HealthQuest Infusion & Specialty

**HealthQuest Infusion & Specialty**
1311 W Sam Houston Pkwy N, Ste 100
Houston, TX 77043

# ADMISSION AGREEMENT

| | |
|---|---|
| Patient Name ______________________ | Responsible Party ______________________ |
| Patient Address ______________________ | Responsible Party Address ______________________ |
| City ____________ State ________ Zip ________ | City ____________ State ________ Zip ________ |
| Birthdate ____________ SS# ____________ | Birthdate ____________ SS# ____________ |

**EACH PATIENT HAS THE RIGHT TO:**

. Be treated with dignity and respect without regard to race, color, creed, sex, age, national or ethnic origin, diagnosis, or source of payment.
. Considerate and respectful care, and have cultural, psychological, spiritual, and personal values, beliefs, and preferences respected.
. Be provided with information regarding ownership, available services, and charges.
. Be informed about his/her illness and treatment, when and how services will be provided, the name and function of any person and agency providing care and service, and the name of person responsible for coordination of care including HealthQuest staff and physicians.
. Be informed concerning advance directives and implementation of your directive to the extent it is known, and within state laws and HealthQuest policies.
. Make informed decisions about his/her care and actively participate in the planning of care.
. Be instructed in his/her care and therapy in order to reach the highest level of self care and wellness.
. Continuity of care and service provided by personnel who are qualified through education and experience to perform the service for which they are responsible.
. Participate in experimental or investigational treatment or research with voluntary, informed consent documented.
. Information regarding your health status, and information regarding continuing care after discharge from our services.
. Voice complaints and grievances, and be informed of procedure for registering complaints without reprisal, coercion, discrimination, or unreasonable interruption of services.
. Receive prompt response to all reasonable interruption of services.
. Appropriate assessment and management of pain if required.
. Access, request amendment to, and receive an accounting of disclosures regarding own health information as permitted under applicable law.
. Assistance in arranging for consultation with a medical specialist at your expense if requested.
. Access to an interpreter or other communication device if needed.
. Access to your medical record within a reasonable time frame.
. To receive an itemized bill if requested.
. Personal privacy subject to the HealthQuest ability to provide adequate medical care.
. Confidential treatment of your medical records and other medical information, unless otherwise required by law, unless you consent to the release of this information, or unless the disclosure is required to provide continuity of care for you.
. Refuse treatment, within the confines of the law, after being fully informed of and understanding the consequences of such action.
. Confidentiality and privacy in treatment and care, including confidential treatment of patient records, and to refuse their release to any individual outside, except in the case of transfer to another health facility or as required by law or third-party contract.

**PATIENT IS RESPONSIBLE:**

. For providing accurate and complete information regarding his/her medical history.
. For agreeing to a schedule of services and reporting any cancellation of scheduled appointments and/or refusal of treatment.
. For participating in the development and updating of a plan of care.
. For communicating whether he/she clearly understands the course of treatment and plan of care.
. For following the plan of care and clinical condition as well as instructions from the health care personnel, and HealthQuest rules and procedures.
. For reporting problems, unexpected changes in physical condition, re-hospitalizations, concerns, complaints, or if your pain is not being controlled.
. For accepting responsibility for his/her actions if refusing treatment.
. For fulfilling financial obligations for services. $______________ approximate patient payment responsibility.
Insurance company/provider: ________________________________________.
. For respecting the rights of home care givers, including the property of others, and being considerate and respectful of HealthQuest personnel.

**STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER**

"I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services or its intermediary any information needed for this or a related Medicare claim. I request that payment or authorized benefits be made on my behalf. I assign the benefits payable for covered Medicare services to 'Supplier' as provider furnishing services."

**AGREEMENT TO PAY**

As 'Supplier' has agreed to supply patient with any supplies and services ordered by patient or on behalf of patient, the undersigned patient or responsible party agree that each of them is responsible for payment for all such supplies and services provided patient.

