MARIE STAR HOME HEALTH SERVICES, LLC
PATIENT CONSENT

CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT

PATIENT NAME (Last, First, MI): Jimenez, Aida PATIENT MR#: 00343

CONSENT TO RECEIVE SERVICES: I hereby, authorize the Agency to render, appropriate home health services to me. I certify that I am homebound and cannot leave home without the assistance of someone. I have been fully informed of the Agency's assessment and evaluation of my home care needs, the risk of receiving the care of declining the home care services. I understand that the Agency does not do drug testing on its employees. I accept the proposed Plan of Care and authorize services to be provided by the Agency. In accordance with the orders of my physician and supervision to be done by agency personnel. I recognize that I have the right to refuse treatment or terminate services at any time by notifying the agency office. Also, the Agency may terminate service by notifying me of termination and reason.

AUTHORIZATION FOR PAYMENT TO PROVIDER: I certify that information given by me in applying for payment under title XVIII or title XIX of the Social Security ACT, or other third party pay or coverage is correct. I authorize any holder of medical or other information about me to be released to the SSA or its intermediaries, or other third party payers any information needed for this or other related claims. I request that payment as authorized be made on my behalf to the Agency. This authorization and request shall apply to the certification period starting _____, 20 _____ until the order is discontinued by my physician. **CHARGE FOR SERVICES**: Your initial services from the Agency will include the following services and initial frequency of visits and charge per visit if private insurance or private pay.

SERVICES AND/OR SUPPLIES	FREQUENCY OF VISITS	CHARGE PER VISIT
Skilled Nursing	1W1,3W2,1W5	
Speech Therapy	—	
Home Health Aide	2W8	
Physical Therapy	Eval	
Occupational Therapy	—	
Medical Social Services	—	

PATIENT LIABILITY FOR PAYMENT: You have the right to be advised, before care is initiated, of the extent to which payment for services may be expected from Medicare or other sources and the extent to which payment may be required from you, the patient. We are advising you, orally and in writing, about the cost of items and services to be provided: **Medicare part A or part B and Medi-Cal: Services provided are paid in full by Medicare/Medicaid. No cost to patient.** HIC NUMBER: _____
If Medicare is unable to cover rendered services, you will be responsible for charges related to the services provided to you by this agency. *See service charge per visit attached.* Payment for services is required if rendered with my signature below. Medicare Part B Outpatient: Patient is responsible for the annual deductible and 20% co-payment for all charges for PT, ST. OT services. You will receive a bill monthly for charges incurred and not covered by your insurance or Medicare or Medi-Cal. As the patient, you will be notified of any change in the charges for items or a service provided through Medicare, Medi-Cal, commercial insurance or other relevant Federal Programs as soon as possible, but no later than 30 days from the date the home health agency becomes aware of a change.
Commercial Insurance: Please circle one of the following: Black Lung Veteran Administration Worker's Compensation or Private Insurance. Your Insurance Company is Medicare.

This insurance company covers 100% of the charges. You are responsible for $ 0 per visit, which is the balance after insurance pays. The deductible amount of $ 0 will be billed to you. You will be responsible for charges related to the services provided to you by this agency. Payment required if rendered with my signature below. This assignment shall not extinguish or diminish the patient's obligation to pay the full fee to the company for services rendered but the

patient shall receive credit for all sums collected pursuant to the agreement. If the enrolled patient is in another insurance plan of HMO, it is the patient's responsibility to notify the Agency or the patient will be held responsible for payment.

I ACKNOWLEDGE that the Agency has notified informed and explained to me the **CLIENT BILL OF RIGHTS**. I have received information on Directives to Physician, Durable Power of Attorney for Home Health Care, and Out of Hospital DNR orders, the services to be provided, the supervision of the services, and charges for services rendered the client/family will be responsible for paying the charges.

I AUTHORIZE the Agency to release any medical information requested by representatives of local, state or federal agencies, accrediting bodies, insurance companies, or other organizations or entities as may be required by said representatives for payment of claims out of this home health care which are due. The agency has notified me of the Policies and Procedures regarding Disclosure of Clinical Records.

I acknowledge that the Agency has provided me with information on **Advance Directives, HIPAA, SPOA, Living will and DNR** which indicates that I may accept or reject any medical treatment, including any particular care specified:

- Living Will or Out of Hospital Do Not Resuscitate (DNR) (POLST)
- Statutory Power of Attorney for Health Care decisions
- Advance Directives in California
- HIPAA/Home Care Privacy Rights
- Transfer/Discharge Policy

I also understand that it is my responsibility to ask question about the information provided by the Agency. They have offered to provide a copy of the state's illustrative forms under state law if I request. I have also been advised to consult with my physician, lawyer, family, clergy, social worker or other qualified personnel for additional information or contact with a lawyer should I need assistance in changing the forms to reflect my treatment wishes or in executing a living will or statutory Power of Attorney for health care decisions. I understand that this Agency will honor the advance directives and is willing and able to provide any procedure specified on the advance directives.

