SKILLED CARE, INC.
PATIENT SERVICE AGREEMENT

PATIENT: _____ MR# _____

CONSENT TO TREAT	I HEREBY AUTHORIZE AGENCY TO PERFORM **ANY SERVICES/TREATMENTS** PRESCRIBED BY MY PHYSICIAN , OR BY ANY OTHER PHYSICAN WHO MAY BE TREATING ME, INCLUDING ALL DIAGNOSTIC AND THERAPEUTIC TREATMENTS THAT MAY BE CONSIDERED ADVISABLE OR NECESSARY IN THE JUDGEMENT OF THE PHYSICIAN.
EMERGENCY MEDICAL SERVICES/TRANSFER	I UNDERSTAND THAT DURING THE COURSE OF MY THERAPY THE NEED FOR EMERGENCY TREATMENT AND/OR TRANSFER TO A HOSPITAL MAY BECOME NECESSARY AND APPROPRIATE I UNDERSTAND THAT THE AGENCY DOES NOT PROVIDE EMERGENCY MEDICAL CARE AND THEREFORE SHOULD THE NEED FOR SUCH TREATMENT AND/OR TRANSFER BE DEEMED NECESSARY AND APPROPRIATE BY MY PHYSICIAN AGENCY STAFF WILL CALL 911. I CONSENT TO SUCH EMERGENCY TREATMENT AND/OR TRANSFER TO A HOSPITAL AND I HEREBY INDEMNIFY THE AGENCY AND ITS OWNERS, STAFF AND PHYSICIAN WHO MAY BE IN ATTENDANCE FROM ANY LOSS RESULTING FROM SUCH EMERGENCY TREATMENT AND/OR TRANSFER. I AGREE TO ASSUME SOLE RESPONSIBILITY FOR ALL CHARGES INCURRED FOR SUCH TREATMENT.
RELEASE OF INFORMATION	I AUTHORIZE ALL PHYSICIANS, HOSPITALS, NURSING HOMES, CLINICS AND OTHER HEALTH CARE PROVIDERS TO RELEASE MEDICAL INFORMATION RELEVANT TO MY CARE TO THE AGENCY. I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION FROM MY RECORDS TO ANY LICENSED INSTITUTIONS, CASE MANAGEMENT, ACCREDITATION AND REGULATORY BODIES AND OTHER HEALTH PROVIDERS FOR THE PURPOSE OF PROVIDING CONTINUITY OF CARE. I PLACE NO LIMITATIONS ON HISTORY OF ILLNESS OR DIAGNOSTIC/THERAPEUTIC, INFORMATION INCLUDNG ANY TREATMENT FOR SUBSTANCE ABUSE, PSYCHIATRIC DISORDERS, ACQUIRED IMMUNE DEFICIENCY SYNDROME.
INSURANCE BENEFITS	I HEREBY AUTHORIZE MY PRIVATE INSURANCE CARRIER TO PAY INSURANCE BENEFITS DUE TO ME DIRECTLY TO THE AGENCY AND AGREE TO THE RELEASE OF MEDICAL INFORMATION TO MY INSURANCE CARRIER. IF I SHOULD BE REQUIRED BY THE CARRIER. I ALSO AGREE TO BE PERSONALLY RESPONSIBLE FOR MY DEDUCTIONS, CO-INSURNACE, OR DISALLOWANCE OF PAYMENTS.
ASSIGNMENT OF BENEFITS	I HEREBY AUTHORIZE THE AGENCY TO BILL MEDICARE, MEDICAID, OR HMO FOR ANY SERVICES PROVIDED BY THE AGENCY AND AUTHORIZE MEDICARE, OR HMO TO MAKE DIRECT PAYMENT TO THE AGENCY FOR SAID SERVICES. I UNDERSTAND THAT I AM LIABLE FOR PAYMENT FOR ANY SERVICES NOT COVERED BY MEDICARE, AND/OR HMO.
STATEMENT OF PATIENT RIGHTS AND RESPONSIBILITY AND ABUSE REGISTERY	I CERTIFY THAT I HAVE READ, UNDERSTAND AND RECEIVED A COPY OF THE STATEMENT OF PATIENTS RIGHTS AND RESPONSIBILITY WHICH HAS BEEN EXPLAINED TO ME ORALLY BY A REPRESENTATIVE OF THE AGENCY. I UNDERSTAND THE POLICYAND HAVE RECEIVED A COPY WITH THE TOLL FREE ABUSE REGISTRY PHONE NUMBER
ONE AGENCY ONLY TO PROVIDE SERVICES	I HAVE VOLUNTARILY CHOSEN SKILLED CARE, INC. AS MY SOLE PROVIDER FOR MY HOME CARE SERVICES. I AM AWARE THAT MEDICARE WILL ONLY PAY FOR SERVICES TO ONE AGENCY DURING ANY PERIOD OF TIME. I WILL NOT ENTER INTO ANY AGREEMENT FOR SERVICES WITH ANY OTHER HOME CARE PROVIDER WHILE RECEIVING SERVICES BY SKILLED CARE, INC., I WILL NOTIFY SKILLED CARE, INC. IF I CHOOSE TO TRANSFER TO ANOTHER PROVIDER. FAILURE TO DO SO MAY RESULT IN MY BEING RESPONSIBLE FOR ANY CHARGES DENIED BY MY INSURER AND TO THE AGENCY DUE TO THE FACT THAT ANOTHER AGENCY WAS PROVIDING HOME CARE SERVICES SIMUTANEOUSLY.

