CLIENT AGREEMENT FORM
PRIMARY CARE AT HOME

Client Name: ______________________________ DOB: __________ Gender: ____Social Security #:_ _ _/_ _/_ _ _ _

Address: _________________________ Apt:______ City:__________________ State:_______ Zip Code:__________

Facility: _________________________ Phone: (____)_________ Mobile: (____)___________ Email: _____________

Guardian/POA/Emergency Contact: ____________________________Relationship:_________ Phone: (____)________

Address: _________________________City: _______________ State: ______ Zip Code: ______ E-mail: ____________

I. CONSENT TO SERVICES AND RELEASE OF INFORMATION: I have personally requested primary care house call services from BAYADA Primary Care at Home. I consent to such primary care services by the Medical Director, Supervising Physician, and Non-Physician Providers (NPPs). Routine Primary Care Services are generally provided by our NPPs who are Advanced Registered Nurse Practitioners. I agree that BAYADA shall be waived of all liability related to or as the result of such services, excepting acts of negligence.

I hereby authorize any and all physicians, hospitals, skilled nursing facilities, and other health care facilities, programs, or agencies who possess my medical records to release to BAYADA any portions of my medical records or copies of them that BAYADA may request. I authorize BAYADA to release and disclose my medical records as required to communicate with physician specialists that I may be referred to, outside referral sources for special tests, accrediting or certifying bodies, or as requested by my insurance companies or other payments sources.

II. RECEIPT OF PRIVACY NOTICE: I have received and reviewed the BAYADA Privacy Notice 0-2188. I have had an opportunity to ask questions about it. I understand and agree that BAYADA may notify the police, emergency services, and/or utility companies about circumstances related to my care for safety reasons or for emergency preparedness.

III. CLIENT RIGHTS AND RESPONSIBILITIES: I acknowledge that prior to signing this document, I have received and reviewed a copy of my rights and responsibilities and a representative of BAYADA has explained them to me. I have had an opportunity to ask any additional questions, and my questions have been answered to my satisfaction.

I understand that I share in the responsibility for the safety of BAYADA's employees while providing care to me in my home. I will take reasonable steps to make the areas where care is provided safe for myself and the employees caring for me. If BAYADA notifies me of any high priority safety risks, I agree to ensure that they are promptly repaired or remedied.

I have been informed, verbally and in writing, of the procedure for filing complaints or concerns about the hospice services I am receiving, directly to BAYADA and to applicable State, Regulatory and Accrediting organizations. I have been provided with the available hotline number(s) and days and hours these organizations can receive complaints or questions about hospice agencies. I have also been advised where I may get additional information, including information about Advance Directives, if needed.

IV. RECEIPT OF INFORMATION: My signature on this form certifies that I have been provided with a thorough explanation of the services provided and gives my permission for BAYADA to assume and administer primary care procedures necessary for my ongoing care.

V. PAYMENT FOR SERVICES RENDERED: I understand I will be receiving the following types of services from BAYADA:
☐ Physician or Non-Physician Provider (Nurse Practitioner or Physician Assistant).

I have provided BAYADA with complete and accurate information as indicated below regarding my health insurance and other payment sources. Based on that information, BAYADA has determined that the following may be available to pay for my care, subject to confirmation by my health insurance company or other payment sources. I understand that I will be responsible for all co-payments, deductibles and non-covered services. If my health insurance or other third party payor coverage changes (e.g., the plan, deductible, co-payments, eligibility for coverage), I will immediately inform BAYADA. I certify that information given by me in applying for payment under TITLE XVIII and XIX of the Social Security Act and other health insurance benefits is correct.

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BAYADA® Home Health Care

Insurance Information

Primary Insurance: ____________________ Phone #: (____)__________ Policy #: __________ Group #: ________

Secondary Insurance: __________________ Phone #: (____)__________ Policy #: __________ Group #: ________

Responsible Party: ________________________________ Relationship: ______________ Phone: (____)________

Responsible Party Address: _________________________ City: ______________ State: ______ Zip Code: _______

VI. ASSIGNMENT OF INSURANCE BENEFITS: I assign to BAYADA all benefits payable under any insurance policy for services rendered by BAYADA and specifically authorize the appropriate insurance carrier to pay such benefits directly to BAYADA. BAYADA may submit a copy of this assignment to the appropriate insurer in lieu of the original. I authorize the insurer to rely on a copy of this assignment.

VII. GUARANTEE OF PAYMENT: I agree and understand that the assignment of benefits above shall not relieve me or any of my guarantors of responsibility for payment of services rendered by BAYADA, including payments for any co-payments and deductibles that may be required by my insurance carrier, unless otherwise required by law. I further agree to pay interest on any past due balances at the rate of 1.25% per month (15% per year), and I agree to pay the reasonable costs of collection, including attorneys' fees and expenses. I understand the rates and my financial obligations for these services.

All sections of this Agreement have been reviewed with me; I understand and agree to the provisions outlined above. The information that I have provided above is truthful and complete. With my signature below, I agree to be legally bound and acknowledge receipt of a copy of this Agreement.

VIII. AUTHORIZATION: I hereby authorize Bayada Primary Care at Home services to begin on ____________________.

____ ____________________ ____________________

Signature of Client *Social Security #* *Date*

____ ____________________

Representative & Relationship to Client *Date*

____

Reason Client Unable to Sign