

**Patient Consent / Authorization
and Assignment of Benefits**



Patient Name: _____ Date of Birth: _____ Social Security # _____

Consent to Treatment

I hereby request services of Chartwell PA and I consent to such care, treatment, medications, and procedures as are ordered by my physician and my physician's associates to be provided by Chartwell PA. I agree that Chartwell PA is not liable for any act or omission when following a physician's instructions. I also understand that if I am in a condition to need hospitalization or special services during the course of my care, which are not provided by Chartwell PA, the services and hospitalization must be arranged by me/my legal representative, or my physician, and are my responsibility.

Medical Information Release Authorization

I hereby authorize release of all records pertaining to my medical history, treatment, or payment information to an agent of Chartwell PA, which are required for the provision of treatment, payment, or healthcare operations. I also authorize the review of my medical records by any local, state, or federal regulatory agency and accrediting bodies.

Liability Release and Use of Equipment Notice

I understand that there are risks known and unknown associated with the use of all medical equipment, supplies, drugs, access devices, and the administration of medication. I further understand that because I am using the drugs, devices, equipment and/or supplies at home, immediate emergency medical attention may not be available for any complications, injuries, or adverse results that may occur in connection with their use. I recognize my obligation to return any rented equipment after the termination of my therapy or in the event that the equipment received is no longer necessary and I promise to do so. In addition, I hereby authorize my payer and/or physician to release any personal information to Chartwell PA to assist in locating the equipment in the event it is not returned.

Assignment of Insurance Benefits and Release of Information

I hereby authorize my public and/or private insurance company or fund responsible for payment of my care, if applicable, to pay benefits on my behalf directly to Chartwell PA for any products and services, including physician services, furnished to me by Chartwell PA. I also authorize Chartwell PA to request, on my behalf, all public or private insurance benefits for products or services provided to me by Chartwell PA.

I agree to inform Chartwell PA of any change in my status, including but not limited to: change of address, admission to hospital or nursing facility, any change that affects third party payments or my own ability to pay for products and services prescribed by my physician and rendered by Chartwell PA.

Receipt of Admission Information

Prior to admission to homecare, I have received, read or had explained to me, been afforded the opportunity to discuss, and acknowledge the receipt of the following documents and/or information:

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| Patient Bill of Rights and Responsibilities | Ability to participate in my plan of care |
| Emergency Preparedness Plan | 24 hour Pharmacist/Nurse availability to discuss medications |
| Medicare Supplier Standards (If applicable) | How to file a complaint by calling 1-800-755-4704 |
| Treatment and Therapy Information | Advanced Directive Information (if applicable) |
| Notice of Privacy Practices | How therapy will be paid for and any financial responsibility |

Signatures

Patient/Guardian/Responsible Party	Relationship	Date
Witness	Printed Name	Date