matrix
www.matrixhomecare.com

# Consent Form

PATIENT/CLIENT NAME:_____ DATE: _____

**Consent to receive services**

I hereby authorize a home care professional employed or contracted by Matrix Home Care to render appropriate home care services to the patient/client named above. I understand that a home care professional with an appropriate level of skill and experience will provide such care. I recognize and agree that I have the right to refuse treatment, terminate services, or request a different home care professional at any time by notifying the Matrix Home Care office. In addition, Matrix Home Care may terminate service by notifying me of termination and the reason.

**Authorization for emergency medical services**

At any time while receiving services from a home care professional employed or contracted by Matrix Home Care, and in the event of any medical emergency, I authorize Matrix Home Care or its employees/contractors to provide or obtain such medical treatment as they deem advisable under the circumstances, and I agree to assume sole responsibility for all charges for such treatment.

**Release of medical records**

I hereby consent and request that copies, if necessary, of my prior medical records be delivered to Matrix Home Care to establish or continue my home care plan.

I hereby authorize Matrix Home Care to release copies of my medical records or reports or such portions or summaries thereof as may be relevant, as permitted by HIPAA and as subject to HIPAA's minimum necessary standards, to other health care providers or regulatory or accrediting bodies for the purpose of continuing and coordinating my home care plan and for quality assurance, survey and accreditation purposes.

I acknowledge that I can revoke this authorization over time as permitted by HIPAA.

**Vehicle Release**

I understand and agree that it is my responsibility to maintain automobile liability insurance at the minimum level established by the state covering my automobile and authorized drivers, including Matrix Home Care employees/contractors, should I permit a Matrix Home Care employee/contractor to operate my automobile. I understand and agree that Matrix Home Care does not provide insurance coverage under any circumstances for any damages to my automobile, bodily injury or damage to property resulting from the use of my automobile by Matrix Home Care employees/contractors.

I hereby release Matrix Home Care and its employees/contractors assigned to me, and hold Matrix Home Care and such employees/contractors harmless and indemnify them from any claim, liability, or cause of action for any injury to my person (including death), bodily injury to a third party, or property damage resulting from the use of an automobile (whether or not owned by me) if operated by a Matrix Home Care employee/contractor, whether or not prior authorization from the Matrix Home Care office has been obtained.

**Statement of Patient Bill of Rights**

I certify that I have read, received a copy of, and understand the Patient Bill of Rights which has been explained to me orally by a representative of Matrix Home Care.

**Statement of HIPAA Privacy Practices**

I certify that I have read, received a copy of, and understand the Matrix Home Care HIPAA Privacy Practices which has been explained to me orally by a representative of Matrix Home Care. I also certify that I have been given the opportunity to discuss concerns that I may have regarding the privacy of my health information.

**Patient rights on Advance Directives**
*(Please check the appropriate boxes)*

I certify that I ❑ have executed ❑ have not executed a Living Will
I certify that I ❑ have executed ❑ have not executed a Durable Power of Attorney/Health Care Proxy.
I authorize Matrix Home Care to receive a copy of any of the above documents. The documents are located at or with:
_____

I certify that I have been instructed about, received a copy of, and understand the patient Rights on Advance Directives which was explained to me orally by a representative of Matrix Home Care.

**Assistance with Medications**

I have been informed by Matrix Home Care that I may be receiving assistance with self-administration of medication from an unlicensed person (excluding narcotics).

**Relationship with Matrix Caregivers**

I understand that some of the home care professionals that may provide services to me pursuant to this Consent Form are considered Independent Contractors of Matrix Home Care. Furthermore, I recognize that I, not Matrix Home Care, will have the ultimate right to control and direct such home care professionals as to the manner in which they perform services for me pursuant to this Consent Form. Specifically, I have the right to choose my home care professional, select the services I wish for them to perform, and set their hours for doing so. I accept any exposure (including but not limited to exposure under the Affordable Care Act) that arises due to this right to control and direct the home care professionals in the services they perform for me.

