First Choice home care, inc.

AUTHORIZATION FOR SERVICE, CONSENT FOR TREATMENT, RELEASE OF MEDICAL INFORMATION AND AGREEMENT TO PAY FOR CARE

I hereby authorize First Choice Home Care, Inc. (FCHC), its employees and representatives to perform an assessment, and to provide the care ordered by my physician, myself or my family or other qualified health care providers.

I understand that while First Choice Home Care, Inc. makes every effort to provide care for every requested shift, there is no guarantee of staffing. There must be a family or other caregiver involvement in the even that services cannot be provided.

I authorize any health care provider who either has treated or is currently treating me to release any and all medical information regarding my care and treatment to FCHC. This release shall remain in effect until such time as is notified by me in writing of its revocation or modification.

I also authorize to release any or all information concerning my care to the following individuals or entitles: state Medicaid agencies or their agents; any federal or state inspection, licensing, any professional review organization; and any company that may be responsible for reviewing or paying my FCHC bill (e.g., employer insurance company, private review or audit organization).

I hereby authorize to secure payment directly from any insurance company or other third party who may be responsible for paying for all or a portion of the services. I assign FCHC the right to collect from any third party who may be liable or responsible for payment for all or a portion of the service, and request payment be made on my behalf directly to FCHC.

I hereby authorize FCHC to secure payment for items and services, not paid by an insurance company, government program, or other third party, including among other things non-covered services and all deductible or co-insurance amounts. I understand that I am financially responsible to FCHC for all such charges. If I fail to pay and FCHC refers my account to a collection agency or attorney, I also agree to pay additional collection costs, attorney's fees, and court costs incurred by FCHC in regard to my delinquent account. I understand that all bills will be paid upon receipt. I further agree that my sole remedy and FCHC liability for claims of any kind is limited to the amount available under FCHC bond. I agree that failure to give notice of claim within 30 days constitutes a waiver of all claims present and future. Client and Guarantor agree to pay charged interest together with reasonable attorney's fees for costs of collection.

I agree that in consideration of FCHC furnishing the above employee, I shall not employ the FCHC employee for a period of 90 days after the completion of service. If this consideration is violated, then I shall pay upon demand $3000.00 liquidated damages.

I further agree that my signature and initials on the activity sheet will signify that work was performed in a satisfactory manner, and that hours shown are accurate and complete. Employees are not permitted to smoke on patient's premises.

I, _____, have been informed and provided with a written copy of my rights as a patient receiving Home Care, FCHC Notice of Privacy Practices, and oral and written information regarding payment for Home Care services. I have been advised that for complaints or grievances that the **N.C. Home Health "hotline" 1-800-624-3004**, and/or **Accreditation Commission for Health Care 1-855-937-2224** are available 24 hours per day. I have been informed how to contact the First Choice Home Care, Inc. staff 24 hours a day, seven days a week. I was given input into the plan of care, and this plan of care was discussed with, and approved by me.

I have been informed of my rights to file in my home health care record copies of advance medical directives concerning my medical care, and to have instructions contained within those directives followed as allowed under applicable state law.

Check Appropriate Line:

_____ The above client has not executed an advanced directive, however, information was given and explained to patient and/or their family.

_____ The above client has executed an advanced directive and shall provide a copy when available to FCHC and to his/her physician.

Services _____Weekday/Hourly or per visit Rate_____ Weeknights/Weekend/Holiday* - Hourly or per visit Rate _____

IF THE MAJORITY OF A SHIFT WORKED IS WEEKEND/HOLIDAY HOURS, YOU WILL BE BILLED WEEKEND/HOLIDAY RATE FOR THE ENTIRE SHIFT

_____ _____

Witness **Date** **Signature of Patient or Authorized Representative (& Relationship)**

PLEASE NOTE:

1. We observe the following holidays during the year. New Year's Eve 3p.m.-11p.m., 11p.m.-7a.m.; New Year's Day 7a.m.-3p.m., 3p.m.-11p.m.; Easter Sunday 7 a.m.-3 p.m., 3 p.m.-11 p.m.; Memorial Day 7 a.m.-3 p.m., 3 p.m.-11 p.m.; Independence Day 7 a.m.-3 p.m., 3 p.m.-11 p.m.; Labor Day 7 a.m.-3 p.m., 3 p.m.-11 p.m.; Thanksgiving 7 a.m.-3 p.m., 3 p.m.-11 p.m.; Christmas Eve 3 p.m.-11 p.m., **11** p.m.-7 a.m. and Christmas Day 7 a.m.-3 p.m., 3 p.m.-11 p.m. ***These shifts are billed at the same time and one-half rate.**
2. Our billing week begins on Sunday and ends on the following Saturday. Your bill will be mailed to you on a weekly basis. You may contact the FCHC with any questions you may have regarding your billing.
3. Weekend rate applies from 11 p.m. Friday through 7 a.m. Monday.
4. We do not schedule employees to work over 40 hours weekly unless requested by the client. Any hours in excess of 40 per week, per employee, that are requested by the client, will result in billing charges of time and one half.
5. Should any changes in the service we provide to you be desired, please notify the FCHC office.

Original - Client Record Copy - Client