Good Help Client Admission Checklist

This form should be completed by the Service Supervisor and approved by the agency's Director.

_____ **Welcome Letter** **(patient's copy)**

_____ **In Case of an Emergency**(patient's copy)

_____ **Emergency Plan**(patient's copy)

_____ **Notice of Privacy** **(patient to keep packet)**

_____ **HIPPA**

_____ **Medical Care Decisions Advance Directives** **(patient's copy)**

_____ **Advance Directives Acknowledgement**

_____ **Medication Profile**

_____**Consent for Care**

_____ **Non-Discrimination** **(patient's copy)**

_____ **Transportation**

_____ **Home Safety Checklist**

_____ **In- Home Aide Regulation** **(patient's copy)**

_____ **Registered Nurse Assessment**

I hereby acknowledge that I have received and understand the written verbal instructions given to me, as noted above, regarding my admission with Good Help Home Care Agency

Client Signature: _____ Date: _____

Agency Signature: _____ Date: _____

Name& Title

Welcome!

Our Mission:

The mission of the Good Help Home Care Agency, LLC, we envision a world where everyone can age with dignity and grace in their own homes. We strive to be the leading provider of compassionate and professional in-home care services that meet our clients and their families' unique needs and preferences.

Client's Rights

- ✔ **To be informed and participate in his or her plan of care.**
- ✔ **To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.**
- ✔ **To receive care and services that are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.**
- ✔ **To voice grievances about care and not be subjected to discrimination or reprisal for doing so.**
- ✔ **To have his or her personal and medical records kept confidential and not be disclosed except as permitted or required by applicable state or federal laws.**
- ✔ **To be free of mental and physical abuse, neglect , and exploitation.**
- ✔ **To receive a written statement of services provided by the agency and the charges the client is liable for paying.**
- ✔ **To be informed of the process for acceptance and continuance of service and eligibility determination.**
- ✔ **To accept or refuse services.**
- ✔ **To be informed of the agency's on-call service.**
- ✔ **To be informed of supervisory accessibility and availability.**
- ✔ **To be advised of the agency's procedures for discharge,**
- ✔ **To receive a reasonable response to his or her requests from the agency.**
- ✔ **To be notified within 10 days when the agency's license has been revoked, suspended, canceled, annulled, withdrawn, recalled, or amended.**
- ✔ **To be advised of the agency's policies regarding patient responsibilities.**
- ✔ **Contact names and numbers to express grievances/complaints, including the DHSR Hotline 1-800-624-3004.**
- ✔ **Any complaint will be fully investigated, and a resolution achieved within 72 hours of the complaint with follow up to person filing the complaint.**
- ✔ **All complaints and the related investigation will be documented in the complaint log.**

In Case of An Emergency

Contact Our 24-Hour Crisis Line

800-847-1985

Emergency Plan

Client's Name	
Police	
Fire	
Ambulance	
Doctor	
Electric Company	
Gas Company	
Water Company	

Please include name, address, and contact number*

In case of emergency, meet here:

Choose a place right outside of your house- example: at the end of driveway beside the mailbox or across the street by the tree*

If away from the house and unable to return, meet here:

A place outside of your neighborhood-example:" mom's office or Aunt Jane's house"*

If you are separated from everyone, call:

Name:	**Address:** **Phone Number:**
Name:	**Address:** **Phone Number:**
Name:	**Address:** **Phone Number:**

Choose a friend(s) or relative(s) who are prepared to be your emergency contact(s)*

NOTICE OF PRIVACY PRACTICES
OF
Good Help Home Care Agency

Good Help Home Care must collect timely and accurate health information about you and make that information available to members of your health care team in this agency, so that they can accurately diagnose your condition and provide the care you need. There may also be times when your health information will be sent to service providers outside this agency for services that this agency cannot provide. It is the legal duty of *Good Help Home Care* to protect your health information from unauthorized use or disclosure while providing health care, obtaining payment for that health care and for other services relating to your health care.

The purpose of this *Notice of Privacy Practices* is to inform you about how your health information may be used within *Good Help Home Care*, as well as reasons why your health information could be sent to other service providers outside of this agency.

This *Notice* describes your rights in regard to the protection of your health information and how you may exercise those rights. This *Notice* also gives you the names of contacts should you have questions or comments about the policies and procedures *Good Help Home Care* uses to protect the privacy of your health information.

