ENCARE

P O BOX 653133

MIAMI, FLORIDA 33165

(800) 418 6761

CONSENT FORM FOR ADMISSION AND TREATMENT

I, _____RESIDING AT _____

EREBY REQUEST AND AUTHORIZE EN-CARE INC. (THE “AGENCY”), ITS AGENCIES AND EMPLOYEES TO COME INTO MY HOME TO RENDER SUCH STARTING CARE & OTHER PROFESSIONAL SERVICES AS IS CONSIDERED THERAPEUTICIALLY NECESSARY AND TO RENDER TREATMENT IN ACCORDANCE WITH THE PRESCRIPTION & INSTRUCTIONS BUT NOT LIMITED TO THE ADMINISTRATION OF MEDICINES TO_____ MYSELF OR BY _____MY_____

I HERE CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE REQUEST AND AUTHORIZATION FOR CARE AND TREATMENT. I CONSENT TO SUCH NURSING CARE AND OTHER PROFESSIONAL SERVICES AND TREATMENT TO SUCH CHANGES IN CARE ARE CONSIDERED THERAPEUTICALLY NECESSARY AND SO SUCH CHANGES OR TREATMENT AS PHYSICIAN MAY DIRECT. I ALSO CERTIFY THAT NO GUARANTEE OR ASSURANCE HAVE BEEN MADE BY EN-CARE INC.. ITS AGENTS OR EMPLOYEES AS TO THE RESULTS BE OBTAINED.

I AUTHORIZE EN-CARE INC. ITS AGENTS AND EMPLOYEES TO INSPECT AND COPY ALL MEDICAL, HOSPITAL, OR X RAY RECORDS PERTAINING TO ME FOR THE PURPOSE OF RENDERING THE ABOVE DESCRIBE NURSING CARE, OTHER PROFESSIONAL SERVICES AND TREATMENT

I HEREBY AUTHORIZE THE ASSIGNMENT OF PAYMENTS TO EN-CARE INC. OF BENEFITS FOR ALL HOME HEALTH SERVICES AS PRESCRIBED BY THE PHYSICIAN AND AS PROVIDED UNDER THE TERMS OF MY INSURANCE POLICY. I CERTIFY THAT THE FINANCIAL AND INSURANCE INFORMATION SUPPLIED BY ME IS CORRECT. I AUTHORIZE THE RELEASE OF ALL RECORDS REQUIRED TO ACT ON THIS REPORT.

I UNDERSTAND THAT MY HEALTH INSURANCE MAY NOT COVER OR MAY NOT PARTIALLY COVER SERVICES PROVIDED TO ME BY EN-CARE INC. WILL BILL ME FOR ANY BALANCE NOT COVERED BY INSURANCE. I AGREE TO COMPLETE A FINANCIAL INFORMATION FORM TO DETERMINE IF I AM ELIGIBLE FOR CARE AT A REDUCED RATE OR FREE OF CHARGE. IN THE EVENT THAT THE INSURANCE COMPANY PAYS ME DIRECTLY, OR MYESTATE, WILL BE FULLY RESPONSIBLE FOR RESULTING FOR REIMBURSING TO EN-CARE INC.

I HEREBY ACKNOWLEDGE RECEIPT OF THE PATIENTS ADMISSION PACKET INCLUDING:

1.EN-CARE INC BROCHURE
2.PATIENTS BILL OF RIGHTS AND RESPONSIBLITIES
3.ADVANCE DIRECTIVE
4.HEALTH CARE PROXY
5.DISPOSAL OF HOUSEHOLD WASTE SHEET

I ACKNOWLEGE THAT I HAVE RECEIVED COPIES OF THE NEW YORK STATE DEPARTMENT OF HEALTH PAMPHLETS PLANNING IN ADVANCE FOR YOUR MEDICAL TREATMENT, AND APPOINTING YOUR HEALTH CARE AGENTS NEW YORK STATE’S PROXY LAW.

PATIENT SIGNATURE _____ DATE_____

PERSON AUTHORIZED TO CONSENT FOR PATIENT_____

RELATIONSHIP TO PATIENT_____

EXPLANATION WHY PATIENT CANNOT SIGN CONSENT_____