Sphinx Home Health Care

ADMISSION CONSENT

PATIENT NAME: ______________________ **PATIENT ID:** ______________

INSTRUCTIONS: This form is used to acknowledge receipt of our Orientation Booklet and confirm your understanding and agreement with its contents. Your signature below indicates your approval.

PATIENT RIGHTS & RESPONSIBILITIES

I acknowledge receipt of my rights and responsibilities as a patient (including OASIS rights) and I understand them. The state home health hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of Sphinx Home Health Care has solicited or coerced my decision in selecting a home health agency.

CONSENT FOR TREATMENT

I hereby give my permission for authorized personnel of Sphinx Home Health Care to perform all necessary procedures and treatments as prescribed by my physician for the delivery of home health care. I consent to permit the agency to draw labs from me in the event of an infectious potential exposure to bodily fluids. I understand that Sphinx Home Health Care will supervise services provided, I may refuse treatment or terminate services at any time, and Sphinx Home Health Care may terminate their services to me as explained in my orientation. I agree and consent to the home care plan and payment as outlined in this admission booklet.

I consent to permit state/federal/and other accreditation agency or health survey personnel to conduct a home visit to ensure that federal requirements are met and to assist in evaluating the effectiveness and quality of home health services which I am receiving. I understand that consent for this visit is voluntary and refusal to consent to a home visit will have no effect on the level and nature of Medicare benefits to which I am entitled. ☐ **Yes to visit** ☐ **No to visit**

RELEASE OF INFORMATION

I acknowledge receipt of the **Notice of Privacy Practices** and was given an opportunity to ask questions and voice concerns. I understand that the agency may use or disclose protected health information about me to carry out treatment, payment or health care operations. The agency may release information to or receive information from insurance companies, health plans, Medicare, Medicaid or any other person or entity that may be responsible for paying or processing for payment any portion of my bill for services; any person or entity affiliated with or representing for purposes of administration, billing and quality and risk management; any hospital, nursing home or other health care facility to which I may be/have been admitted; any assisted living or personal care facility of which I am a resident; any physician providing my care; family members and other caregivers who are part of my plan of care; licensing and accrediting bodies and other health care providers in order to initiate treatment.

INITIAL SERVICES & FREQUENCY

I understand that this is the initial plan and I will be notified by Sphinx Home Health Care each time there are changes made in my plan of treatment

Service	Frequency	Cost	Ins. Pays	You Pay	Service	Frequency	Cost	Ins. Pays	You Pay
Skilled Nursing		$			**Occupational Therapy**		$		
Physical Therapy		$			**Medical Social Svcs.**		$		
Speech Therapy		$			**Home Health Aide**		$		

AUTHORIZATION FOR PAYMENT

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits from Medicare, Medicaid or other responsible payor be made in my behalf to Sphinx Home Health Care, LLC.

If I have Medicare Part A benefits, I understand that Medicare payments will be accepted as payment in full and I have no financial liability, unless I have been notified in writing that service(s) will not be covered by Medicare and wish to receive the care or service. I understand that while I am under the agency's plan of care, the agency will coordinate all medically necessary therapy services and medical supplies for me. If I arrange for these services or supplies on my own, I understand that Medicare will not reimburse me or my supplier and I will be responsible for the total cost.

If I have other insurance, I may be responsible for the co-payment and any charges that my insurance will not cover. I will refer to the rates for service provided above for the exact dollar amounts that I may be required to pay. I understand that I am responsible for all amounts not paid by my insurance. If I am a Private Pay patient, I agree to pay for all services rendered by the agency.

REPRESENTATION IN DENIAL: In the event that my care is considered non-covered by Medicare or by other insurances, I request that Sphinx Home Health Care represent me in reconsideration and appeal hearings on my behalf to the fiscal intermediary.

HEALTH INSURANCE CLAIM NUMBER: ______________________

CONSENT TO FILM OR RECORD

I hereby consent for the agency to record or film my care, treatment and services and allow Sphinx Home Health Care to use the photographs/recordings for their internal use, for advertising, for documenting my medical condition or for insurance providers to document my condition for payment purposes.

ADVANCE DIRECTIVES

I understand that the Federal Patient Self-Determination Act of 1990 requires that I be made aware of my right to make health care decisions for myself. I understand that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak for myself.

1. **I have made a Living Will** ☐ **No** ☐ **Yes** *(If yes, provide a copy to Sphinx Home Health Care.)*
2. **I have made a Patient Advocate Designation** ☐ **No** ☐ **Yes** ☐ *I was informed and will consider later.*
   (If yes, write the name & phone number of the patient advocate.) ______________________
3. **I have a Durable Power of Attorney for Health Care** ☐ **No** ☐ **Yes** **Name:** ______________
4. **I have a Do Not Resuscitate (DNR) Order** ☐ **No** ☐ **Yes**

