WellSpan®
VNA Home Care

PATIENT CONSENT

PATIENT NAME: _____ **PATIENT ID:** _____

ADVANCE DIRECTIVES: I understand that the Federal Patient Self-Determination Act of 1990 requires that I be made aware of my right to make health care decisions for myself. I understand that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak for myself. I have been given information regarding Advance Directives.

I have a Living Will. ☐ No ☐ Yes

I have an Advance Directive. ☐ No ☐ Yes

I have a Health Care Power of Attorney. ☐ No ☐ Yes *(If yes, provide copy to agency.)*

If yes, name/phone number of Health Care Power of Attorney: _____

I have a Pennsylvania Orders for Life-Sustaining Treatment. ☐ No ☐ Yes *(If yes, provide copy to agency.)*

I have an Out-of-Hospital Do-Not-Resuscitate (DNR) Order. ☐ No ☐ Yes *(If yes, provide copy to agency.)*

CONSENT FOR TREATMENT: I hereby give my permission for authorized personnel of your agency to perform all necessary assessments, procedures and treatments as prescribed by my physician for the delivery of home health care. I understand that the agency will supervise services provided, I may refuse treatment or terminate services at any time, and the agency may terminate their services to me as explained in my orientation. I agree and consent to the home care plan and payment as outlined in this admission booklet. I understand that this is the initial plan of care. I will be notified by the agency in advance each time there is a change made to my plan of care.

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 consent to the release of all records required to act on this request. I request that payment of authorized benefits from Medicare, Medicaid or other responsible payer be made in my behalf to WellSpan VNA Home Care.

If I have Medicare Part A benefits, I understand that Medicare payments will be accepted as payment in full and I have no financial liability, unless I have been notified in writing that service(s) will not be covered by Medicare and wish to receive the care or service. I understand that while I am under the agency's plan of care, the agency will coordinate all medically necessary therapy services and medical supplies for me. If I arrange for these services or supplies on my own, I understand that Medicare will not reimburse me or my supplier and I will be responsible for the total cost.

If I have other insurance, I may be responsible for the co-payment and any charges that my insurance will not cover. I will refer to the rates for service provided by the agency for the maximum dollar amounts that I may be required to pay. 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.

RELEASE OF INFORMATION FOR DISASTER SITUATIONS: I agree that the agency may share my protected health information with emergency officials or others involved in my care to assist in disaster relief efforts. ☐ Yes ☐ No

By signing this consent, I acknowledge receipt of the admission booklet and confirm my understanding and agreement with its contents. I understand a copy of this consent shall be as valid as the original and shall remain in effect until I am discharged from the agency. I also understand that I may revoke this consent in writing at any time. I understand that my signature on page 1 of this consent verifies my understanding of and agreement with all information on pages 1 and 2.

Patient Signature	Date/Time	Responsible Person, Legal Representative or Legal Guardian Signature
Agency Representative Signature/Title	Date/Time	Printed Name and Relationship of Person Above

☐ *Patient unable to sign due to:* _____

WELLSPAN®
VNA Home Care

PATIENT CONSENT
(CONTINUED)

PATIENT RIGHTS AND RESPONSIBILITIES: I acknowledge verbal explanation and written receipt of my rights and responsibilities as a patient (including OASIS rights, agency administrator's name and contact information, agency discharge, transfer and referral policy and how to contact local resources) and I understand them. The state home health hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency.

RELEASE OF INFORMATION: I acknowledge receipt of the **Notice of Privacy Practices** and was given an opportunity to ask questions and voice concerns. I understand that the agency may use or disclose protected health information (PHI) about me to carry out treatment, payment or health care operations. The agency may release information to or receive information from insurance companies, health plans, Medicare, Medicaid or any other person or entity that may be responsible for paying or processing for payment any portion of my bill for services; any person or entity affiliated with or representing for purposes of administration, billing and quality and risk management; any hospital, nursing home or other health care facility to which I may be/have been admitted; any assisted living or personal care facility of which I am a resident; any physician providing my care; family members and other caregivers who are part of my plan of care; licensing and accrediting bodies, other health care providers in order to initiate treatment.

CONSENT TO FILM OR RECORD: I hereby consent for the agency to record or film my care, treatment and services and allow the agency to use the photographs/recordings for their internal use, for documenting my medical condition or for insurance providers to document my condition for payment purposes.

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