AGENCY REPRESENTATIVE INITIALS _____

PATIENT/REPRESENTATIVE INITIALS _____

PATIENT: _____ MR# _____

ADVANCED DIRECTIVES AND LIVING WILLS

I HAVE RECEIVED WRITTEN INFORMATION REGARDING MY RIGHTS TO MAKE DECISIONS CONCERNING MEDICAL CARE, INCLUDING THE RIGHT TO ACCEPT OR REFUSE MEDICAL TREATMENT AND THE RIGHT TO FORMULATE ADVANCED DIRECTIVES UNDER STATE LAW.

I HAVE A LIVING WILL: YES _____ NO _____

IF YES, LOCATION OF LIVING WILL: _____

I HAVE A " PATIENT ADVOCATE/PROXY": YES _____ NO _____

MY PATIENT ADVOCATE/PROXY IS:

NAME: _____

ADDRESS: _____

_____

CITY, STATE, ZIP: _____

PHONE: (_____) _____

CERTIFICATION REGARDING HMO MEMBERSHIP

I HEREBY DECLARE THAT AT THE PRESENT TIME I DO NOT BELONG TO AN HMO; I WILL NOTIFY AGENCY IMMEDIATELY SHOULD I CHOOSE TO ENROLL IN AN HMO IN THE FUTURE. I AGREE TO PAY FOR ALL SERVICES RENDERED TO ME BY AGENCY SHOULD I FAIL TO NOTIFY AGENCY OF MY ENROLLMENT.

CONSENT FOR OASIS

I UNDERSTAND THAT THE AGENCY IS REQUIRED TO COLLECT HEALTH CARE DATA ON ALL PATIENTS ADMITTED FOR SERVICES AND THAT THIS DATA IS THEN TRANSMITTED TO THE AGENCY FOR HEALTH CARE ADMINISTRATION (AHCA) AND THEN TO HEALTH CARE FINANCING ADMINISTRATION (HCFA). AGENCY PERSONNEL HAVE DISCUSSED THE OASIS INFORMATION FORMS AND ANSWERED ALL OF MY QUESTIONS. I AUTHORIZE THE AGENCY TO RELEASE TO HCFA OR ITS AGENTS ANY/ALL INFORMATION INCLUDED IN THE OASIS FORM. I PERMIT A COPY OF THE AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. I HAVE BEEN ASSURED THAT ALL INFORMATION WILL BE KEPT IN THE STRICTEST CONFIDENCE.

PHOTOGRAPHY PERMISSION

I UNDERSTAND AND AUTHORIZE PHOTOGRAPHS OF MYSELF TO BE TAKEN AND KEPT ON FILE AT THE AGENCY. THESE PHOTOGRAPHS WILL BE USED AS DEEMED APPROPRIATE BY THE AGENCY.

NOTICE OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE AGENCY'S NOTICE OF PRIVACY PRACTICES.

OR

ACKNOWLEDGEMENT NOT SIGNED BECAUSE:

_____

STATEMENT OF PATIENT RIGHTS AND RESPONSIBILITY AND ABUSE REGISTERY

I CERTIFY THAT I HAVE READ, UNDERSTAND AND RECEIVED A COPY OF THE STATEMENT OF PATIENTS RIGHTS AND RESPONSIBILITY WHICH HAS BEEN EXPLAINED TO ME ORALLY BY A REPRESENTATIVE OF THE AGENCY. I UNDERSTAND THE POLICYAND HAVE RECEIVED A COPY WITH THE TOLL FREE ABUSE REGISTRY PHONE NUMBER.

