SALEM HOSPITAL
REGIONAL HEALTH SERVICES

HOME CARE
HOME HEALTH
COMMUNITY BASED SERVICES
P.O. BOX 14001
SALEM OR 97309

CONDITIONS OF ADMISSION

Request for Treatment: I hereby request ☐ Home Health Care ☐ Community Based Services from Salem Hospital Home Care (SHHC). I hereby consent to the performance of all treatments and tests, which may be considered advisable or necessary by my attending physician. SHHC reserves the right to terminate treatment at any time on notice to patient and physician.

Limitations of Service and Indemnities: I understand SHHC will not provide continuous care. Should my safety or condition become such as to require continuous medical care and/or supervision, it shall be my responsibility or the responsibility of my legal representative to arrange for same. I agree to indemnify and hold SHHC harmless from any and all claims or liability arising from the fact that I have not been provided with the same. I further absolve SHHC, its personnel and representatives from responsibility for any injury or illness, which may result from accident.

Complaints: I understand if I have a concern or complaint about services I can call **(503) 561-5999** during regular business hours, between 8:00 AM and 4:30 PM. State of Oregon Home Health Hot Line #1-800 542-5186.

Billing Information-Liability for payment: If criteria of payment source is met the following will apply

- Medicare/Medicaid/Managed Medicare/Kaiser Managed Care programs accept assignment of Benefits and cover the cost of **Home Health** services 100%. There will be no cost to you.
- **Financial responsibility**: You will be called if you have any financial responsibility. **The cost of services will be explained to you, by a phone call, before care is provided. A letter will also be sent to you.** Please call **(503) 561-5999** and ask for the billing department to discuss billing questions or to make payment arrangements.

Services Ordered By M.D.	Projected Frequency/Duration	Services Ordered by M.D.	Projected Frequency/Duration
X Registered Nurse:	1w 7x30	☐ Speech Therapist	
☐ Physical Therapist:		X Medical Social Worker	Eval
☐ Occupational Therapist:		X Home Health Aide	2w 7x30

Staff will explain changes in the frequency, length, or type of services as your physician orders.

Financial Agreement: The undersigned agrees, whether he/she signs as agent or as patient, to pay the account of SHHC in accordance with the rates and terms of SHHC. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney fees and collection expense. All delinquent accounts bear interest at the legal rates. **Request for Federal and State of Oregon Assistance:** I authorize Salem Hospital to apply to local social service agencies for the purpose of requesting financial assistance and determining eligibility for assistance under programs offered by State of Oregon and federal government.

Authorization: I authorize release of medical information **From:** SHHC **To:** The Insurance Providers **Purpose:** Payment review. **Information includes:** Information in my clinical record **Except:** ______________________.
I acknowledge that data to be released may include information that is specific to drug and/or alcohol and/or psychiatric treatment which cannot be released without this consent. **Payment request for Medicare Benefits:** I request payment of authorized benefits to me or on my behalf for services furnished by SHHC.

Medicare/Insurance Name: ____________________ **Medicare /Insurance Claim number:** ____________________

Patient Warranties I acknowledge that I have received a copy and understand the above SHHC conditions of admissions. If English is not primary language and/or if you are hearing impaired an interpreter will be provided to interpret this information. I understand, with these terms, I have also received the following and have had the information explained to my satisfaction: Statement of Patient Privacy Rights, Patient Handbook, Patient Rights & Responsibilities including my rights to participate in my plan of care. Photostat of this authorization will be considered as effective and valid as the original. The Signed may cross off and initial a phrase of this consent provided it does not change the intent of the form.

Evelyn L. Moreno — [signature] P.O.A. — [signature]

Patient Signature — Date — Responsible Party/Relationship — Date — SHHC Staff Signature — Date

Patient Full Name (Print): Moreno Evelyn

Original to Home Care
Copy to Remain in Home

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