LEE REGIONAL VNA, INC. d/b/a PORCHLIGHT VNA
PATIENT SERVICE PLAN & CONSENT FORM

Patient Client Name:_____

DISCIPLINE	DATE EFFECTIVE	ESTIMATED VISIT FREQUENCY & DURATION	PAY SOURCE	INSURANCE PAYMENT	PATIENT CHARGE (up to and including)
SKILLED NURSING					$
HOME HEALTH AIDE					$
PHYSICAL THERAPY					$
OCCUPATIONAL THERAPY					$
SPEECH THERAPY					$
MEDICAL SOCIAL WORK					$
DME/SUPPLIES					$

1. **CONSENT FOR SERVICE: I voluntarily consent to any examinations and therapeutic treatments** prescribed by my physician(s) and rendered by the professional and support staff of Porchlight VNA. I understand that I have the right and the responsibility to participate in the development of my plan of care.

2. **RESPONSIBILITY FOR PAYMENT / ASSIGNMENT OF BENEFITS: I give permission to my insurance carriers**, including Medicare and Medicaid, to make direct payment of my authorized benefits to Porchlight VNA for services and supplies provided to me. **I understand that I am financially responsible for all charges incurred for services and supplies rendered**, including any deductibles, co-payments, or services not covered by insurance. I understand that I will be informed by Porchlight VNA verbally and in writing as soon as possible of any change in payment; notification will be no later than thirty (30) calendar days from the date the agency becomes aware of the change. A finance charge of 1.5% will be incurred monthly for untimely payment. I agree to the fee and service plan stated above.

3. **NONDISCRIMINATION**: I understand that Porchlight VNA renders services without regard to race, color, religion, disability, gender, sexual preference, or national origin.

4. **ACKNOWLEDGMENT OF RECEIPT OF INFORMATION: I have received the Patient Handbook** which contains the Patient Bill of Rights and Responsibilities, information on advance directives, instruction on safety and infection control, the Statement of Patient Privacy Rights regarding the Outcome and Assessment Information Set (OASIS), and Porchlight VNA privacy practices as required by HIPAA.

5. **AUTHORIZATION OF RELEASE OF INFORMATION: I hereby authorize PORCHLIGHT VNA to request and/or release any and all information from my medical and billing records necessary** for treatment and coordination of Porchlight VNA with community services (including emergency planning), accrediting agencies, regulatory agencies, and associated payment sources. Information may be released to determine entitled benefits and/or to determine the quality of care being provided to me.

   I authorize PORCHLIGHT VNA to release any information contained or included in the Outcome and Assessment Information Set (OASIS) to CMS and its agents. I permit a copy of the authorization to be used in place of the original. I understand that my health records are confidential and that they are the sole property of Porchlight VNA.

   Porchlight VNA will only disclose your information for the purpose of treatment, payment, business operations, technical support from its business partners, or when required by law. Information authorized for release may include records that indicate the presence of communicable or venereal diseases, which may include hepatitis, syphilis, gonorrhea, human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS). **I give consent to Porchlight VNA to provide information regarding precautionary measures related to communicable diseases to those in close contact with me**. I acknowledge and understand that PORCHLIGHT VNA has a legal obligation to report communicable diseases to the appropriate authorities. All other information requested and/or released by Porchlight VNA will require a signed Release of Medical Information Form, a subpoena, or a court order.

6. **CERTIFICATION OF PATIENT INFORMATION**: I certify that the insurance information I have provided is correct.

I agree to notify Porchlight VNA, regarding changes in my insurance coverage.

SIGNATURE OF PATIENT OR REPRESENTATIVE*:_____ DATE:_____

*An Authorized Representative signs only when the patient is unable to sign.

The Authorized Representative signs the patient's name, own name, date, relationship to patient and reason patient is unable to sign.

SIGNATURE OF STAFF MEMBER:_____ DATE:_____