AUTHORIZATION/AGREEMENT FOR SERVICES

Patient Name: _____

RIGHTS AND RESPONSIBILITIES

My signature below acknowledges that I have received the statement of rights and responsibilities and it has been explained to me.

AUTHORIZATION FOR TREATMENT

I authorize the D&P Healthcare Staffing Agency to provide home health treatment as ordered by my physician. I understand that I have the right to make decisions concerning my medical care, including the right to accept or refuse home health care services from the agency and any recommended changes to the care plan. I understand that I am consenting to assistance by a non-licensed individual with treatments of a routine nature, or with the self-administration of medications

ASSIGNMENT OF BENEFITS/GUARANTY

I authorize payment directly to the D&P Healthcare Staffing Agency of any benefits otherwise payable in respect to examination or treatment of patient. I agree to pay any charges not covered by insurance benefit plans, excluding Medicare and Medicaid recipients and where payment is prohibited by law.

Insurance pays for _____ %. Patient pays for _____ or $ _____ per visit.

RELEASE OF INFORMATION

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act, or under a policy of insurance is correct. I authorize the D&P Healthcare Staffing Agency or any other holder of medical or other information about the above-named patient, to release or receive such information to any government agency or insurance company to whom application has been made for payment for services rendered to the above patient; to any physicians, hospitals, other healthcare providers or facilities, institutions, or agencies providing treatment to the patient or providing continuity of care; and to quality reviewers.

EMERGENCY PLAN

My signature below acknowledges that I have established and understand my emergency plan.

I have received D&P Healthcare Staffing Agency' brochure; I have been informed of the nature and frequency of visits I will receive; and I have participated in the planning of my care.

Indicate frequency of visit range under each projected discipline:

SN	HHA
_____	_____

INFECTION CONTROL

In the event that an employee or other representative of D&P Healthcare Staffing Agency sustains percutaneous, mucous membrane, or open wound exposure to my blood or other body fluids, I agree to have my blood tested for HIV or Hepatitis infection, and I agree that the results of the tests may be released to D&P Healthcare Staffing Agency and the exposed person, but not to anyone else unless required or authorized by law.

_____ _____

Signature of Patient or Responsible Person Date