Southeast Homecare

SOUTHEAST HOMECARE CORPORATION
MANAGED CARE

NAME:_____
ADDRESS:_____ DISTRICT #: _____
INSURANCE: _____ SHC ADM. DATE: _____

CONSENT FOR TREATMENT

I hereby personally, or throu ih my physician, request home health services and treatment by SOUTHEAST HOMECARE CORPORATION in my home. I have had an explanation of all services to be received, and I do hereby consent to such servi es and treatment by the Nurses and/or Therapists and/or Medical Social Workers and/or Nurse Assistants of S IUTHEAST HOMECARE CORPORATION. The services and treatment should be reasonably prescribed by ph sician and/or may be indicated by prudent medical practice by my illness, injury or condition. This consent is ntended as a waiver of liability for such services. I have also been explained and have been provided with a c py of Patient Rights and Responsibilities. I understand that the nurse will explain the care plan prescribed und r the direction of the physician and the nurse will solicit my input for participation in the care plan. I have rece ved and understand the OASIS Privacy Act Statement.

RECIPROCAL RELEASE OF INFORMATION

I hereby authorize S.H.C. to elease the complete medical records in your possession concerning my illness and/or treatment to hospital, hysician, and other medical agencies or institutions, as necessary. By this form, I also authorize my physician hospitals, skilled nursing facilities, AHCA HIV/AIDS contract office, Health Council of South Florida, SFAN, and other medical agencies to release to SOUTHEAST HOMECARE CORPORATION any portion of my medical re ords copies, thereof which they may request.

PATIENT'S CERTIFICATION:
AUTHORIZATI ON TO RELEASE INFORMATION AND PAYMENT REQUEST

I certify that the information ven to me in applying for payment under Title XVIII/XIX 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 be made on my bel alf.

My Physician has ordere the following services for me that will be paid by my insurance:

Skilled Nursin for_____ Physical Therapy for_____
Speech Thera y for_____ Occupational Therapy for_____
Home Health ide for_____ Medical Social Workers for_____

Services not covered by my insurance:_____ Fee:_____

I will be billed directly for these services, and I will be responsible for payment in full.

ASSIGN IENT OF BENEFITS AND GUARANTEE OF PAYMENT

1. To Insurance and Thi d Party Payors: I, the undersigned, hereby assign, transfer, and convey payment and authorize said p yment to be made directly to Southeast Homecare Corporation, the insurance benefits herein spec ied and otherwise payable to me, but not to exceed the balance due. I, the undersigned, unders nd that I am financially responsible to SOUTHEAST HOMECARE CORPORATION for the charges not overed by this authorization, including Medicare Part B Co-Insurance. I, the undersigned, further authorize the release of any information required for payment and services rendered.
2. I, the undersigned, ac nowledge financial responsibility for the above consented treatment. I understand the SOUTHEAST HOI ECARE CORPORATION philosophy of patient care regardless of my ability to pay, and I agree to follow the guidelines as stated on the Financial Assessment Sheet.

Signed:_____ Witnessed:_____ Date: _____
(Patient or Legal G iardian)

(CONS-SE.MAN)