Duke HomeCare & Hospice
Duke University Health System

PATIENT CONSENT & CERTIFICATION

☐ Duke Home Health ☐ Duke Hospice ☒ Duke Home Infusion

PATIENT NAME _____ **DATE OF BIRTH**_____
(Last Name, First Name, Middle Initial)

CONSENT FOR CARE

I understand that by signing this agreement, I hereby give consent for the care and treatment and provision of products or services given to me by Duke HomeCare & Hospice. I also understand that these services are provided as ordered and directed by my physician and that Duke HomeCare & Hospice is not liable for any act or omission when following the orders of said physician. I understand that my care is under the supervision and control of my attending physician, and I consent to all medical treatments, procedures, examinations and tests reasonably necessary for my proper care, including HIV testing. I understand further that I have the right to more complete information concerning any particular diagnostic or therapeutic procedure and I may be asked for a more specific consent (verbal or written) to such procedures if the risk involved so indicates. I understand and agree that there may be circumstances under which my health care provider is required to report to organizations such as health departments or CDC, information pertaining to communicable diseases such as HIV and TB.

CLINICAL INFORMATION AUTHORIZATION

The undersigned authorizes Duke HomeCare & Hospice to disclose all or any parts of the patient's clinical record to applicable voluntary accrediting bodies, private review organizations and agencies (including fourth party review organizations), or to any person or corporation or authorized agent or representative of any person or corporation which is or may be liable under a contract to Duke HomeCare & Hospice or to a patient or to a family member or employer of the patient for all or any part of Duke HomeCare & Hospice charges for its services, including but not limited to hospital or medical service companies, insurance companies, workmen's compensation carriers, welfare funds, or the patient's employer. This authorization includes requests for both retrospective and concurrent clinical information.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

The undersigned also authorizes DHCH to release information from the Patient's Medical Records to any referring physician, to any health care facility to which the patient may be transferred, or to any health care provider involved in the patient's care. This authorization includes requests for both retrospective and concurrent medical information. The undersigned also authorizes DHCH to receive information from medical records or other patient records held by any referring physician or health care facility, or held by any health care provider involved in the patient's care.

ASSIGNMENT OF BENEFITS/PAYMENT AUTHORIZATION

I authorize direct payment of any benefits, otherwise payable to me, to the entity indicated above that is rendering services and providing products pertaining to my care. I understand that I am financially responsible for all deductible and copay portions, as well as any dollar amount not paid by my insurance company(ies). I also authorize my insurance company(ies) to furnish to Duke HomeCare & Hospice any information pertaining to my benefits and status of claims submitted by the entity indicated above. This assignment of benefits may be revoked in writing at any time. If I have Medicare benefits, I understand that Medicare Part A payment will be accepted as payment in full for Part A covered services and I will have no financial liability unless I have been notified in writing that the service(s) will not be covered by Medicare Part A.

CERTIFICATION I ACKNOWLEDGE:

I have received a copy of and understand the "Patient's Bill of Rights and Responsibilities"
I have received a copy of the Notice of Privacy Practices in effect for Duke HomeCare & Hospice and the Organized Healthcare Arrangement in which it operates.
I have received information regarding my financial responsibility.
I have been informed that my medical information may be reviewed and/or disclosed to Licensed Surveyors during the course of a Department of Health and Human Services Licensure Inspection of Duke HomeCare & Hospice.
I have been informed of how to file a complaint if need be and have received information about Duke HomeCare &Hospice.
I have been informed about the Home Health Hotline (telephone number 1-800-624-3004).
I understand and have participated in decisions about my plan of care.
I have received safety information, including what to do in case of an emergency.
If I am receiving Home Health, Hospice or Nursing services I have been informed that the Federal Patient Self-Determination Act of 1990 requires that I be made aware of my right to make healthcare decisions for myself. I understand that I may express my wishes in a document called an Advance Directive. I have received information about and understand my right to make decisions about medical treatment. I have received written information regarding making health care decisions and formulating advance directives.
I have received information on how to reach the agency including after hours on-call services.
If I am receiving Home Health Services, I have received and understand the OASIS Statement of Patient Privacy Rights, if applicable.
If I am receiving Hospice Services, I understand that if my physician or the Hospice Team no longer consider Hospice Care appropriate, or sufficient to meet my needs, I may be discharged from Hospice without liability to either party: I understand that Hospice Care is not intended to be curative, but is designed to provide symptom control and management. I have been given the opportunity to ask questions about my Hospice Care and all questions have been answered. I accept the conditions of Hospice Care as described, with the understanding that I may withdraw my consent for Hospice Care at any time.

☒ **NO,** I do not have an Advance Directive at this time.
☐ **YES** I have an Advance Directive at this time, and I will supply Duke HomeCare & Hospice with a copy for my clinical record.

Signature of Patient, Parent, Guardian, or Legal Representative*	**Date**	**Time**
Laura P Helms RN BSN		
Signature of Witness	**Date**	**Time**

* If signature is not that of the Patient, Parent, or Guardian, indicate the relationship of person signing for the Patient and the reason the Patient i s unable to Sign.

Relationship: _____ **Reason:** _____

AGREEMENT TO ALTERNATIVE DISPUTE RESOLUTION

In accordance with the terms of the United States Arbitration Act, I agree that any dispute arising out of or related to the provision of health care services to me by Duke University, Duke University Health System, Inc. (DUHS), Duke Primary Care (DPC) , the Private Diagnostic Clinic PLLC (PDC) or the employees, physician members, and agents, shall be subject to final and binding resolution exclusively through the Health Care Claim Settlement Procedures of American Arbitration Association, a copy of which is available to me upon request, I understand that this agreement includes all health care services which previously have been or will in the future be provided to me and that this agreement is not restricted to those health care services rendered in connection with this admission or visit. I understand that this agreement also is binding on any individual or entity claiming by or through me or on my behalf. I understand that this agreement is voluntary and is not a precondition to receiving health care services. NOTE: If the individual signing this agreement is doing so on behalf of his or her minor child any other person for whom he or she is legally responsible, the signature below affirms that he or she has the authority or obligation to contract with Duke University, DUHS, DPC, and the PDC for the provision of health care services to that minor child or other person, and that his or her execution of this agreement is in furtherance of that authority or obligation.

Signature of Patient, Parent, Guardian, or Legal Representative*	**Date**	**Time**