AMERICAN HOME HEALTH CARE LLC
ADMISSION AGREEMENT

NAME OF CLIENT: _____ **ID #:**_____

ADDRESS: _____ **DOB:** _____

_____

CONSENT FOR CARE

The services to be provided to me by the Agency staff have been explained to me. I hereby consent to the staff of said program to visit my home periodically to render PCA Services as ordered by my physician in a plan of care.

RELEASE OF INFORMATION

I authorize information in my medical record to be released to authorized representatives of Medicare, Medicaid, or another medical insurance carrier for use in determining home health care benefits payable to the Agency on my behalf. I authorize any hospital, nursing home, physician's office or other health facility where I have been a client to disclose any part or all of my medical record to the Agency. Also, I authorize the release of medical and other related information to appropriate agency staff and social/health care agencies and medical equipment/supply vendors whose services may be required in conjunction with the services provided by the Agency

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY RIGHTS

I have received the notice of privacy rights and had it reviewed with me. I have had the opportunity to ask questions, and have been given the names of contact persons for future questions.

REQUEST FOR PAYMENT

I request payment of authorized Medicaid, or other health insurance benefits and hereby assign benefits payable on my behalf directly to the Agency. I understand that should payment not be made to the Agency, I will be responsible for services rendered to me, and that this payment is contingent upon written notice from the Agency that services rendered are not authorized benefits under Medicaid or other health insurance. I understand that I am responsible for any insurance deductible, co-pay and coinsurance.

CERTIFICATION

I certify that I have read the above agreement, received a copy thereof, agree with the above conditions, and am the client, or am duly authorized by the client as the client's general agent to execute the above and accept its terms. I understand that this agreement can be revoked at any time.

_____ _____

SIGNATURE OF CLIENT OR REPRESENTATIVE (STATE RELATIONSHIP) DATE SIGNED

_____ _____

WITNESS (SIGNATURE BY MARK OR REPRESENTATIVE MUST BE WITNESSED) DATE SIGNED

IF CLIENT UNABLE TO SIGN, GIVE REASON _____

AMERICAN HOME HEALTH CARE LLC

*N*otice of *P*rivacy *P*ractices *P*olicy

What is HIPAA?

HIPPAA is the health insurance portability and accountability act of 1996 which applies to the storage and/or electronic transmissions of patient related information, and is intended to ensure patient confidentiality for all health care related information.

Banaadiri Home Health Care: is required by state and federal laws to protect the confidentiality of your health information. The confidential information that we obtain as we deliver services to you is called "protected health information". We can use and disclose your protected health information as is illustrated below:

1. We are permitted to use protected health information to provide treatment and to help us coordinate services among Banaadiri Home Health Care personnel and with others involved in your care such as family members, your physician, or other medical personnel.
2. We are permitted to use protected health information to obtain payment such as including your health on invoices on invoices and insurance forms to collect payment information.
3. We are permitted to use protected health information for health care operations to evaluate and improve the quality of services or to write new guidelines to provide more effective care; to conduct supervision of PCA or evaluated their performance; to train our employees; to determine satisfaction with our services; and general administrative activities.

For the aforementioned reasons of sharing protected health information to sharing protected health information to provide treatment, obtain payment or for healthcare operations, written consent or permission is not needed by the client. However if the information is to be used of any purpose other than those indentified , a written statement from the client or authorized representative saying that we may share information is needed.

You, as the client, have the right following rights regarding the use and disclosure of the protected health information:

1- The right the request restriction or limitation on how your personal history/information is used. For example, you can ask that your information is not shared with a particular family member. Banaadiri Home Health Care personnel cannot agree to or refuse a specific patient's request for restrictions. Banaadiri Home Health Care may end a restriction if we believe it puts you, your health or caregiver at risk. You can end a restriction yourself at any time. The client needs to make this request in writing to the Administrator.
2- The right to select the way in which you receive information from us. The client needs to make this request in writing to the Administrator.
3- The right to ask to see your health record, to copy it, or revise it. The client needs to make this request in writing to the Administrator.

There are some important exceptions to requiring an authorization stated in the federal regulation. We can provide your health information to representatives in the fallowing capacity without your written permission:

- To Public Health Authorities
- To a government representative responsible for responding to concerns/complaints about abuse, neglect or domestic violence permitted by law.
- For judicial or administrative proceedings.
- For purpose of worker's compensation.
- To avert a serious threat to health or safety.

If you believe that your confidentiality has been violated you can contact the Administrator of Banaadiri Home Health Care at 612 870 2738 to file a complaint.

This notice is available to any client upon request. We reserve to change the terms of this notice and provide notice to any client who is receiving our services.

Client Signature_____ Date_____

RN _____ _____ _____ Date_____

AMERICAN HOME HEALTH CARE LLC
2716 Portland Ave S Minneapolis MN 55407
Phone 763-334-6957 Fax 763-334-6958

PCA EMERGENCY BACKUP PLAN

Client Name:_____ **Date:**_____

1. If the above named client should require emergency medical care, the plan is to call 911 and admit to _____**Hospital.**

PRIMARY CAREGIVER NOTIFICATION OF EMERGENCY

2. If the primary caregiver is not available and an **emergency** occurs, the company will call:

Name Relationship Telephone

a._____and/or

b._____

AND AT THE SAME TIME CONTINUE TO NOTIFY THE PRIMARY CAREGIVER

3. If the above named client's condition requires that a physician be contacted, the plan is to notify:

a._____Telephone_____and/or

b._____Telephone_____

4. In the situation where an unforeseen event causes the company to be unable to provide adequately trained staff, the plan will be that:

a. The company will attempt in every way to secure immediate, trained staff.

b. If the company is unable to secure immediate replacement staffing and no other trained staff is available, the plan is to notify the following backup caregiver(s) who will provide backup care:

Name Relationship Telephone

1._____and/or

2._____

c. If the backup caregiver(s) are not available to provide immediate backup care, and the company is unable to locate adequately trained staff, the plan is to admit the above named client to: _____Hospital/Nursing Home/Skilled Nursing Facility (circle one) until adequately trained staff is readily available to care for the client at home.

ALLERGIES:_____

ADVANCE DIRECTIVE: ☐ Yes ☐ No If yes, type_____

☐ Do Not Resuscitate ☐ Full Resuscitation

COMMENTS:_____

_____

Client /Responsible Party Signature:_____ Date_____

PCA Signature: _____ Date_____

Supervisor Nurse Signature:_____ Date_____