Please review this document carefully and ask for clarification if you do not understand any portion of it.

Client Acknowledgement

I have received *Good Help Home Care*'s *Notice of Privacy Practices*, which describes this agency's methods for protecting the privacy of my health information that is used in providing health care services to me.

_____/_____

Client (or Personal Representative) Date

_____/_____

(Company Representative) Date

Note: DHHS Agency retains this signed page. Client retains the Notice of Privacy Practices document.

NOTICE OF PRIVACY PRACTICES
Good Help Home Care Agency

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Responsibilities of *Good Help Home Care Agency, LLC*

Good Help Home Care Agency is required by state and federal law to protect the privacy of your health information that may identify you. This health information includes mental health, developmental disability and/or substance abuse services that are provided to you, payment for those health care services, or other health care operations provided on your behalf.

This agency is required by law to inform you of our legal duties and privacy practices with respect to your health information through this *Notice of Privacy Practices*. This *Notice* describes the ways we may share your past, present and future health information, ensuring that we use and/or disclose this information only as we have described in this *Notice.* We do, however, reserve the right to change our privacy practices and the terms of this *Notice*, and to make the new *Notice* provisions effective for all health information we maintain. Any changes to this *Notice* will be posted [in our agency offices *(applies only to providers with direct relationship)*] and on our agency web site at **www.goodhelphca.com**. Copies of any revised *Notices* will be available to you upon request.

If at any time, you have questions or concerns about the information in this *Notice* or about our agency's privacy policies, procedures and practices, you may contact our agency Privacy Official at 919-371-5362 .

Use and Disclosure of Health Information without Your Authorization

Treatment

Good Help Home Care may use your health information, as needed, in order to provide, coordinate or manage your health care and related services. This includes sharing your health information with other health care providers within this agency.

> **Example:** Your treatment/habilitation team, composed of staff such as doctors, nurses, and social workers, will need to review your treatment and discuss plans for your discharge.

We will disclose your health information outside of this agency for treatment purposes only with your consent or when otherwise allowed under state or federal law. [*The following is based upon*

State law (GS 90-109.1) and applies to substance abuse providers, "If you request treatment and rehabilitation for drug dependence, your request will be treated as confidential. We will not refer you to another person for treatment and rehabilitation without your consent."]

> **Example:** We may disclose your health information to other mental health facilities or professionals (i.e., community based area mental health, developmental disabilities and substance abuse services program or psychiatric service at UNC Hospitals) in order to coordinate your care.
>
> **Example:** We may share your health information with a health care provider for emergency services.

Payment for Services

The treatment provided to you will be shared with our agency's billing department so a bill can be prepared for services rendered. We may also share your health information with agency staff who review services provided to you to make certain you have received appropriate care and treatment. We will not disclose your health information outside of this agency for billing purposes (i.e., bill your insurance company) without your consent *[the following exception is not applicable to substance abuse providers]* except in certain situations when we need to determine if you are eligible for benefits such as Medicaid, Medicare or Social Security.

> **Example:** A Social Worker may contact your local Department of Social Services to determine if you are currently eligible for Medicaid or if you would qualify for Medicaid. *(Example not applicable for substance abuse providers)*
>
> **Example:** Our billing department will collect insurance and other financial information from you at the time of admission.

Health Care Operations

Good Help Home Care may use or disclose your health information in performing a variety of business activities that we call "health care operations". Some examples of how we may use or disclose your health information for health care operations are:

- Review the care you receive here and evaluate the performance of your treatment/habilitation team to ensure you have received quality care.
- Review and evaluate the skills, qualifications and performance of health care providers who are taking care of you.
- Provide training programs for agency staff, students and volunteers.
- Cooperate with outside organizations that review and determine the quality of care that you receive.
- Provide information to professional organizations that evaluate, certify or license health care providers, staff or facilities.
- Allow our agency attorney to use your health information when representing this agency in legal matters.
- Resolve grievances within our agency.
- Provide information to your internal client advocate who is available to represent your interests upon your request.

