# PATIENT CONSENTS AND AUTHORIZATIONS

### Request for Admission & Consent to Treatment

I request admission to Helms Home Care, LLC and consent to such care and treatment as is ordered by my attending physician. I understand that my care is directed and monitored by my attending physician. Helms Home Care, LLC is responsible for following my physician's orders for home care, but assumes no responsibility for any act or omission of the physician.

Patient's Initials _____

### Authorization to Release Information

I hereby authorize Helms Home Care, LLC to release copies of my medical records or such portions thereof as may be relevant or reports or summaries thereof, to hospitals, physicians, insurance providers, other health or social service agencies or facilities to which I may be referred, transferred or who may be involved in my care as necessary for the purpose of continuing coordination or reviewing my care or to assist in determining third party reimbursement liability. I further authorize any and all physicians and/or health care facilities which have rendered me care and services in the past to release all medical information to Helms Home Care, LLC when necessary to establish or continue my plan of care. I have been advised that certain governmental, licensing and accrediting bodies may conduct reviews of my records as part of survey processes and in regards to release of my medical information, records, or other confidential information to agents of the Department of Human Resources, Division of Facility Services, Division of Medical Assistance, etc. or other medical agencies that I have the right to object in writing to the release of such information.

Patient's Initials _____

### Payment Authorization and Assignment of Insurance Benefits

I understand that Helms Home Care, LLC is not authorized or responsible for contacting my insurance provider to obtain prior authorization of benefits or payment for services rendered. I understand that Helms Home Care, LLC will not bill me or my insurance provider directly and that payment of any authorized benefits for services rendered by Helms Home Care, LCC is the responsibility of my attending pharmacy. I hereby agree and understand that Helms Home Care, LLC cannot answer benefits or financial questions related to the care received by Helms Home Care, LLC. Therefore I will contact my pharmacy provider and/or insurance provider for all financial related concerns. I further understand that this assignment of benefits does not relieve me or other responsible parties of liability for any indebtedness hereunder until such indebtedness is paid in full.

Patient's Initials _____

### Vehicle Release

I understand and agree that Helms Home Care, LLC does not carry or provide insurance coverage under any circumstances for damages to my automobile or other property resulting from the use of my automobile by a Helms Home Care, LLC employee. I agree not to allow or ask any Helms Home Care, LLC employee or representative to operate my automobile or transport me in a Helms Home Care, LCC employee's automobile. I hereby release Helms Home Care, LLC and its employees assigned to me and hold them harmless and indemnify them from any claim, liability, or cause of action for any injury to my person or property resulting from the use of an automobile (whether or not owned by me) if operated by a Helms Home Care, LLC employee.

Patient's Initials _____

### Patient's Rights, Responsibilities, and Advance Directives

I have received a copy of the Client Rights and Responsibilities and have reviewed and had the opportunity to ask and have all of my questions and concerns regarding these answered. I have also received information regarding advance directives.

I have previously signed an advance directive prior to this admission. ❑ Yes ❑ No

**If Yes,** the name and address of my patient representative authorized to make medical decisions on my behalf is:

Name: _____ Phone: _____

Address: _____ Patient's Initials: _____

**The undersigned certifies that he/she has read and received a copy of the foregoing, and is the patient, or is duly authorized by the patient's general agent to execute the above and accept its terms.**

Patient's Name: _____ DOB: _____

Signature of Patient or Representative: _____ Date: _____

Relationship of Representative: _____