Powell Supportive Services, Inc.
33845 SR-54 Suite 102
Wesley Chapel, FL 33545
Office: 813-355-4891 Fax: 866-249-9709

CLIENT AUTHORIZATION/CONSENT FOR SERVICE

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Client Name			
Social Security Number		DOB	

CONSENT TO TREATMENT/PROVISION OF SERVICE
I have been informed that Powell Supportive Services, Inc., is my primary nurse registry and is licensed to provide nurse registry services under a Plan of Care authorized by my physician. I hereby consent to treatment by the nurses, home health aides, and others referred by Powell Supportive Services as per my request, or as ordered by my physician, or as may be necessary in an emergency situation in order to save my life or to prevent permanent injury. This consent releases Powell Supportive Services from liability for any claim based on unauthorized treatment.
I understand that it is my right and responsibility to be involved in my care and that I will be informed as to the nature and purpose of any technical procedure.

FREEDOM OF CHOICE I understand that it is my right to receive care from any provider of health care services. I have chosen Powell Supportive Services, a nurse registry, to provide referrals of Independent Contractors for the care I desire.

"Nurse Registry" means referral of independent contractors to provide health care related services to a patient or client in the person's home or place of residence. F.A.C. 59A-18.002(10)

"Independent Contractor" means a person who contracts through a referral from a nurse registry. The independent contractor maintains over the the method and means of delivering the services provided, and is responsible for the performance of such services. F.A.C. 59A-18.002(8)

RELEASE OF INFORMATION
It is the policy of Powell Supportive Services, Inc., to protect all clinical records against loss, defacement, tampering, and use by unauthorized persons. I hereby authorize Powell Supportive Services to release my medical records and information concerning my illness and/or injury and treatment therefore to health care providers, payment sources, or possible payment sources, and as otherwise required by law. By signing this form, I also authorize all other health care providers involved in my care to release any portion of my medical records in their possession or control to Powell Supportive Services upon request.
Consent to Photography. I hereby consent for the Agency to take pictures of me and treatment being done and consent to the release of those photographs for use in advertisement or public education regarding nurse registry services or to insurance providers to document my medical condition.

FREQUENCY OF SERVICE/RN SUPERVISION & AVAILABILITY
I understand that the frequency of services provided to me may vary and change according to need. I understand that a replacement caregiver may provide services to me in the event that the regular caregiver is unable to fulfill his duties.
I understand that an RN will supervise all services. I understand that Per Florida Statute 400.506(6)(c) – When a certified nursing assistant or home health aide is referred to a patient's home by a nurse registry, the nurse registry shall advise the patient, the patient's family, or any other person acting on behalf of the patient at the time the contract for services is made that registered nurses are available to make visits to the client's home for an additional cost.

CLIENT RESPONSIBILITY REGARDING PRIVATE INSURANCE
* I understand that the Independent Contractor caregiver through Powell Supportive Services will promptly present claims for the payment of my referred home care services to my insurance company.
* I also understand that I am responsible for the entire amount due if submitted claims or any part of them are denied for payment.
* I understand that if the Independent Contractor is delayed in requesting immediate payment, it shall not release me or my estate from the obligation to pay the escrow account managed by Powell Supportive Services.

FINANCIAL AUTHORIZATION
I authorize benefits to be made on my behalf.

Bill Primary Insurance		% Primary Insurance Co				
Bill Secondary Insurance		% Secondary Insurance Co				
Bill Patient: Co-Payment		Payment of		Per Visit		Per Hour

I am responsible to inform the Agency if I change to an HMO. I will pay any service or supply charge not reimbursed by my insurance company on a monthly basis. I will pay all charges incurred on a monthly basis if I do not have insurance coverage. If a claim is denied for nurse registry services which Powell Supportive Services, Inc. has submitted on my behalf, I hereby elect not to appeal the denial myself, but I do hereby authorize Powell Supportive Services, Inc. to resubmit the claim for me and represent me in any negotiations. I authorize the Agency to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

AUTOMOBILE WAIVER (Transportation)
Powell Supportive Services does not provide screening or background checks with respect to an Independent Contractor caregiver's driving record or auto insurance coverage. The decision to utilize an Independent Contractor caregiver to transport me in either the caregiver's or my own automobile, therefore, is entirely my own choice subject to the consent of the caregiver. I agree to hold Powell Supportive Services harmless against any losses that may arise out of any accident while being transported by an Independent Contractor caregiver referred to me, whether transportation is being provided in my vehicle or the Independent Contractor caregiver's vehicle.

POLICIES
I have received a **HIPAA** Notice of Privacy Practices and consent to the agency's use and/or disclosure of protected health information for payment, treatment, and the agency's health care operations.
I have been informed about **Emergency Preparedness** and what to do in an emergency and I have a Personal Emergency Plan.
I have received information about the agency's policy on **Abuse, Neglect, and Exploitation**.
I have received information about how to make a **Complaint**.
I have received a copy of my Patient **Bill of Rights** and the Rights of the Elderly/Persons with Developmental Disabilities, as appropriate.

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CLIENT RIGHTS

Per Florida Administrative Code 59A-18.011(7), the client, caregiver, or guardian must be informed by Independent Contractors for the Nurse Registry that:

(a) They have the right to be informed of the medical plan of treatment,
(b) They have the right to participate in the development of the medical plan of treatment,
(c) They may have a copy of the medical plan of treatment if requested,
(d) The caregiver being referred is an Independent Contractor of the registry.

If you have a concern or complaint regarding the referred caregiver or the services you are receiving, please contact Powell Supportive Services immediately at 813-355-4891. This telephone number is available 24 hours a day, 7 days a week.

To report a complaint regarding the Florida Statutes or Administrative Code for Nurse Registries, please call toll-free 1-888-419-3456.
To report abuse, neglect, or exploitation, please call toll-free 1-800-962-2873.
To report suspected Medicaid fraud, please call toll-free 1-866-966-7226.

HEALTH CARE SURROGATE/MEDICAL POWER OF ATTORNEY/AUTHORIZED AGENT			
Health Care Surrogate Name		Phone #	
Medical Power of Attorney Name		Phone #	
Authorized Agent Name		Phone #	

LIVING WILL/ADVANCED DIRECTIVE/DO NOT RESUSCITATE ORDER (DNRO)				
	I have		I have not	signed a Living Will/Advanced Directive. (Please Initial One)
	I am		I am not	providing a copy of my Living Will/Advanced Directive for my record. (Please Initial One)
	I have		I have not	signed a DNRO. (Please Initial One)
	I am		I am not	providing a copy of the DNRO for my record. (Please Initial One)

I agree to abide by all of the above conditions and I acknowledge this agreement shall bind me and my heirs, executors, administrators, and assigns.

I hereby certify that I have read and understand this agreement and I have executed said agreement of my own free will, effective as of the date below.

Client Signature		Date	
Authorized Agent Signature		Date	
Printed Name Authorized Agent			
Reason Client Unable to Sign			
Witness Signature		Date	
Nurse Registry Representative		Date	