Other Circumstances

Good Help Home Care may disclose your health information for those circumstances that have been determined to be so important that your authorization may not be required. Prior to disclosing your health information, we will evaluate each request to ensure that only necessary information will be disclosed. Those circumstances include disclosures that are:

- Required by law;
- For public health activities. For example, we may disclose health information to public health authorities if you have a communicable disease and we have reason to believe, based upon information provided to us, that there is a public health risk such as evidence of your noncompliance with your treatment plan. If you suffer from a communicable disease such as tuberculosis or HIV/AIDS, information about your disease will be treated as confidential. Other than circumstances described to you in other sections of this Notice, we will not release any information about your communicable disease except as required to protect public health or the spread of a disease, or at the request of the State or Local Health Director;
- Regarding abuse, neglect or domestic violence; *(Not applicable to substance abuse providers – for substance abuse providers say "Regarding child abuse or neglect")*
- For health oversight activities such as licensing of nursing homes;
- For law enforcement purposes unless otherwise prohibited by state or federal law; [*Not applicable to substance abuse providers – for substance abuse providers say, "If you request treatment and rehabilitation for drug dependence, we will not disclose your name to any police officer or other law-enforcement officer unless you authorize such disclosure; except that if you later commit a crime or threaten to commit a crime on the premises of this agency or against program personnel, law enforcement may be notified."]*
- For court proceedings such as court orders to appear in court;
- Related to death such as disclosure to a funeral director;
- Related to donation of organs or tissue;
- To avert a serious threat to the health or safety of a person or the public;
- Related to specialized government activities such as national security;
- To correctional institutions or other law enforcement officials when you are in their custody;
- For Worker's Compensation in cases pending before the Industrial Commission; *(Not applicable to substance abuse providers)*
- To your next of kin or other person involved in your care upon their request; however, information to be disclosed will be limited to admission, transfer, discharge, referrals and appointments and you will be notified of this request; *(Not applicable to substance abuse providers)* and
- Related to medical research.

Contacting You

(Note: If your agency does not perform the activities noted below, this section does not need to be in the notice – only include those activities your agency would perform.)

Good Help Home Care may use your health information to contact you to:

- Remind you of upcoming appointments;

  Example: This agency may send an appointment reminder on a folded postcard to your home to remind you of a scheduled appointment.

  Example: This agency may send a letter to your home concerning the need for follow up care of medical conditions.

- Make you aware of alternative treatment, services, products or health care providers that may be of interest to you;

  Example: If you are receiving treatment for a particular condition and your health care team learns of new or alternative treatments, we may contact you to inform you of such possibilities.

- Contact you to request your participation in raising funds for this agency. If you object to being contacted in this way for fund-raising efforts, you must notify our Privacy Official who is listed in this *Notice*.

  Example: If our agency Foundation requested information be sent to you about an upcoming fund raising event, we may send the information to your home.

Disclosure of Your Health Information That Allows You An Opportunity To Object

There are certain circumstances where we may disclose your health information and you have an opportunity to object. Such circumstances include:

- The professional responsible for your care may disclose your admission to or discharge from this agency to your next of kin *(Not applicable to substance abuse providers)*
- Disclosure to public or private agencies providing disaster relief.

  Example: We may share your health information with the American Red Cross following a major disaster such as a flood.

If you would like to object to our disclosure about your health information in either of the situations listed above, please contact our agency Privacy Official listed in this *Notice* for consideration of your objection.

Disclosure of Your Health Information That Requires Your Authorization

Good Help Home Care will not disclose your health information without your authorization except as allowed or required by state or federal law. For all other disclosures, we will ask you to sign a written authorization that allows us to share or request your health information. Before you sign an authorization, you will be fully informed of the exact information you are authorizing to be disclosed/requested and to/from whom the information will be disclosed/requested.

You may request that your authorization be canceled by informing our agency Privacy Official that you do not want any additional health information about you exchanged with a particular person/agency. You will be asked to sign and date the Authorization Revocation section of your original authorization; however, verbal authorization is acceptable. Your authorization will then

be considered invalid at that point in time; however, any actions that were taken on the authorization prior to the time you cancelled your authorization are legal and binding.

If you are a minor who has consented to treatment for services regarding the prevention, diagnosis and treatment of certain illnesses including: venereal disease and other diseases that must be reported to the State; pregnancy; abuse of controlled substances or alcohol; or emotional disturbance, you have the right to authorize disclosure of your health information. Disclosure of health information to external client advocates will require authorization by you and your personal representative if one has been designated. *(The following applies to substance abuse providers only – "If you are a minor whose parent or guardian has consented to your treatment for substance abuse, both you and your parent or guardian must authorize disclosure of your health information.")*

Your Rights Regarding Your Health Information

You have the following rights regarding your health information as created and maintained by this agency.

