Focus Health
Consent and Financial Responsibility Form

Notice of Charges: The services will be provided to me as indicated below by Focus Health

Services	Benefit Covered	Payor	Expected Patient Financial Responsibility
☒ SN	☒ Yes ☐ No	Medicare	$ 0 / visit
☒ PT	☒ Yes ☐ No		$ 0 / visit
☒ OT	☒ Yes ☐ No		$ _____ / visit
☐ ST	☐ Yes ☐ No		$ _____ / visit
☒ MSW	☒ Yes ☐ No		$ _____ / visit
☒ HHA	☒ Yes ☐ No		$ _____ / visit

*financial information is an estimation from the information available to Focus Health and may change as more specific information becomes available fro the patient or payer(s).

Financial Responsibility: I understand that I am responsible to Focus Health for any/all charges not paid by a third party including any co-payment, agreements, coinsurances, lifetime maximums, or charges for non-covered services except where program requirements or contractual agreements hold me harmless. I further understand that I will be held liable for payment if I fail to notify Focus Health if I un-enroll from or become ineligible for coverage under my current payer(s). If Medicare is the primary payer, Focus Health will accept Medicare payment as 100% payment for home care for home care charges.

Equipment: I agree that any leased, loaned, or rented equipment by Focus Health for my treatment are to remain the property of Focus Health. I agree to use and maintain the equipment per the manufacturer's guidelines and as instructed by Focus Health personnel and to return the equipment in good condition upon completion of care or when I am no longer receiving services from Focus Health. I understand that I will be responsible for the replacement cost of this equipment should this equipment be lost or not returned to Focus Health.

☐ Please do not leave any of my medical information on my answering machine as there will be other people listening to the messages than myself.

This form must be signed by patient of Focus Health unless patient is unable to sign due to: patient is a minor, incompetent, or physically unable to sign.

I acknowledge that I have been given sufficient time and opportunity to review this entire document. By signing this I confirm that all my questions have been answered fully and to my satisfaction.

X _____ Pt. 5-7-11

Signature of Patient or Authorized Representative | Relationship | Date

Nelli Morgan _____ 5-7-11

Print Patient's Name | Signature of Witness | Date

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Consent for Treatment: I hereby authorize Focus Health to perform the treatments and care prescribed by my physician. I recognize and agree that I have the right to refuse treatment or terminate services at any time by notifying the Focus Health office. In addition, Focus Health may terminate services by notifying me of termination and the reason. Focus Health is not liable for acts of omission in following instructions of said physician. I understand that if I am in such condition as to need hospitalization or special services not provided by Focus Health such services must be arranged by me or my legal representative or my physician and Focus Health should in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that I am not provided with such additional care.

Assignment of Benefits: I hereby assign to Focus Health insurance coverage available to me and authorize payment directly to Focus Health for Medicare, Medi-cal, government program benefits, and other insurance benefits otherwise payable to me for services that are necessary for my health and personal safety. Further, I will cooperate with Focus Health to ensure that payment to Focus Health is obtained within the requirements of the law. If Focus Health accepts assignment for the insurance(s) or health plan, and payment is denied or only paid in part, I understand that I am responsible for payment on unpaid accounts.

Authorization to Release: I consent to the release of information and/or disclosure to Focus Health of all or any part of my medical record by any physician, hospital, insurance carrier, or other facility of which I have been a patient and accrediting bodies or other health care providers involved in my care including any successors of Focus Health.

Receipt of Information: I acknowledge that I have received and understand the following information:

- Patient Rights and Responsibilities
- Notice of Privacy of Medical Information Practices
- OASIS Privacy Notice
- Advance Directive Information
  - ☐ I do not have an Advance Directive and do not need any further information **OR**
  - ☒ I do not have an Advance Directive and DO need further information **OR**
  - ☐ I do have and Advance Directive; ☐ Copy obtained **OR** ☐ Copy requested
- Emergency Preparedness Information
- Procedure for After Hours Contact
- Procedure for patient comments, questions or complaints.

Molly Morgan
Patient Name

_____
Initials