HealthQuest Infusion & Specialty

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

PATIENT AUTHORIZATION, ASSIGNMENT, AND 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, 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 HealthQuest's ability to provide adequate medical care.
. Confidential treatment of your medical records and other medical information, unless otherwise required by law, you consent to the release of this information, or 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, and promptly informing HealthQuest of any changes to insurance. $____________ 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.

ASSIGNMENT OF INSURANCE BENEFITS

I assign to HealthQuest all rights, benefits and payments to which I am entitled under any insurance for items and services furnished to me by HealthQuest. I authorize HealthQuest to inquire about, submit and appeal claims to my insurance for products and services received from HealthQuest. I direct any payer to make payment on my behalf directly to HealthQuest for any medical products or services provided by HealthQuest. If my insurance prohibits direct payment to HealthQuest, I direct my insurance (or its administrator) to provide documentation of such prohibition to myself and HealthQuest upon request. If I receive payment directly, I agree to immediately notify, sign over, and send directly to HealthQuest any funds that I receive from my insurance related to the products or services provided by HealthQuest.

I hereby certify that the insurance information that I have provided to HealthQuest is true and accurate as of the date of service and that I am responsible for keeping it updated at all times. I will promptly notify HealthQuest of any changes to my insurance. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I understand that all costs not covered by my insurance, as determined by HealthQuest or my insurer, are my responsibility. I accept responsibility for any co-payment, co-insurance, deductible and remaining balance due.

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APPOINTMENT OF REPRESENTATIVE AND JUDICIAL REVIEW

I hereby appoint HealthQuest (or its agent) as my duly authorized representative and assignee for any administrative, appeal, review or legal process necessary to submit and collect on claims for products and services received from HealthQuest. I hereby authorize HealthQuest to take all necessary actions to resolve disputes regarding such claims, including the filing of all necessary appeals and complaints with the proper authorities and the use and disclosure of all information related to such claims. If my claim for benefits is administratively denied in whole or in part, I hereby assign HealthQuest all legal or administrative claims or causes of action, for judicial review, arbitration or appeal of the denied claim.

AGREEMENT TO PAY

. I understand that by signing this form, I am accepting full and complete financial responsibility for payment of all charges for the products and services provided by HealthQuest

RELEASE OF INFORMATION

I agree and understand that HealthQuest may release my health information for payment purposes, for the purpose of medical audits and review, and for any other purpose permitted by law. Further, HealthQuest may release my information to other providers for my continued care. I acknowledge that my past or present healthcare providers, suppliers, and insurers may release my health information to HealthQuest for the purpose of my treatment or for HealthQuest's payment or health care operations. This information may include but is not limited to: benefit coverage and amounts, types of service, dates/times of service, medical history, diagnosis, treatment plans, progress of therapy, and treatment notes or summaries.

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 HealthQuest.

CLIENT/PATIENT DOCUMENT ACKNOWLEDGMENT

By my signature below, I certify that I have read and received a copy of the following 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
- ☑ DMEPOS Supplier Standards
- ☑ Grievance/complaint procedure
- ☑ HIPAA Notice of Privacy Practices
- ☑ 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

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CONTACT INFORMATION		Check Preferred Method (s) of Contact	May we leave a detailed message?
HOME			☐ Yes ☐ No
CELL			☐ Yes ☐ No
WORK			☐ Yes ☐ No
EMAIL**			☐ Yes ☐ No

** **EMAIL.** By providing an email address above, you request that HealthQuest communicate with you about your medical information via unsecured email. Email communication is not secured and can be intercepted or read by others. You do not have to receive your medical information via email and can opt-out at any time by contacting HealthQuest.

TEXT MESSAGES
[ ] Yes [ ] No By checking "Yes", I request that HealthQuest communicate my protected health information with me via unsecured text/SMS messages. I understand text messages are not secured and can be intercepted or read by others. I am not required to receive protected health information via text messages and can opt-out at any time by contacting HealthQuest.

ALTERNATE / EMERGENCY CONTACTS: I authorize HealthQuest to disclose my protected health information to the following individual(s) as my personal representatives:		
NAME	RELATIONSHIP	PHONE NUMBER

NOTICE: Failure to notify HealthQuest 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. *A duplicate copy of this signed Agreement 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 (Please provide copy to HealthQuest).

☐ 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)

3. ______________________________
(Name) (Relationship)

2. ______________________________
(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