Right to receive a copy of this *Notice*

You have the right to receive a copy of *Good Help Home Care* 's *Notice of Privacy Practices*. At your first treatment encounter with this agency, you will be given a copy of this *Notice* and asked to sign an acknowledgement that you have received it. In the event of emergency services, you will be provided the *Notice* as soon as possible after emergency services have been provided.

In addition, copies of this *Notice* have been posted in several public areas throughout this agency, as well as on the *Good Help Home Care* 's Internet web site at **www.goodhelphca.com**. You have the right to request a paper copy of this *Notice* at any time from our agency Admissions Officer or our agency Privacy Official.

Right to request different ways to communicate with you

You have the right to request to be contacted at a different location or by a different method. For example, you may request all written information from this agency be sent to your work address rather than your home address. We will agree with your request as long as it is reasonable to do so; however, your request must be made in writing and forwarded to our agency Privacy Official.

Right to request to see and copy your health information

Whether you are a minor, incompetent adult or competent adult, you have the right to request to see and receive a copy of your health information in medical, billing and other records that are used to make decisions about you. Your request must be in writing and forwarded to our agency Privacy Official. You can expect a response to

your request within 30 days. If your request is approved, you may be charged a fee to cover the cost of the copy.

Instead of providing you with a full copy of your health information record, we may give you a summary or explanation of your health information, if you agree in advance to that format and to the cost of preparing such information.

Your request may be denied by your physician or a professional designated by our agency director under certain circumstances. If we do deny your request, we will explain our reason for doing so in writing and describe any rights you may have to request a review of our denial. In addition, you have the right to contact our agency Privacy Official to request that a copy of your health information be sent to a physician or psychologist of your choice.

Whenever you have a personal representative who consented to your treatment, the personal representative has the same rights to request to see and copy your health information.

Right to request amendment of your health information

You have the right to request changes in your health information in medical, billing and other records used to make decisions about you. If you believe that we have information that is either inaccurate or incomplete, you may submit a request in writing to our agency Privacy Official and explain your reasons for the amendment. We must respond to your request within 30 days of receiving your request. If we accept your request to change your health information, we will add your amendment but will not destroy the original record. In addition, we will make reasonable efforts to inform others of the changes, including persons you name who have received your health information and who need the changes.

We may deny your request if:

- The information was not created by this agency (unless you prove the creator of the information is no longer available to change the information);
- The information is not part of the records used to make decisions about you;
- We believe the information is correct and complete; or
- Your request for access to the information is denied.

If we deny your request to change your health information, we will explain to you in writing the reasons for denial and describe your rights to give us a written statement disagreeing with the denial. If you provide a written statement, the statement will become a permanent part of your record. Whenever disclosures are made of the information in question, your written statement will be disclosed as well.

Right to request a listing of disclosures we have made

You have a right to a written list of disclosures of your health information. The list will be maintained for at least six years for any disclosures made after April 14, 2003. This listing will include the date of the disclosure, the name (and address, if available) of the person or organization receiving the information, a brief description of the information disclosed and the purpose of the disclosure.

This agency is not required to include the following on the list of disclosures:

- Disclosure for your treatment;
- Disclosure for billing and collection of payment for your treatment;
- Disclosures related to our health care operations;
- Disclosures that you authorized;
- Disclosures to law enforcement when you are in their custody; or
- Disclosures made to individuals involved in your care.

Your first request for a listing of disclosures will be provided to you free of charge. However, if you request a listing of disclosures more than once in a 12 month period, you may be charged a reasonable fee. We will inform you of the cost involved and you may choose to withdraw or modify your request at that time, before any costs are incurred.

Right to request restrictions on uses and disclosures of your health information

You have the right to request that we limit our use and disclosure of your health information for treatment, payment and health care operations. You also have the right to request a limit on the health information we disclose about you to your next of kin or someone who is involved in your care. (Example: you could ask that we not disclose information about your family history of heart disease.) We will provide you with a form to document your request.

We will make every attempt to honor your request but are not **required** to agree to such request. However, if we do agree, we must follow the agreed upon restriction (unless the information is necessary for emergency treatment or unless it is a disclosure to the U.S. Secretary of the Department of Health and Human Services).

You may cancel the restrictions at any time and we will ask that your request be in writing. In addition, this agency may cancel a restriction at any time, as long as we notify you of the cancellation.

