Professional Nursing Service
2497 State Road
Cuyahoga Falls, OH 44223
330-929-5512

Patient Name_____ **Date** _____

This form is used to acknowledge receipt of our Patient Information Guide and to confirm your understanding and agreement with its contents. Your signature at the bottom of this form indicates your acknowledgement.

CONSENT TO TREATMENT

I wish to be admitted to PNS. By signing below, I agree to permit my doctor, PNS, its employees and all authorized personnel caring for me to treat me in ways that I agree to. I understand that this care may include tests, examinations, home infusion medication, medical treatment, the use of health care supplies, equipment, products and other necessary services ordered by treating physicians. No guarantees have been made to me about the outcome of this care.

PATIENT RESPONSIBILITIES

My rights and responsibilities listed in the "Patient Information Guide" have been reviewed with me and I understand this information. ☐ Yes ☐ No
I have received of a copy of the pamphlet "Notice of Privacy Practice". ☐ Yes ☐ No

If no, please comment why_____
I agree to be involved in my care to the fullest extent possible and comply with the established treatment plan.

ADVANCE DIRECTIVES

I understand that the Patient 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 express my wishes in a document called an Advance Directive (Living Will/Durable Power of Attorney for Health Care) so that my wishes may be known when I am unable to speak for myself.

A. I have an advance directive. ☐ Yes ☐ No If yes, will you please provide a copy to the agency? ☐ Yes ☐ No

COPIES GIVEN TO: _____

B. Advance Directive Information has been provided to patient/family in Patient Information Guide.

AUTHORIZATION FOR REVIEW AND RELEASE OF INFORMATION

The undersigned hereby permits PNS and/or its authorized personnel access to and/or release all or any part of the patient information (including information regarding substance abuse, HIV testing, AIDS, and psychiatric treatment) to, including but not limited to, the appropriate health care insurer(s), third party payer(s), and/or PNS agents, accrediting and/or licensing bodies, attorneys, and/or consultants for purposes including treatment of the patient, billing and/or collecting payment for services and health care operations including improving patient care, training or educating staff, performance improvement initiatives, accreditation, licensing, discharge planning, risk management , and/or as required by law.

SPECIAL SERVICES

I hereby authorize PNS to take pictures of myself during treatment and authorize release of those photographs to insurance providers to document my medical condition. I understand that, if I need hospitalization or special services not provided by PNS, my legal representative or I must make arrangements for these services. The agency should in no way be responsible for failure to provide the same and is hereby released from any liability arising from the fact that I am not provided with such additional care.

CLAIM PAYMENT AUTHORIZATION

I (as patient or agent of the patient) hereby assign and transfer all rights to Medicare and any other insurance benefits for home care services rendered to me, to PNS and authorize third party payments to be made directly to PNS. I certify that the information given to me in applying for payment under Title XVII or Title XIX of the Social Security Act, or under the terms of any other carrier is correct. I understand that it is my responsibility to inform PNS prior to any change regarding my insurance carrier. I assign the benefits payable for covered Medicare services and any other services to PNS and authorize PNS to submit a claim to Medicare or other third party payor for payment. Any assignment of benefits is limited to the Medicare allowed charge for services or to an amount not to exceed PNS's regular charges. I understand that in consideration of the services to be rendered, I may be responsible for payment for any services not covered by third party payors and I will pay any and all charges due and owing PNS in accordance with their regular rate, terms and policies. All amounts will be billed to you in accordance with agency procedures. Payment is due upon receipt of the bill.

_____ _____
Patient's Signature Witness Signature/Agency Representative

The patient is unable to consent because _____
I therefore consent for the patient and I have read, understand and have received all the information above:

_____ _____
Responsible Person or Legal Guardian Signature Printed Name & Relationship to Patient