PATIENT'S RIGHT/EMERGENCY PLAN/COMPLAINT PROCEDURE: I have been informed of my rights and received a copy of the Client's Bill of Rights and California Rights of the Elderly prior to the start of care procedure, "Advanced Directives, Emergency Plan, Out-of-Hospital, Do-Not-Resuscitate, Patient's Conduct & Responsibilities, Abuse/Neglect/Exploitation". I have been allowed to participate in planning my care and have received a copy of the Toll Free Home Health Agency Hotline Number 1-510-620-3900, which receives complaints or grievances 24 hours a day, seven days a week. I have received the Patient Information Booklet, which includes:

1. Service Outline
2. Emergency Contact Information
3. Non-Discrimination Polices
4. Patient Rights and Responsibilities
5. Patient Grievance
6. Abuse, Neglect, and Exploitation
7. Home Health Aide Duties
8. General Home Safety
9. Notice of Privacy/Privacy Act Statement

ACKNOWLEDGEMENT OF PATIENTS TRANSFER AND DISCHARGE POLICY: The Agency will maintain a process for the ongoing assessment of each patient/client's continuing care and discharge planning needs. This is required to ensure that patient/client discharges are adequately planned to terminate services when the patient/client no longer has a need or desire for care, and to ensure that the patient/client's continuing care needs are met and that the patient/client participates in the discharge planning process. Patients/clients may be discharged for various reasons including the patient expires, the client/patient's condition improves and therefore the client/patient no longer needs the care provided, the physician discontinues the order for home care services, the patient moves out the Agency geographic service area or the client/patient refuses the care and requests discontinuation of services.

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CONFIDENTIALITY/HIPAA: It is our policy to protect all clinical records against loss, defacement, tampering and use by unauthorized person(s). All patient identifiable information in the clinical record, including OASIS data, remains confidential and is not released to the public. OASIS data will be electronically transmitted to the state. The patient's written consent shall be required for the release of medical information to persons not otherwise authorized by law (federal and state) to receive this information. Authorized persons who may review the clinical record include surveyors, physicians, Centers for Medicare and Medi-Cal Services (CMS), and external and internal auditing personnel.

RELEASE OF RECORDS: I understand the agency policy with regard to confidentiality and release of records prohibits access to my records by persons other than personnel involved in care. I therefore give written consent for release of medical records to health care providers in my treatment care.

NOTICE OF MEDICARE NON-COVERAGE OF CARE: When a question/concern arises regarding coverage or non-coverage of care whether it is a Medicare, Medi-Cal or other third-party payer or Executive Director/Administrator/Case Manager, the individual receiving the notification, whether by letter or telephone, will immediately inform the Director of Patient Care Services. 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. 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.

CONSENT FOR PHOTOGRAPHY: I consent for medical photographs to be made of me or my child (or person for whom I am legal guardian). I understand that the information may be used in my medical record, for the purpose of medical treatment. By consenting to these medical photographs I understand that I will not receive payment from any party. Refusal to consent to photograph will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future, I may contact Marie Star Home Health Services.

INFECTIOUS DISEASE SCREENING: It is our policy to screen all patients for infectious diseases prior to provision of care, and in accordance with Federal and Local regulations, in order to assure the safety of clients and their clinicians. Prevention and reduction of risks for infection or its potential is mandatory and will be conducted by all direct care clinicians prior to provision of care. I understand that refusal or failure to comply implies refusal of care and termination of services will proceed with care. Patients/Clients with reportable infections will be subject to initiation of infection control/mitigation, and will be reportable to the local health department in accordance with state law, if they have not been previously reported.

TELEPHONE/VIDEO VIRTUAL CHECK-INS In-person visits are the preferred mode of home visits for MARIE STAR HOME HEALTH SERVICES. TELEHEALTH/VIRTUAL CHECK-IN VISITS are TELEPHONE/VIDEO VIRTUAL CHECK-INS that are initiated and occur under unusual circumstances when a planned in-person home visit had already been scheduled.

MARIE STAR HOME HEALTH SERVICES Agency is not equipped to provide full scope telemedicine. Telehealth will be **limited to <u>TELEPHONE/VIDEO VIRTUAL CHECK-INS</u>** until the next available scheduled in-person visit. *If no in-person scheduled visit, it MUST be scheduled within 5 days of the TELEHEALTH/VIRTUAL CHECKS*

MARIE STAR HOME HEALTH SERVICES, LLC
PATIENT CONSENT

I have reviewed this consent for treatment and agreement which includes receipt of the following:

- ✓ Consent for treatment
- ✓ Acknowledgement of patient rights (Bill of Rights)
- ✓ HIPAA/NOTICE OF PRIVACY RIGHTS
- ✓ Patient information and advance directive information booklet
- ✓ Notice of Medicare Non-Coverage
- ✓ Acknowledgement of discharge and transfer policy
- ✓ Emergency Disaster Information
- ✓ Physician Orders for Life-Sustaining Treatment Form (POLST) (if applicable)
- ✓ Consent for photography (if applicable)
- ✓ Infectious Disease Screening
- ✓ Non-visit surveillance