Violations/Complaints

(Applicable to substance abuse providers – "Violation of the Federal law and regulations relative to a substance abuse program is a crime. Suspected violations may be reported to our agency Privacy Official who will report the violation to appropriate authorities in accordance with Federal regulations.")

If you believe we have violated your privacy rights, or if you want to file a complaint regarding our privacy practices, you may contact our agency Privacy Official. Contact information is as follows:

Good Help Home Care Agency
Privacy Official: Nathan Coley, BSN, RN
COMPANY Address: 200 W. Ash Street Ste 104 Goldsboro NC 27530
COMPANY Phone Number: 8008471985
COMPANY Fax Number: 919-800-5115
COMPANY email address: admin@goodhelphca.com

The North Carolina Department of Health and Human Services operates an information and referral service located in the Office of Citizen Services, known as **CARE-LINE**, which has been designated to receive and document complaints and concerns regarding your privacy. Contact information is as follows:

CARE-LINE
2012 Mail Service Center
Raleigh, NC 27699-2012

Voice Phone (English and Spanish):
1-800-662-7030 (Toll Free)
(919) 733-4261 (Triangle Area and Out of State)
FAX: (919) 715-8174
TTY: 1-877-452-2514 (TTY Dedicated)
(919) 733-4851 (TTY Dedicated for local or out of state calls)
Email: **care.line@ncmail.net**

You may also send a written complaint to the United States Secretary of the Department of Health and Human Services. Contact information is as follows:

Office for Civil Rights
U.S. Department of Health and Human Services
Atlanta Federal Center, Suite 3B70
61 Forsyth Street, S.W.
Atlanta, GA 30303-8909

Voice Phone: (404) 562-7886
FAX: (404) 562-7881
TDD: (404) 331-2867

If you file a complaint, we will not take any action against you or change the quality of health care services we provide to you in any way.

Legal References

Primary Federal and State laws and regulations that protect the privacy of your health information are listed below.

Confidentiality of Alcohol and Drug Abuse Patient Records – 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR Part 2 for Federal regulations.

Health Insurance Portability and Accountability Act (HIPAA), Administrative Simplification, Privacy of Individually Identifiable Health Information – 42 U.S.C. 1320d-1329d-8 and 42 U.S.C. 1320d-2(note) for Federal laws and 45 CFR Parts 160 and 164 for Federal regulations.

NC General Statutes – Chapter 122C, Article 3 (Client's Rights and Advance Instruction), Part 1 (Client's Rights). Chapter 90 (Medicine and Allied Occupations), Article 1 (Practice of Medicine).

NC Administrative Code – 10 NCAC 18 D (Confidentiality Rules).

HIPAA Privacy Authorization

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1.Authorization

I authorize _____to use and disclose the protected health information described below to **Good Help Home Care Agency, LLC.**.

2. Effective Period

This authorization for release of information covers the period of healthcare.

☐ a. _____ to _____

or

☐ b. all past, present, and future periods

Extent of Authorization

☐ a. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV/AIDS, and treatment of alcohol or drug abuse)

or

☐ b. I authorize the release of my complete health record with the exception of the following information:
_____ Mental Health Records
_____ Communicable Diseases (including HIV/AIDS)
_____ Alcohol/Drug Abuse Treatment
_____ Other (please specify): _____
_____

Medical Care Decisions and Advance Directives: What You Should Know

(See Attached Brochure)

Patient will keep brochure

Medical Care Decisions and Advance Directives Acknowledgment

I have received information on Advanced Directive and understand that I can talk to my family about executing an advance directive.

_____	_____	_____
Client's Printed Name	**Client's Signature**	**Date**
_____	_____	_____
Company Representative (Print)	**Company Representative's Signature**	**Date**

Client Medication Profile

Client's Name:	**DOB:**

Name of Physician: **Address:** **Phone Number:** **Fax Number:**	**Name of Pharmacy:** **Address:** **Phone Number:** **Fax Number:**
Allergies: ☐ **NKDA**	**Diagnosis:**

Date	Name of Medication	Dose	Route	Frequency	Comment(s)

- This list of medications in which the client states they have on hand in the home and at the time of the initial nursing assessment evaluation. These are the medications in which the client is currently taking.
- Please verify and check for accuracy.

RN Printed Name:	RN Signature:
Date:	

Consent for Care

Client's Last Name:_____First Name:_____M.I____.

