New Tech Mobility
Unique Mobility Solutions

AUTHORIZATION/AGREEMENT FOR SERVICES

Client Name: ____

RIGHTS AND RESPONSIBILITIES

My signature below acknowledges that I have received the statement of rights and responsibilities and it has been explained to me.

AUTHORIZATION FOR TREATMENT

I authorize the home care company to provide care and/or services as ordered by my physician. I understand that I have the right to make decisions concerning my medical care, including the right to accept or refuse medical or surgical treatment.

MEDICARE

Name of Beneficiary: ____________________________

Claim #: ____

MEDICAID

Recipient Name: _________________________________

ID#: _____________ Physician Sponsor: ___________

Eligible Period ____/____/____ Thru ____/____/____

BLUE CROSS

Subscriber Name: ______________________________

Contract #: ______________ Group #: ____________

PRIVATE INSURANCE

Insurance Co.: _________________________________

Insured's Name: ________________________________

Claim #: _____________ Phone #: _______________

ASSIGNMENT OF BENEFITS/GUARANTY

I authorize payment directly to the home care company of any benefits otherwise payable in respect to examination or treatment of client. I agree to pay any charges not covered by insurance benefit plans, excluding Medicare and Medicaid recipients and where payment is prohibited by law.

Insurance pays for __________ %. Client pays for __________ or $ __________ per visit.

RELEASE OF INFORMATION

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act, or under a policy of insurance is correct. I authorize the home care company or any other holder of medical or other information about the above named client, to release or receive such information to any government agency or insurance company to whom application has been made for payment for services rendered to the above client; to any physicians, hospitals, other healthcare providers or facilities, institutions, or agencies providing treatment to the client or providing continuity of care; and to quality reviewers.

EMERGENCY PLAN

My signature below acknowledges that I have established and understand my emergency plan.

I have received the home care company's brochure; I have been informed of the nature and frequency of visits I will receive; and I have participated in the planning of my care.

Indicate frequency of visit range under each projected discipline:

SN	RT	PT
_____	_____	_____

INFECTION CONTROL

In the event that an employee or other representative of __________________ sustains percutaneous, mucous membrane, or open wound exposure to my blood or other body fluids, I agree to have my blood tested for HIV or Hepatitis infection, and I agree that the results of the tests may be released to the company and the exposed person, but not to anyone else unless required or authorized by law.

____ ____________________

Signature of Client or Responsible Person Date

____ ____________________

Signature of Company Representative Date

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