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### RELEASE OF INFORMATION

The undersigned hereby authorize our insurer(s) and any other third party payor who provides patient with coverage to disclose to 'Supplier' any information regarding such coverage, including but not limited to 1) payments made by such insurer(s) or third party payor(s) to any of us, for home therapy rendered to patient by 'Supplier' and 2) the scope and extent of coverage available from time to time. Patient authorizes all medical personnel to provide information to 'Supplier' concerning patient/client medical history, as it may relate to patient/client therapy. The undersigned consents to the review of patient/client records including medical records by any Federal, State, or Accrediting Body or Agency as required by the Regulatory, Licensing, or Accrediting body.

### CONSENT TO HOME THERAPY

I have been advised of and understand the benefits and risks of home therapy. I further understand that any complications, injuries, or adverse results, cannot be given the immediate emergency medical attention in the home as in the hospital setting. I also understand that in any drug therapy there are risks that are known as well as unknown. I have discussed these matters with my physician and have indicated my willingness to undergo home therapy. I hereby consent to receive the home care services provided by "Supplier."

## CLIENT/PATIENT DOCUMENT ACKNOWLEDGMENT

**I acknowledge receipt of the following standard client/patient documents:**

- ☑ Basic Home Safety
- ☑ Emergency Preparedness
- ☑ Bill of Rights & Responsibilities
- ☑ Infection Control
- ☑ Description of Services
- ☑ Billing & Collection Policies
- ☑ Information on Advanced Directives
- ☑ Capped Rental Fact Sheet, if applicable
- ☑ Warranty Information, if applicable
- ☑ Satisfaction Survey
- ☑ Supplier Standards, if applicable
- ☑ Grievance/complaint procedure
- ☑ HIPPA Privacy Notice
- ☑ Verbal/written review of the Plan of Service/Care

## EDUCATION

**I acknowledge receipt of the following therapy specific patient documents consisting of education, storage, and disposal:**

- ☐ Ambulatory Infusion Pump Packet
- ☐ Equipment Manuals/Warranty info
- ☐ Other: ______________________
- ☐ Stationary Infusion Pump Packet
- ☐ Syringe Pump Packet
- ☐ Elastomeric Instruction
- ☐ Enteral Pump Packet
- ☐ IV Push Packet
- ☐ Rate Flows

**DISCLAIMER:** Failure to notify HealthQuest Infusion & Specialty of your insurance changing prior to its effective date may cause you, the patient, to be responsible for 100% of the cost of your therapy.

The undersigned certifies that he/she has read the foregoing and received a copy, as well as a copy of the Patient Rights and Responsibilities documented above and the CMS Medicare DMEPOS Supplier Standards. The undersigned also certifies that he/she is the patient, or is duly authorized by the patient as patient's general agent to execute and accept its terms.

**NOTE**: *A duplicate copy of this Agreement and Consent shall be considered as an original.*

| ______________________ | __________ | ______________________ | __________ |
|---|---|---|---|
| **Patient's Signature** | **Date** | **Or, Responsible Party's Signature** | **Date** |

If this form is not signed by patient, please explain below:

☐ Medical Power of Attorney

☐ Patient is a minor—if minor, state relationship: ______________________

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# HIPAA PRIVACY AUTHORIZATION FORM

## AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, ______________________________ authorize HealthQuest to use and disclose the protected health information described below to the following individuals:

1. ______________________________ (Name) (Relationship)
2. ______________________________ (Name) (Relationship)
3. ______________________________ (Name) (Relationship)
4. ______________________________ (Name) (Relationship)

**This authorization for release of information covers the period of healthcare from:**

a. ☐ all past, present, and future periods.

**OR**

b. ☐ Only while on service with HealthQuest Infusion Services.

*****EXTENT OF AUTHORIZATION*****

a. ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

**OR**

b. ☐ I authorize the release of my complete health record with the exception of the following information:

☐ *Mental health records* ☐ *Communicable diseases (including HIV and AIDS)* ☐ *Alcohol/drug abuse*
☐ *Other (please specify):* ______________________________

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing, or claims payment, or other purposes as I may direct. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient, and may no longer be protected by federal or state law.

______________________________
Signature of patient or personal representative

______________________________
Printed name of patient or personal representative, and his or her relationship to patient

______________________________
Date