FORECASTLE HOME AND HEALTHCARE SERVICES. LLC

INFORMED CONSENT & VERIFICATION OF RECEIPT OF INFORMATION

I hereby consent to treatment and care. I acknowledge and consent to the following: Medicaid, Private Pay, and Insurance.

I understand my care is based on a treatment plan and/or ordered by my physician per agency policy. I have participated in the development of, and am in agreement with, the treatment plan outlined. My treatment plan may change as my care needs change and I will be informed.

I understand that this is the initial plan and I will be notified by the agency each time there are changes made in my plan of care.

I understand that the agency will provide supervision for all services rendered to me. I understand that I have the right to refuse care or treatment at any time.

I have read, understand and received a copy of:

- Welcome Letter / Hours of Operation
- Client Rights, Responsibilities and Grievance Procedure
- Abuse, Neglect, Exploitation Policy and Drug Testing Policy
- HIPAA Notification of Privacy Rights
- Forecastle Home and Healthcare Services information and Privacy Rights
- Advance Directive Information
- Infection Control Guidelines and Sharps Disposal
- Reimbursement for Services Rendered
- Consent & Verification of Receipt of Information

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Signature-Client or Representative Date

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Signature- Title Witness Date