**Visiting Nursing Association Of WNY, Inc.**

# PATIENT AGREEMENT

| NAME: | | ID NUMBER | | | |
|---|---|---|---|---|---|
| PATIENT NAME: | | GUARANTOR: | | CO-PAYMENT $ | PER |
| | | | | | |
| Primary Insurance | | Policy Number | | Group Number | |
| Secondary Insurance | | Policy Number | | Group Number | |

**Consent for Treatment**
I (we), the undersigned, being advised of the needs for home health/equipment as ordered by the patient's physician, do hereby consent to all such treatments, which in the judgement of the patient's physician, may be considered necessary or advisable for me/my child. If I (we), should decline treatment without the consent of the patient's physician, I (we) hereby relieve Visiting Nursing Association of WNY, Inc. and said physician of all responsibility from my (our) action. No guarantees or promises have been made about the outcome of this care.

**Consumer Information: Changes in the Agency Plan of Care:**
I, (we) certify that I have been informed that services to be provided to me as determined by the assessment/reassessment to be conducted at this time may be subject to change if there is: a change in my health care needs, or the availability of relations, friends, or significant others, or a change in the health related services, or other community services become available to meet my needs. I acknowledge that I have received the agency transfer and discharge policies.

**Patient Bill of Rights & Responsibilities**
I, (we) the undersigned, have reviewed the Patient Bill of Rights & Responsibilities with the agency representative and attest to understanding these rights and responsibilities.

**Advance Directives:**
I, (we) certify that I have received copies of the New York State Department of Health pamphlets, Deciding About Health Care – a Guide for Patients and Families and Health Care Proxy – Appointing Your Health Care Agent in New York State. I also acknowledge that I was asked whether or not I have an advanced directive.

**Statement of Changes/Agreement to Pay:**
I (we) certify that I have received the Visiting Nursing Association of Western New York, Inc.'s statement of customary changes. I understand that the VNA of WNY, Inc. will pursue payment for services from my insurance carrier. However, I understand that I may be responsible for co-payments/charges that are not covered by my insurance carrier. I understand that I may be eligible for payment assistance.

**Consent to Use and Disclosure of Information/Assignment of Benefits:**
I consent to the use and disclosure of my protected health information for treatment, payment or operation purposes by or to: (1) authorized representatives or business associates of VNA of WNY, Inc. (2) regulating bodies and accrediting organizations, (3) any public agency which may be involved with me/my child's care or (4) as otherwise permitted by law. I consent to the release of the patient's medical record upon transfer to another health care facility. I assign to the VNA of VNA, Inc., all payments for services that have been provided to myself, my child or to my dependents. Also, I consent to the use and disclosure of my Protected Health Information for training and educational purposes to students in health-related professions from local colleges and universities affiliated with the VNA of WNY.

**Guarantor Agreement to Pay:**
The estimated guarantor financial responsibility is $_____ per visit, which is the amount not covered by your insurance. Your co-payment may be adjusted after the time of service depending upon the final reconciliation of insurance payments. I understand that the guarantor is responsible for unmet deductibles and co-pays, when applicable, as determined by the insurance carrier(s). Initials _____

**Certification:**
I certify that I am the patient's parent or legal guardian and have the authority to grant this consent. This form has been fully explained to me and I understand its purpose and content. I permit a copy of this Agreement to be used in place of the original. I certify that the information given to me is correct.

**Statement of Patient Privacy Rights:**
I have received and read the statement of Home Health Agency Outcome Assessment information set (OASIS) statement of patient privacy rights.

I have received the VNA of WNY, Inc. Notice of Privacy Practice regarding the use and disclosure of my protected health information.

| _____ | _____ | _____ |
|---|---|---|
| Patient/Guardian/Health Care Agent/Signature | Relationship | Date |
| _____ | _____ | _____ |
| Guarantor Signature (if applicable) | Relationship | Date |