Patient Name	Patient Number	Pharmacy Name
Ebel Ronald	19699	Walgreens Lodi

Pharmacy Address

Pharmacy Phone

Diagnosis: Hx PNA COPD Hypercholesterol NIDDM CABG x 4 Afib CAD, HTN Afib Emphysema, Asthma Dyspnea Cough H. Pylori Diverticulitis Constipation (L) LE Thrombophlebitis resolved 3.8 cm [illegible] Aneurysm

Allergies: NKDA

Physician Name: Dr. F. Buhari 464 7681

Physician Phone: Dr. I. Felahy 466 3457

*KEY: N = New in the Last 30 Days ; C = Changed in the Last 60 Days

*N or C	Initials	Date	Drug / Dose / Route / Frequency	Date Disc.	Comments
N	TF	1/23/13	Milk of Magnesia 30 ml Po Daily prn		Constipation
N	TF	1/23/13	Slomag ī tab Po 2x Daily x 7 days		supplement
N	TF	1/24/13	Lovastatin 40mg tab ī Po Bedtime		Cholesterol
N	TF	1/23/13	Amiodarone 200mg mg tab ī Po Daily		Rhythm BP.
N	TF	1/23/13	Aspirin 81 mg EC tab ī Po Daily		Stroke Prevention.
N	TF	1/23/13	Plavix 75mg tab ī Po Daily		Blood Thinner
N	TF	1/23/13	Benazepril 2.5 mg tab ī Po every 12 hrs.		Blood Pressure
N	TF	1/23/13	Coreg 3.125 mg tab. ī Po every 12 hrs.		Blood Pressure
N	TF	1/23/13	Xopenex HFA MDI 45mcg 2 puffs Inh		3x Daily COPD
N	TF	1/23/13	Spiriva 18mcg cap ī Inh per HandiHaler Daily		COPD
N	TF	1/23/13	Protonix 40mg cap ī Po Daily.		GI Acid Reducer
N	TF	1/23/13	Vicodin 5/500mg tab ī to ii Po Q4-6hrs. PRN		pain

Comments

Po = By Mouth PRN = as needed

Clinical Associate Completing Form

Signature Terry Fitter RN Title RN Date 1/24/13

Each signature below documents a complete medication review. This includes a review of all medications including changes/additions made during the episode. The medications have been reviewed for potential adverse effects and drugs reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and non-compliance with drug therapy.

Signature: Clinical Associate ______ Title ______ Date ______

Medication Update	Date	Initials	Signature	Title	Date	Initials	Signature	Title

White: Clinical Record
Yellow: Patient
Pink: Employee

Medication Profile

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GCL2079

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A photocopy of this authorization shall be as valid as the original.

Patient Name: Ebel, Ronald Patient # 179699 Location # 0588

Patient's Rights and Responsibilities

I have received, reviewed and understand my patient rights and responsibilities as provided to me by a Gentiva Health Services Representative.

Consent for Treatment

I consent to treatment from Gentiva Health Services consistent with my established plan of care. I confirm that I have been informed and have participated in planning the care and procedure (s) to be carried out by Gentiva Health Services and sign this consent willingly and voluntarily. I understand that this consent is valid from the date of the initial visit by Gentiva Health Services personnel and that I may withdraw my consent at any time by notice to Gentiva Health Services, and, if I do so, the services will not thereafter be provided. I understand that admission to and continuation of services are subject to Gentiva Health Services policies and procedures.

Notice of Services/Charges

Gentiva Health Services available from this provider include the following (check as appropriate):

- ☑ RN
- ☑ LPN/LVN
- ☑ Physical Therapy
- ☑ Medical Social Services
- ☐ Transportation
- ☐ Housekeeping (or Homemaker)
- ☑ Speech/Language Pathology
- ☐ Other
- ☐ Home Health Aide
- ☐ Nutritional Services
- ☑ Occupational Therapy
- ☐ Hospice Services

The services which Gentiva Health Services will provide for me are indicated below.

Services/Supplies	Expected Frequency & Duration	Payer	Expected Charge(s)	Expected* Patient Financial Responsibility**
Skilled nurse	[illegible]	Medicare	$ 0 per n/a	$ 0 per n/a
Physical Therapy	Declined	Medicare	$ 0 per Visit	$ 0 per Visit
HHAide	TBD	Medicare	$ 0 per Visit	$ 0 per Visit
			$ per	$ per
			$ per	$ per
			$ per	$ per

*or financially responsible party, if other than patient.

** financial information is the best information available at this time and may change as more specific information becomes available from the patient or payer(s).

