J&D ULTRACARE CORP
99 Washington Ave. Suffern, N.Y. 10901
845-357-4500

Patient Name _____ **DOB**_____

CONSENT FOR CARE

My physician has prescribed Nursing and any other health services to be provided at my home or another appropriate site. I consent to the plan of care and home health services provided by J&D Ultracare Corp. including, but not limited to, administration, supervision and teaching of all therapies as prescribed by my physician. The purpose of the therapy and the associated potential risks as well as alternatives, have been explained to me. I have also been informed of my participation and responsibility in performance of the prescribed plan of care.

INTERRUPTION OF SERVICES

I understand J&D Ultracare Corp. will use its best effort to prevent an interruption of services, but sometimes interruptions are unavoidable. In the event of an interruption in service, the undersigned (*circle **one** that applies)* self / parent/ guardian agrees to assume responsibility for care and/or make arrangements to have the client transferred to an appropriate facility if needed. I understand that I will receive advance notification of planned discontinuation of services and should I, myself, choose to discontinue patient services against the medical advice of the patient's physician and/or agency's staff, I am releasing J&D Ultracare Corp. from responsibility for the consequences of this Act.

AUTHORIZATION FOR DISCLOSURE

I authorize J&D Ultracare Corp. to release or disclose any or all parts of my personal health information (PHI) in their possession to hospitals, physicians, social services agencies, Medicaid, insurance companies, medical service companies, accreditation and regulatory bodies and/or other institutions as necessary for treatment, payment or healthcare operations (TPO). I also authorize the release of medical information necessary for continuity of care and follow up or if referred to another health care organization, agency or facility. I also authorize my physician, hospitals and other social service agencies to release to J&D Ultracare Corp. any portion of my personal health information or copies which they may deem necessary.

I have received and read a copy of the Patient Bill of Rights, the Patient and Family Responsibilities, Privacy Policy, Grievance Procedures, Home Safety Tips, Emergency Protocol and Advance Directives, if applicable.

I understand what I have read and what was explained to me. I freely and voluntarily give my consent for home care services under the terms and conditions outlined above. I understand I may terminate home care services under this agreement at any time. I request the following restrictions to the use or disclosure of my personal health information:

_____

_____

_____

_____	_____	_____
Signature of Patient/ Guardian	Print Patient / Guardian Name	Date
_____	_____	_____
Witness Signature (Agency Employee)	Print Witness Name	Date

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ASSIGNMENT OF BENEFITS

I hereby authorize my insurance company or third-party payor (s) to pay J&D Ultracare Corp. directly for the services rendered to myself or my dependents that are covered by said policy. I understand and agree to assume responsibility for and guarantee the payment for any portion of billed charges not paid by the insurance company or third-party payor. In the event that the payment is made directly to me from the insurance company or third-party payor, I agree to immediately endorse and forward payment directly to J&D Ultracare Corp.

FINANCIAL RESPONSIBILITY

I agree to pay for those deductibles, co-payments, or non-covered services, which are not included in my Medicaid or insurance benefit, unless prohibited by law or regulations. If I have no insurance coverage, I accept full financial responsibility for the services. These charges include, but are not limited to, the following:

☐ Deductible of $_____ ☐ Co-Payment _____% _ $_____ ☐ Per visit

☐ Self Pay_____%_____☐Other_____

In the event it becomes necessary to collect this account, I agree to pay all costs incurred by J&D Ultracare Corp. including attorneys fees and delinquent charges equal to 2% on the unpaid balance per month, unless prohibited by law or regulations.
In connection with the review of this agreement, J&D Ultracare Corp. may obtain a consumers report from a consumer reporting agency. Not applicable for Medicaid only patients.

_____ _____ _____
Signature of Insured/Guarantor Print Guarantor Name Date

_____ _____ _____
Witness Signature (Agency Employee) Print Witness Name Date