**Additional Terms:**

❑ All charges for services rendered on holidays will be one and one-half times the applicable rate. Holidays rates applicable for: New Year's Eve, New Year's Day, Easter, Memorial Day, Fourth of July, Labor Day, Thanksgiving Day, Christmas Eve, Christmas Day, and other local holidays as indicated.

❑ I acknowledge the considerable expense incurred by Matrix Home Care in advertising, recruiting, evaluating and retaining home care professionals. Accordingly, I agree that during the term of this Agreement, I will not (without prior written consent of Matrix Home Care) solicit, employ, or seek to employ any individual who is currently employed or contracted by Matrix Home Care.

❑ I agree that to ensure accurate billing and recordkeeping, I will not pay home care professionals employed or contracted by Matrix Home Care directly. Home care professionals employed or contracted by Matrix Home Care are not authorized to accept, have custody or the use of cash, credit cards or other valuables of a client. If I choose to advance cash or other items to a home care professional, I waive any right to offset this amount from the invoice. Matrix Home Care will not be responsible for claims against its Fidelity Bond unless such claims are reported in writing to Matrix and to the local police within ten (10) days after notice of loss.

**Service:**

❑ I agree to pay Matrix Home Care a minimum of four (4) hours of service charges on behalf of any home care professional employed or contracted by Matrix Home Care who reports for duty should I decide to terminate this Agreement without proper notice.

**Service Interruption:**

❑ I understand Matrix Home Care uses its best efforts to provide uninterrupted services; however, sometimes interruptions are unavoidable. During any interruption of service, I understand that I may be responsible for and agree to provide or arrange for backup care. However, Matrix Home Care will make all reasonable attempts to provide service through their caregivers or another agency.

**Termination:**

❑ I understand that I may terminate this Agreement by giving at least four (4) hours notice to Matrix Home Care. I understand that Matrix Home Care may terminate this Agreement by providing at least three (3) calendar days notice or other minimum notice required under applicable state law. I recognize that notification may be furnished verbally, in person, or by telephone, and that written confirmation will follow by mail. In those circumstances in which the life, safety, or well-being of home care professionals employed or contracted by Matrix Home Care is or may be jeopardized, Matrix Home Care may terminate this Agreement without prior notice.

**Freedom of Choice:**

❑ I understand that I have the right to choose any provider of personal care services. I voluntarily select Matrix Home Care as my provider of services.

PAYMENT TERMS:

**Deposits**

❑ I agree to pay simultaneously with the signing of this Agreement $ _____ in the form of a check number cash/and/or other agreed upon terms, a one-week deposit for services to be rendered. This deposit will be applied to your last invoice of service. The Driver's License number of the depositor is: _____, in the State of _____

**Credit Card**

❑ I hereby authorize payment through my (Circle one) : MasterCard Visa Discover Card Security Code:

Name on card:_____Card #: _____ Expiration date: _____

Billing Address of Card:_____

for services and/or supplies provided by Matrix Home Care and its employees or contractors. I understand I am personally financially responsible for payments if the information provided by me is invalid or payment is not authorized by the credit card company. I further understand that this credit card must be presented for imprint and signature verification.

Signature: _____ Date: _____

*Note: This form must be signed by the Matrix Home Care patient/client unless the patient/client is a minor; incompetent, or physically incapable of signing.*

I have read and fully understand the content of the three-page Consent Form and hereby agree to and authorize the foregoing provisions.

As used in this document, the terms "I," "me" and "my" refer to and include, in addition to the undersigned, that patient/client named above and others for whom the undersigned is responsible or for whom the undersigned has assumed responsibility in engaging Matrix Home Care to provide service to the patient/client.

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|---|---|
| _____ | _____ |
| PATIENT/CLIENT SIGNATURE | AUTHORIZED REPRESENTATIVE IF PATIENT CANNOT SIGN |
| _____ | _____ |
| WITNESS SIGNATURE | PRINT NAME OF AUTHORIZED REPRESENTATIVE |
| _____ | _____ |
| DATE | AUTHORIZED REPRESENTATIVE'S RELATIONSHIP TO PATIENT/CLIENT |