Island Home Care Agency Inc.

1- 800-649-0134

PATIENT AGREEMENT

Patient Name:_____S.S.#:_____

Patient Address: _____

Phone Number:_____Date:_____

Request for Provision of Services

You have been referred to us to provide Licensed Health Care Services. We are a Licensed Home Health Care Services Agency. I have received a copy of the "Patient Bill of Rights & Responsibilties", "Service Fees","Planning in Advance for your Medical Treatment", "Appointing your Health Care Proxy and Proxy form", "Policy on Advanced Directives", "Notice of Privacy Practices" and "Emergency Preparedness Checklist".

Agreement to Pay and Payment Responsibilities

I and/or the responsible party, fully understand that I am liable (or if a responsible party has signed below, we are liable jointly and severally) being responsible for payment of all bills submitted by Island Home Care Agency Inc., for all services rendered. Based upon the information you have provided this Agency and assuming you maintain the insurance in effect throughout the term of care, it is expected that we will receive compensation from your Insurance carrier. However, if you fail to maintain your insurance or your insurance carrier determines you are no longer eligible, the patient and/or responsible party will be responsible for payment in full. The Agency shall advise the patient/responsible party of any changes that they become aware of both orally and in writing as soon as possible, but no later than 30 calendar days from the date the Agency becomes aware of the change. I and/or the responsible party understand that by signing this agreement, I engage together with Island Home Care Agency Inc. (a provider of nursing and health care services).

Assignment of Benefits

In consideration of Island Home Care Agency Inc. awaiting payment, I and/or responsible party hereby assign benefits of any/all Insurance Policies covering myself and my illness for the services rendered. I and/or the responsible party agrees to cooperate fully with all requirements of the Insurance carrier to facilitate payment under this assignment of benefits. Island Home Care Agency Inc., will do everything possible to maximize the return of your insurance coverage by full cooperation and documentation necessary to implement those payments. In the event your carrier denies coverage, we will bill you at our customary & reasonable charges. I and/or responsible party understand that my Insurance carrier may not cover specific item(s) my Physician has ordered on my behalf , and if Island Home Care Agency Inc. has provided such a service, then I and/or responsible party will be billed the difference. In the event payments for Insurance benefits are made directly to any of the undersigned, the payee will endorse all checks for such payments and forward them to Island Home Care Agency Inc., within 48 hours of receipt.

Release of Information

The undersigned authorizes the Insurance carrier(s) and any other third party payor(s) to disclose to Island Home Care Agency Inc. any information regarding such benefits, including but not limited to A) Payments made by such Insurance carrier(s), and B) The availability of continuing benefits from time to time. I and/or responsible party authorize Island Home Care Agency Inc. to act as my representative to bill and collect money from my Insurance carrier and to initiate a complaint with the State of New York Insurance Department when necessary. I and/or responsible party further authorize Island Home Care Agency Inc. to release all information related to the claim for purposes of facilitating payment of that claim. I and /or the responsible party understand that it would be prudent and in my best interests to establish a Home Health Service Plan of Care in the event of an emergency such as fire, hurricane, severe snowstorm, or other natural disaster. Therefore, I and /or the responsible party, hereby grant Island Home Care Agency Inc. permission to reveal to any governmental agency, supplemental provider agency, community volunteer service or other providers of services medical records regarding care, except where otherwise prohibited by law. I and /or the responsible party further understand this would be done as necessary, upon request, in order to insure a safe and effective emergency preparedness plan of care.

Security Agreement

Patient Name:_____(Address) of_____
_____ hereby grants to Island Home Care Agency Inc., a security interest (right to the proceeds) on Policy #_____, to secure payment of all obligations for medical, nursing, services rendered by Island Home Care Agency Inc. during my infirmity. Patient authorizes Island Home Care Agency Inc to file a financing statement. The undersigned certifies that he/she has read the foregoing and received a copy.
The undersigned also certifies that he/she is the patient, or is duly authorized by the patient as the patient's "significant others" to execute the above items and accept those items and terms.

x_____ _____ _____
(Patient Signature)/ (Parent/Legal Guardian) Witness Date

x_____ _____
(Responsible Party) Date

x **Island Home Care Agency Inc.**_____ _____
(Signature/ Title) Date

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x_____ _____ _____
(Patient Signature)/ (Parent/Legal Guardian) Witness Date

x_____ _____
(Responsible Party) Date

x **Island Home Care Agency Inc**._____ _____
(Signature/ Title) Date