✓ MY PATIENTS' RIGHTS HAVE BEEN VERBALLY EXPLAINED TO ME IN English LANGUAGE (If applicable)

PATIENT OR AUTHORIZED AGENT/REPRESENTATIVE SIGNATURE:

x Rita M. Jimenez 10/8/2022

RN Signature: Nicole Smith RN Date: 10/8/2022

CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT

Addendum

SERVICES	CHARGE PER VISIT
Skilled Nursing	$90-160
Physical Therapy	$90-160
Occupational Therapy	$90-160
Speech Therapy	$90-160
Medical Social Worker	$140
Home Health Aide	$45/HR
Personal Aide Services	$30/HR

PAYMENT SOURCES

1. Medicare
2. Medi-Cal
3. Third Party Payment
4. Private Payment

Fees for services provided to patients who are covered by insurance plans are billed directly by the Agency to the appropriate insurance company

*All patients are billed directly for services that are not reimbursed by insurance

X Aida M. Jimenez
Patient signature or representative

10/8/2022
Date

Clinician signature

10/8/2022
Date

MARIE STAR HOME HEALTH SERVICES

IDENTIFICATION OF PATIENT APPROVED REPRESENTATIVE AND PHYSICIAN INFORMATION

1) **INDICATE PERSON APPROVED TO RECEIVE INFORMATION REGARDING CARE AND MEDICAL INFORMATION:**

Jeff Jimenez **PHONE/CONTACT** 510-837-0517

2) **INDICATE PERSON APPROVED TO RECEIVE LEGAL INFORMATION OR PATIENT LEGAL REPRESENTATIVE (IF ANY)**

Jeff Jimenez **PHONE/CONTACT** 510-837-0517

3) **INDICATE PATIENT'S DIRECT PRIMARY CARE GIVER (IF DIFFERENT FROM #1, e.g IHSS worker, personal care assistant, etc)):**

Son Jeff E **PHONE/CONTACT**

4) **ALL PHYSICIANS PROVIDING CARE:**

a) **Name:** William Chen **Contact** office (510) 235-9247
2089 Vale Rd Suite 34 fax (510) 235-9248

b) **Name:** San Pablo, CA 94806 **Contact:**

Clinician acknowledgement

Kelly Smith RN

Date:

10/8/2022

EMERGENCY/DISASTER INFORMATION – HOME HEALTH PATIENTS

KEEP THIS PLAN WHERE IT CAN EASILY BE LOCATED.

General Instructions to Patient on Use of This Form:

This information is provided to you as a quick reference source in case any emergency occurs. Keep this document where it can easily be found. Inform other persons close to you (relative, neighbor, etc.) of its location.

1. Marie Star Home Health Services, LLC has a nurse on call 24 hours a day. You can reach the nurse through 925-891-4981. After office hours and on weekends and answering service will reach the nurse and he/she will return your call, come see the patient if necessary, or simply answer any questions you may have.
2. In case of a serious Medical emergency, call 911. Marie Star Home Health Services, LLC does not operate as an emergency service, therefore, valuable time may be lost by contacting The Agency for an emergency such as a diabetic coma, severe chest pain, unconsciousness, etc.

Name: Aida Jimenez | Date: 10-08-2022

Allergies: NKA | EDP Classification:

In case of Medical Emergency Dial 911

The Emergency Medical Service Dispatcher will need to know:

- Your Name: Aida Jimenez
- Your Telephone Number: 510-838-0517
- Your Address: 2517 Shamrock Dr San Pablo, CA 94806

List of My Current Medications | **List of My Supplies / DME**

See List | See List

Emergency contact information

In Case of Emergency Please Notify the Following Individual:

Name: Jeff Jimenez Phone: 510-837-0517 Relationship: Son

Disaster Plan Code

☐ Level 1 – Must be seen and/or evacuated ASAP. ☐ Level 2: Family responsible for care and evacuation of patient
☐ Level 3: Services can be postponed for 24-48 hours. ☒ Level 4: Services can be postponed for 72-96 hours

Emergency contact information

I Will:

- ☒ Stay Home
- ☐ Stay with Family or Friend — Name and Telephone #:
- ☐ Evacuate to a Shelter — Shelter's Name and Address:
  - ☐ Standard
  - ☐ Special Needs Registry
  - ☐ MMF
- ☐ Evacuate to hospital

Comments

Describe how services will continue in the event of an emergency:

Son primary caretaker Patient is Diabetes On insulin

Physician

Name: William Chen

Telephone Number: (510) 235-9247

Address: San Pablo, CA

Pharmacy Walgreen

Name:

Telephone Number:

Address:

MARIE STAR HOME HEALTH SERVICES, LLC
1950 WILLOW PASS RD
STE 306
CONCORD, CA 94520

MARIE STAR HOME HEALTH SERVICES

Notice of Medicare Non-Coverage

Patient name:
Patient number:

The Effective Date Coverage of Your Current Services Will End:

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current {insert type} 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: (877) 588-1123 (TOLL FREE; TDD (855) 887-6668 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

MARIE STAR HOME HEALTH SERVICES
(for information only)

Form CMS 10123-NOMNC

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