Client's Address:

_____

_____

_____

Client's Telephone Number: (_____) Client's Gender:_____Male___Female
Client's Social Security Number: _____
Date of Birth :___/____/_____
Client's Marital Status:_____Married_____Single _____
__Divorced __Widowed

Next to Kin or Legal Guardian:

_____

Relationship to Client:

_____

Family Members:

_____Relation _____

_____Relation _____

_____Relation _____

_____

Source of Referral:_____Date of Referral:_____
Date of initial client contact:_____

ASSESSMENT OF HOME ENVIRONMENT

Good Help Home Care environment assessment findings and concerns listed below.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Assessor's Print : _____
Assessor's Signature: _____Title:_____Date: _____

_____

I, the undersigned, hereby make the following acknowledgement and agreements regarding services to be provided by **Good Help Home Care Agency, LLC**

I agree to enter into an agreement for

□ In-Home Aide Service □ Companionship □ Sitter Service □ Respite

I,_____have requested services to include:_____
_____
_____

Notify the office if you would like to make any change to the care identified above. A staff member will contact you and an addendum will be added. In addition, your customized care plan will also be updated, and your companion will be notified.

FREQUENCY AND DURATION OF SERVICE

Good Help Home Care agrees to adhere to the frequency and duration of service: Start Date_____
Frequency_____Time_____-_____Duration_____
Frequency_____Time_____-_____Duration _____

ENTRY TO RESIDENCE

Procedure to entry residence, i.e. gate code etc. _____

FEE FOR SERVICE(S)

Good Help Home Care Agency rates for services listed below. The agreed upon rate(s) is/are: Hourly $_____Live-In $_____Day/Flat $_____

Live-In requires a minimum of (8) hours of sleep. If your level of care does not permit, **Good Help Home Care Agency** will bill you at the hourly rate and may provide (2) employees for your level of service requested based on the required hours.

HOLIDAY PAY

I understand that **Good Help Home Care Agency** will bill at a rate of **1 ½** times the hourly rate for service(s) provided on the following holidays: New Year's Eve (after 5pm), New Year's Day, Memorial Day, Easter Sunday, Independence Day, Labor Day, Thanksgiving Day, Christmas Eve (after 5pm), and Christmas Day.

I understand that **Good Help Home Care Agency** will invoice every Monday (1) week in advance for live-in service(s). Hourly care will be invoiced on Monday for the previous week. Due to billing in arrears, the undersigned agrees to submit payment within (1) calendar day.
Payments can be made online through PayPal, or by authorizing **Good Help Home Care Agency** to withdraw/charge the undersigned Visa or MasterCard, or check. The undersigned will be legally responsible for all collection activity fee(s), legal fees incurred by **Good Help Home Care Agency** for collecting on delinquent invoices/monies owed to **Good Help Home Care Agency**. **Good Help Home Care Agency** will apply a 2% fee on all outstanding invoices which are not paid in full within 3 business days. If a third party is utilizing for payment of service(s) it is still the sole responsibility of the undersigned to ensure **Good Help Home Care Agency** receives payment on time.

Invoices should be mailed to the client/responsible party for payment at the following address:
Name:_____Email:_____
Address: _____
*The undersigned agrees to respect the rights of **Good Help Home Care Agency** and will not directly employ any staff provided by **Good Help Home Care**, OR agrees to pay a liquidation fee equal to (12) weeks of service at (40) hours a week. Initials _____

Banking/Account Information on File

I understand that **Good Help Home Care Agency** will debit via ACH for services rendered within (24) hours after the invoice has been generated. I authorize payment(s) to be withdrawn
from my checking or savings account until I provide in writing to stop payments.
Bank Name:_____Routing #:_____**Account #:**
_____
Billing Address_____
Card Holder's Signature: _____
Date:_____

INSURANCE REIMBURSEMENT

Good Help Home Care Agency's care management team will assist you with verifying benefits via insurance company, submitting claims and providing required Home Care service documents; however, **Good Help Home Care Agency** does not accept assignment of benefits. Initials ___

CANCELLATION POLICY

A client has the right to cancel plan of care with a 48-hour notice and shall only be charged for services actually rendered prior to the time that the provider is notified of the cancellation. If 48-hour notice not given to office, initial deposit will be forfeited. The provider may assess a reasonable charge for travel and staff time if notice of the cancellation plan of care is not provided in time to cancel the service prior to the provider's staff member arriving at the client's house to perform the service.

