matrix
HOME HEALTH CARE

Consent Form

PATIENT/CLIENT NAME: _____ DATE: _____

Consent to receive services

I hereby authorize Matrix Home Care to render appropriate home care services to the patient/client named above. I understand an appropriate level of home care personnel will provide such care. I recognize and agree that I have the right to refuse treatment or terminate services 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 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, 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.

Vehicle release

I agree to notify Matrix Home Care, in advance, and I understand that I must receive written authorization from the Matrix Home Care office, before any Matrix Home Care employee/contractor may operate my automobile or transport me in a Matrix Home Care employee's/contractor's automobile.

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, and understand the Patient Bill of Rights which has been explained to me orally by a representative of Matrix Home Care.

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).

Credit Card

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

Name on card: _____ Card # _____ Expiration date: _____
for services and/or supplies provided by Matrix Home Care. 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: _____

Patient's/Client's Initials