NURSES TOUCH HOME HEALTH PROVIDER, INC.

Admission Services Agreement

I hereby consent and authorize **Nurses Touch Home Health Provider, Inc.**, its agents and associates to provide services to me in my home or place of residence as prescribed by my physician. A representative of **Nurses Touch Home Health Provider, Inc.** has explained to me the services to be provided and my plan of care. I understand that the plan of care may change and if so, these changes will be discussed with me.

I further understand that after I or my family receive instructions to assist me in my care, that my care is my responsibility in the absence of the agency staff in my place of residence and that, it is my responsibility to notify my physician or other care providers of any significant events relating to my health.

I certify that the information given by me to **Nurses Touch Home Health Provider** is correct to the best of my knowledge. I understand that payment of authorized benefits be made in my behalf and will be billed to:

☐Medicare ☐Medi-Cal ☐Bill directly to me ☐Other

My Insurance Company is: _____

I understand and agree to pay deductibles, co-payments and any amounts due after payments of benefits on my behalf by any and all third party payers.

I hereby consent to and authorize the agency to disclose and release information contained in my clinical record to the health care providers involved in my care, third party payers, utilization review and other professional standards review organizations, regulatory review entitles and any other companies that may/will help me to meet my health care needs.

I hereby consent also to have my body or parts of my body photographed for purposes of treatment as part of my physician's plan of treatment when indicated.

I have received an explanation and written information regarding Advance Directives. I understand that Nurses Touch Home Health Provider Inc., does not discriminate or whether or not I have an advance directive.

☐**I DO** ☐**I DO NOT** have an advance directive. I ☐**WILL NOT** provide a copy to the agency.

I have received a copy and an explanation of the Patient/Client Rights and Responsibilities.

THIS ADMISSION AGREEMENT is applicable only to this admission to Nurses Touch Home Health Provider, Inc. I understand what I have read and what was explained to me and agree to the terms and conditions states above. Also, I understand either party may terminate this agreement at any time.

SIGNATURES/DATES:

_____

Patient/Client/Representatives **Date** **Agency Representative (Nurses Touch)** **Date**

_____

Financial guarantor (if applicable) **Date** **Agency Representative (Nurses Touch)** **Date**

Patient Name: _____ **MR #:** _____