CONSENT TO CARE

I authorize the employees of **Good Help Home Care Agency** to render care/services as requested by myself and or family member(s). If required, I understand that I will be fully informed of the anticipated benefits, possible discomforts, and potential side effects prior to the performance of any treatment, and I release **Good Help Home Care Agency** from liability that may arise as the result of such treatment, unless due to sole negligence of its staff.

NORTH CAROLINA STATE MANDATED REPORTERS

Good Help Home Care Agency and its employees are mandated reporters of suspected elder abuse and will report concerns as required by NC. State law.

ADVANCE DIRECTIVES AND DNR ORDERS

Do you have an Advance Directive? □Yes □No If yes, please provide a copy.
Did you receive the (4) page Advance Directive paperwork? □Yes □No

Do you have a DNR Order? □Yes □No If yes, please provide a copy.

PROVISION OF SERVICES

I understand that **Good Help Home Care Agency** assigns staff based on client needs and considerations related directly to the care/services provided. I understand that services and employees are provided regardless of race, ethnicity, religion, sex, age, and veteran or handicap status.

TRANSPORTATION WAIVER

I understand that if I request transportation service from **Good Help Home Care** for professional appointments, errands, shopping etc. and an employee uses his/her personal or rented vehicle there will be a charge of $ 0.50 per mile, in addition to the agreed upon hourly, daily etc. service rate payable on the next invoice. I understand that if I request **Good Help Home Care** employee to provide transportation in my personal or rented vehicle a waiver form must be signed prior to beginning transporting service.

RELEASE OF INFORMATION/PRIVACY RIGHTS

I have been provided with a Notice of Privacy Rights that details the various ways that information about me may be disclosed for treatment, payment, healthcare operations and other purposes permitted or required by law as applicable.

OBSERVATION/REVIEW CONSENT

I understand that nursing, Service Supervisory staff, members of the Governing Board, health care consultants, state and accreditation surveyors and representatives of any other certification/accreditation/professional bodies may observe employees of **Good Help Home Care** perform prescribed care. I understand the purpose is to provide learning experience or for the evaluation of the quality of care and that all information will be kept confidential in accordance with the Notice of Privacy Rights. I hereby grant permission for the above individuals to observe **Good Help Home Care** employees performing prescribed care. I am aware that I may revoke permission for observation verbally or in writing at any time.

GENERAL INFORMATION

This is to give access to client's personal funds when home management services are to be provided and when those services include assistance with bill paying or any activities, such as shopping, that involve access to or use of such funds; similarly, approved authorization for use of client's motor vehicle when services to be provided include transport and escort services and when the client's personal vehicle will be used.

□ **Yes**, I give permission for **Good Help Home Care Agency'**s employee to access my personal funds. If, yes, client agrees to provide a pre-paid card or petty cash account to manage transactions.

□ **No**, I do not give permission for **Good Help Home Care Agency'**s employee to access my personal funds.

□**Yes**, I give access to **Good Help Home Care Agency'**s employee to use my personal/rented vehicle for transportation services. (Must sign transportation waiver form)

□ **No**, I do not give permission for **Good Help Home Care Agency'**s employee to use my personal/rented vehicle for transportation services.

Client's/Payee Initials_____Date _____

CLIENT RIGHTS

I have received a copy of Client Rights and Responsibilities. **Initial here**: _____

Client's Name: _____
Revision Date: _____

CUSTOMER SERVICES/GRIEVANCE PROCEDURE

Good Help Home Care Agency at **200 Ash Street Ste 104 Goldsboro NC 27530** service 365 days a year. Their telephone # is **800-847-1985**

DHHS, NC Division of Health Service Regulation, Complaint Intake Unit
Complaint Hotline: 1-800-624-3004 (within N.C.) or 919-855-4500
Complaint Hotline Hours: 8:30 a.m. - 4:00 p.m. weekdays, except holidays.
Fax: 919-715-7724
Mail: 2711 Mail Service Center, Raleigh, NC 27699-2711

Client's Name:_____

_____

Client Signature_____
Date: _____

Phone Number: _____

Address: _____

City/State/Zip: _____

Financial Responsible Party and/or Insured
Party's Name : _____

Signature:_____
Date: _____

Phone Number: _____

Address: _____

City/State/Zip: _____

Company Representative: Name and Title

_____

Signature:_____

Date: _____