AUTHORITY TO SIGN ON BEHALF OF PATIENT

PATIENT IS UNABLE TO SIGN DOCUMENTS BECAUSE:

_____

NAME OF PERSON AUTHORIZED TO SIGN/: _____

_____ GUARDIANSHIP (ATTACH COPY OF ORDER)

_____ OTHER: (SPECIFY AUTHORITY EMPOWERING SIGNATURE)

AGENCY REPRESENTATIVE INITIALS _____

PATIENT/REPRESENTATIVE INITIALS _____

PATIENT: _____ MR# _____

NOTICE OF SERVICES

AGENCY WILLPROVIDE THE FOLLOWING SERVICES:

_____ SKILLED NURSING FREQUENCY _____
_____ AIDE/CNA FREQUENCY _____
_____ PHYSICAL THERAPY FREQUENCY _____
_____ OCCUPATIONAL THERAPY FREQUENCY _____
_____ SPEECH THERAPY FREQUENCY _____
_____ SOCIAL WORKER FREQUENCY _____
_____ OTHER _____

NOTICE OF CHARGES

_____ MEDICARE IS PAYER, NO CHARGES EXPECTED
_____ MEDICAID PROGRAM, RESPONSIBLE FOR $2.00 CO-PAY/VISIT WITH MAXIMUN OF ONE CO-PAY PER DAY
_____OTHER INSURER AS PER YOUR CONTRACT WITH PAYER; YOU ARE RESPONSIBLE FOR ANY CO-PAY, DEDUCTIBLE AS STIPULATED BY POLICY AS WELL AS FOR ANY NON-COVERED SERVICES
_____PRIVATE PAY: YOU ARE RESPONSIBLE FOR ALL SERVICES AND CHARGES.

METHODOF PAYMENT: _____

_____ CASH _____ CHECK _____ CREDIT CARD

CREDIT CARD NUMBER:_____ EXP DATE:_____

Patient/Responsible party authorizes agency to verify availability of credit card funds prior to start of services, and to bill all services to this account. Should the amount of funds be exhausted, Patient/responsible party is responsible for any outstanding charges and expenses incurred by Agency in attempting to collect this debt.

AGENCY RATES

NURSING: VISIT RN: $125.00 VISIT LPN: $125.00 AIDE: $125.00 PER VISIT
PHYSICAL THERAPY: $125.00 VISIT OCCUPATIONAL THERAPY : $125.00 VISIT
SPEECH THERAPY: $125.00 VISIT SOCIAL WORKER: $125.00 VISIT
OTHER: _____
PLEASE CALL AGENCY ADMIISTRATOR WITH ANY QUESTIONS YOU MAY HAVE REGARDING OUR SERVICES/RATES.

COMMUNICATION AIDS

SHOULD I REQUIRE THE ASSISTANCE OF AN INTERPRETER OR OTHER COMMUNICATION AID, THESE WILL BE PROVIDED FREE OF CHARGE BY SKILLED CARE, INC..

VERIFICATION OF IDENTITY:

Patient identity was confirmed by government issues photo ID::
_____ Drivers License _____ Passport _____ State issued picture ID
No photo ID available, supervisor notified, patient identity confirmed by: (choose 2)
_____ Social Security Card _____ Credit Card with Photo _____
_____ Third Party w/photo ID: Name: _____
Relationship to patient: _____
Other (specify): _____

PATIENT HANDBOOK

I HAVE RECEIVED THE PATIENT HANDBOOK FOR THE AGENCY, INCLUDING THE MEDICARE FRAUD STATEMENT AND IT HAS BEEN VERBALLY EXPLAINED TO ME BY A REPRESENTATIVE OF THE AGENCY. ALL OF MY QUESTIONS/CONCERNS HAVE BEEN ADDRESSED TO MY TOTAL SATISFACTION.

BY MY SIGNATURE, I ATTEST THAT I HAVE READ AND HAVE RECEIVED A COPY OF THE PATIENTS SERVICE AGREEMENT AND I HAVE HAD ALL QUESTIONS AND CONCERNS ADDRESSED TO MY COMPLETE SAISFACTION. I AM FULLY AWARE THAT I MAY CONTACT THE AGENCY SHOULD ANY QUESTIONS/CONCERNS ARISE WHILE I AM A PATIENT.

_____ _____
SIGNATURE OF PATIENT/AUTHORIZED REPRESENTATIVE — DATE

_____ _____
AGENCY REPRESENTATIVE SIGNATURE.TITLE — DATE