I understand that I am responsible to Gentiva Health Services for any/all charges not paid by a third party including any co-payments, deductibles, coinsurance, lifetime maximums, or charges for non covered services except where program requirements or contractual agreements hold me harmless (for example, Home Health Services billed to Medicare)unless prohibited by law.

I further understand that I will be held liable for payment if I fail to notify Gentiva if I disenroll from or become ineligible for coverage under my current payer(s).

If this presents a financial hardship, or if you have any questions or concerns, please do not hesitate to call us.

Authorization for Payment/Assignment of Insurance Benefits

I certify that the information provided by me is correct. I authorize my insurance company (ies) including as appropriate Medicare, Medicaid, TriCare and other governmental programs to furnish any agent of Gentiva Health Services any and all information pertaining to my insurance benefits and status of claims submitted by Gentiva Health Services.

I, Ronald Ebel (PRINT NAME) the insured, authorize payment directly to Gentiva Health Services for Medicare, Medicaid or other government program benefits (as applicable) and other insurance benefits otherwise payable to me under Policy# Medicare.

In the event that my insurance carrier does not accept 'assignment of benefits', or any other payments are sent directly to me, I will hold them in trust for Gentiva Health Services for payment of my bill. I understand that I must promptly make payment for services by either personal check or by endorsing the insurance payment by writing " Pay to the order of Gentiva Health Services" and my signature.

Insured Signature ▶ Ronald Ebel ☒ **Self Insured** ☐ **Relationship to Patient** ____________

WHITE—CLINICAL RECORD
YELLOW—FINANCIAL FILE
PINK—PATIENT

HOME CARE CONSENT

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GCL1052 (4/08)

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Patient Name: Ebel, Ronald Patient # 19699 Location # 0555

Charges: This section ☐ **Does** ☒ **Does not apply in this case**

Holiday/Overtime

All charges for services rendered on holidays or rendered by the same individual, at my request, in excess of 40 hours during any work week will be one and one-half times the applicable weekday or weekend rate. In some states there are different wage and hour laws that may be applicable. Where state wages and hour law differs from federal law, state law (which provides for a richer benefit) shall be applicable. An example would be in the state of Arkansas, Nevada, and California, where charges for services rendered in excess of eight (8) hours in any workday (including holidays) will be paid at one and one half times the applicable rate.

Holidays are Thanksgiving Day, Christmas Day, New Year's Eve, New Year's Day, Fourth of July, Labor Day, Memorial Day and other local holidays as follows:

_____

All rates are subject to change with at least 2 weeks (or as required by applicable law) prior notice to me.

Mileage. Mileage ☐ will ☐ will not be billed at the rate of _____ per mile as recorded on employee time slips signed by the patient or patient's designee.

Deposit. I agree to pay simultaneously with the signing of the Agreement $_____ in the form of check number _____/ cash / credit card type_____ card number_____ Expiration date_____ a deposit for services to be rendered. This deposit will be applied to Gentiva Health Service's first invoice of service.

Unanticipated Service Interruption. I understand Gentiva Health Services uses reasonable efforts to provide uninterrupted services, however, sometimes interruptions in service are unavoidable including but not limited to inclement weather or other natural disasters. During such unanticipated interruption of essential services, I agree to provide or arrange for backup care, or I agree that Gentiva Health Services may assist in arranging for transfer to an appropriate emergency facility.

Time Documents. I agree and acknowledge that time slips record the services provided and constitute the basis of billing. I authorize _____ to sign time slips on my behalf.

Equipment. I agree that any leased, loaned or rented equipment received by me from Gentiva Health Services for my treatment remains the property of Gentiva Health Services. I agree to use and maintain the equipment as taught, and per the manufacturers guidelines and to return the equipment in good condition no later than ten days upon completion of therapy or when I am no longer receiving services from Gentiva. I understand that I will be responsible for the replacement cost of this equipment should this equipment be lost or not returned to Gentiva Health Services.

Hiring of Gentiva Health Services Employees. I understand that if I hire a Gentiva Health Services employee, I must give notice or pay a fee. I also understand I must give sixty (60) days notice prior to hiring the individual or pay 15% of the employee's annualized billing rate to Gentiva Health Services.

Termination. I understand I may terminate this Agreement by giving at least four (4) hours notice or as specified by regulation, whichever is greater. Additionally, Gentiva Health Services may terminate this Agreement by providing at least seventy-two (72) hours or such other minimum notice required by applicable state law, except for emergency terminations by either party for any reason. The obligations contained in sections/paragraphs related to the following shall survive such termination: Services/Charges, Authorization for Payment, Payment, Late Charges, and Overtime, Deposit, Hiring of Gentiva Health Services Employees, Equipment, and Authorization to Release Information.