______________________ Patient's Signature

______________ Date

______________________ Responsible Person or Legal Guardian Signature

______________________ Witness Signature/Sphinx Home Health Care Representative

______________ Date

______________________ Printed Name & Relationship of Person Above

☐ *Patient unable to sign due to:* ______________________

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Sphinx
Home Health Care

MEDICARE SECONDARY PAYER WORKSHEET

PATIENT NAME: ______________________ PATIENT NUMBER: ______________

1. Is this illness/injury covered by Workers' Compensation? ☐ Yes ☐ No
   If yes, note employer name, address and claim number, if assigned, in #11.
2. Is this illness/injury covered by the Black Lung Program? ☐ Yes ☐ No
   If yes, note where billing should be sent in #11.
3. Is this patient a member of a Health Maintenance Organization (HMO)? ☐ Yes ☐ No
   If yes, list the name and address of the HMO in #11.
4. Is this illness/injury due to an automobile accident? ☐ Yes ☐ No
   If yes, write the name of the automobile insurer responsible for coverage in #11.
5. Does this patient feel that another party is responsible for this illness/injury? ☐ Yes ☐ No
   Name of Responsible Party: ______________________
   Name of Liability Insurer/Attorney: ______________________
   Address of Liability Insurer/Attorney: ______________________
6. Is this patient covered by any Employer Group Health Plan (EGHP) including Federal Employees Health Benefits? ☐ Yes ☐ No
   If yes, move to #7. If no, go to questions at bottom of form.
7. Is this patient age 65 or older? ☐ Yes ☐ No
   If no, move to #9. If yes, move to #8.
8. Is this patient or the patient's spouse employed by an employer of 20 or more employees? ☐ Yes ☐ No
   If yes, enter the EGHP data in #11. If no, go to the questions at the bottom of form.
9. Is this patient entitled to Medicare coverage solely on the basis of disability? ☐ Yes ☐ No
   If no, move to #10. If yes, is this patient or the patient's spouse or parent actively employed by an employer of 100 or more employees? ☐ Yes ☐ No
   If yes, enter the Large Group Health Plan in #11.
   If no, go to the questions at the bottom of form.
10. a. Is this patient entitled to Medicare coverage solely on the basis of End Stage Renal Disease (ESRD)? ☐ Yes ☐ No
    If no, go to questions at bottom of page.
    b. Has this patient completed the ESRD coordination period? Has the patient been undergoing kidney dialysis for more than 12 months or been entitled to Medicare for more than 12 months? ☐ Yes ☐ No
11. Name of Insurance Company or HMO: ______________________
    Insured's Name: ______________________ Policy #: ______________
    Employer: ______________________
    Address of Insurance Company or HMO: ______________________
    ____

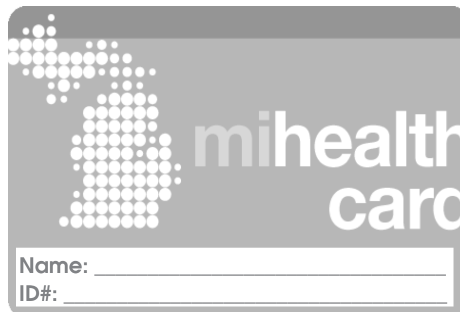
MEDICARE

EFFECTIVE SEPTEMBER 1990
(DOMESTIC)

Health Insurance

SOCIAL SECURITY ACT

NAME OF BENEFICIARY ....
CLAIM NUMBER .... SEX ☐ M ☐ F
IS ENTITLED TO EFFECTIVE DATE
HOSPITAL (PART A) ....
MEDICAL (PART B) ....



Name: ______________________
ID#: ______________________

BLUE CROSS CARD

BlueCross
Blue Shield

EFFECTIVE DATE ON CURRENT COVERAGE
__________ Subscriber

Name: ______________________

Group No. ________ Plan Code ________

Contact Number ________

OTHER INSURANCE:

INSURANCE COMPANY: ______________________ PHONE: ______________

ADDRESS: ______________________

POLICYHOLDER: ______________________ POLICYHOLDER ID: ______________

GROUP NAME: ______________________ GROUP #: ______________

SIGNATURE OF PERSON COMPLETING FORM: ______________________ DATE: ______________

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4. **I have a Do Not Resuscitate (DNR) Order** ☐ **No** ☐ **Yes**

Patient Copy

Patient's Signature ______ Date ______ Responsible Person or Legal Guardian Signature ______

Witness Signature/Sphinx Home Health Care Representative ______ Date ______ Printed Name & Relationship of Person Above ______

Form #105, Rev. 4/14 ☐ *Patient unable to sign due to:* ______________________

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Sphinx
Home Health Care

4415 Metro Parkway, Suite 200
Sterling Heights, MI 48310
Phone: (586) 264-2400

Notice of Medicare Non-Coverage

Patient name: _____________________ **Patient number:** _____________________

The Effective Date Coverage of Your Current Home Health Services Will End: ___________________

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current Home Health services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above;
  - Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: KePRO (1-855-408-8557; TTY: 1-855-843-4776) to appeal, or if you have questions.

See page 2 of this notice for more information.

If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below.

  Plan contact information ____

  ____

Additional Information (Optional):

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

_______________________________________ ________________

Signature of Patient or Representative Date

Sphinx
Home Health Care

4415 Metro Parkway, Suite 200
Sterling Heights, MI 48310
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Signature of Patient or Representative Date

Patient Copy