADVANCE DIRECTIVES

I HAVE EXECUTED AN ADVANCE DIRECTIVE. YES NO

IF YOU HAVE EXECUTED AN ADVANCE DIRECTIVE, IS IT AVAILABLE? YES NO

I have received written information regarding the right to accept or refuse medical treatment and the right to formulate advance directives.

PRIVACY NOTICE

I have received information regarding the Medicare Privacy Statement and understand that my health information may be released to them for data collection and to ensure that proper reimbursement is made. I have also received a copy of the A-Plus Home Care Privacy Notice and have read it (or had it explained to me), and I understand my privacy rights as they have been explained to me.

MEDICAL DOCUMENTS IN THE HOME

I understand that some medical documentation will be left in my home for purposes of treatment and will secure these documents in such a way that I can maintain the level of privacy that I require.

AUTHORIZATION TO RELEASE INFORMATION

I authorize release of health information to A-Plus Home Care for treatment purposes.

REQUEST TO RESTRICT THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I request that you not disclose my health information, my location, or my death to the family members, friends, or relatives I have named below:

______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________

By signing this form, I am confirming that it accurately reflects my wishes.

____ _____/_____/_____
Signature Date

If signed by personal representative:
Name of Personal Representative: ___________________________________

Relationship to Patient: ____

____ _____/_____/_____
Signature of Personal Representative Date

____ _____/_____/_____
Signature of Witness Date