IndependenceFirst

SERVICE INFORMATION AGREEMENT

Consumer Name: _____
Last First M.I.

Address: _____ Phone: _____

_____

_____

Payment Source: ___ T-19 ___ Private Pay ___ Other: _____

MA Number: _____ Valid: _____

SERVICES ORDERED	FREQUENCY	CHARGES	PAYER LIABILITY	CONSUMER LIABILITY

I have received and understand the information on advanced directives: Yes No

I agree to allow my PCW's to practice Universal Precautions: Yes No

AUTHORIZATION OF TREATMENT AND AGREEMENT TO PAY

I understand the duties and responsibilities of my care givers, and understand that I am ultimately in control of the service that I receive from my caregivers. I will not hold Independence*First* responsible for my failure to abide by doctor's orders. I understand that there may be circumstances beyond the control of Independence*First* when there may be short interruptions in service. During such interruptions, I will arrange for appropriate care.

I request payment of authorized benefits be made on my behalf directly to Independence*First* and thereby irrevocably assign to Independence*First* any benefits due me from third parties, such as insurance companies or Medicaid. I authorize release of information about this claim to other payment sources listed above upon their request. I understand that I am responsible for any fees not covered by these payment sources.

I understand that with insurance coverage, there may be contract rules and guidelines that define my financial obligations and responsibilities for co-payment. If, for whatever reason, my insurance does not / will not cover my services provided by Independence*First*, I will assume total financial responsibility for this obligation. If I am receiving Medicaid, the Department of Social Services will make me aware of any spend-down requirements as they occur, and I will assume total financial responsibility for this obligation.

AGREEMENT CONT. CONSUMER:_____

I have been fully informed of my rights and responsibilities and of the rules and regulations governing Independence*First*. I acknowledge the receipt of the "Consumer Rights and Responsibilities" and the Wisconsin Division of Health Complaint Form, and request the services listed above at the rates listed above.

I approve the release of any information required for the coordination of my personal cares. I authorize Independence*First* to disclose information to the following: including, but not limited to physicians and other health care providers, medical equipment providers, _____ County, health care entities, and _____. I understand that only the information necessary will be released and only to further the goal of coordination of my personal care service. this release shall remain valid until the coordination of my discharge is complete.

The following are my designated representatives who may sign and verify my PCW time sheets:

_____ _____

Signed: _____ Date:_____
Consumer

Signed: _____ Date:_____
Representative/Legal Guardian

Witness: _____ Date:_____