Property Damages

In consideration for the health treatment being provided to me by Gentiva Health Services, I hereby release Gentiva Health Services, Inc., it subsidiaries and affiliates from any and all claims, demand, and causes of action involving any and all damages to my property except that caused solely by the negligence of Gentiva Health Services agents or employees acting within the scope of their employment.

Home Care Consent Addenda:

I have read, understand, and consent to services as described in the Home Care Consent Addendum (a) provided to me in conjunction with this Home Care Consent, as checked below:

- ☐ Patient Bill of Rights Addendum specific to the state of _____
- ☐ OASIS Statement of Patient Privacy Rights for Medicare/Medicaid patients (CMS form)
- ☐ Privacy Act Statement - Health Care Records
- ☐ OASIS Notice About Privacy for Patients Who Do Not Have Medicare/Medicaid Coverage (CMS form for non- Medicare/Medicaid patients whose services are subject to OASIS data collection through a Medicare certified/certifiable agency)
- ☐ Notice of Medicare Bundled Services
- ☐ Other State Notices (specify): _____
- ☐ Notice of Information and Privacy Practices

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A photocopy of this authorization shall be as valid as the original.

Patient Name: Ebel, Ronald Patient # 196919 Location # 0558

Advance Directives

I have received and reviewed Advance Directives information specific to the state of PA.
I certify that I have read and received a copy of the Patient Rights and Advance Directives information specific to my state of residence and that I am the patient, or I am acting in the patient's behalf, and accept their terms.

☐ I have prepared an Advance directive regarding my healthcare Specify: Full Code

☐ I have not prepared an Advance Directive regarding my health care.

Authorization to Release Information

I consent to the release of information and/or disclosure to Gentiva Health Services of all or any part of my medical record by any physician, hospital, or other facility of which I have been a patient (except when services provided by Gentiva are not health related services, e.g., housekeeper or homemaker services), checking of my credit and financial rating and history with any person, firm or credit bureau if I may have any self-pay responsibility; and release of information by Gentiva Health Services to individuals acting in official capacities as my advocate, representing governmental or third party payers, governmental agencies, accrediting bodies or other health care providers involved in my care including any successors of Gentiva Health Services.

I hereby authorize the staff of Gentiva Health Services to disclose information related to my care to the following persons upon request:

Name and Relationship: Tiffany Anderson D Name and Relationship

Name and Relationship: Mary Jo Parvin Wife Name and Relationship

Choice of Agency: Patient/Authorized Representative must select on of the following:

☐ I understand the services I will receive will be provided by an agency that DOES participate in the Medicare home health program and that services paid by Medicare (and some other payers) must be provided by this agency.

☐ I understand that the services I will receive will be provided by an agency that DOES NOT participate in the Medicare home health program and that any service I receive from this agency CANNOT be billed to Medicare now or at any time in the future. I am aware that a bill cannot be submitted to Medicare requesting a decision on coverage now or at any time in the future for services provided by the non-certified agency.

Signature: X Ronald Ebel Date: 11/24/13 Patient Name:

(Patient or Authorized Representative Signature) √ If ☐ **Power of Attorney** **(Applicable only if Authorized Representative signs for Patient)** **Relationship to Patient**

Gentiva Health Services Representative Print Name (as witness): Terry Fitzpatrick Signature Terry Fitzpatrick Date: 11/24/13

If patient did not sign, please state the reason including patient's understanding that representative is signing.

Financially Responsible Party if other than Patient

I understand and agree that as the financially responsible party I am responsible to Gentiva Health Services for any/all charges not paid for by this patient or third parties including, but not limited to, any co-payments, deductibles, coinsurance, or any amount which exceeds but is not limited to lifetime maximums or for any charges for non-covered services. I also consent to the release of information and/or disclosure to Gentiva Health Services for checking of my credit and financial rating through a credit bureau.

Printed Name Signature SS#

Party Accepting Responsibility for Payment

Address Phone # Relationship to Patient

Signing in the capacity of: ☐ Parent ☐ Court appointed legal guardianship ☐ Health Care Proxy
☐ Other *** A copy of proof to be provided and attached to form if available(except for Parent capacity)**

For Translations:

☐ This document was translated to patient/authorized representative into prior to signature. (Language/Sign Language)

☐ This document was read to the patient verbatim/provided on an audio cassette and questions, if any were answered prior to signature.

Translated By (Signature/Title): Date:

Note: this document shall not be valid if altered in any way.

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