All Med Network Corp.

CONSENT ASSISTANCE WITH SELF-ADMINISTERED MEDICATIONS BY NON-LICENSED PERSONNEL

CONSENTIMIENTO PARA RECIBIR AYUDA CON LA ADMINISTRACION DE MEDICAMENTOS QUE PUEDO ADMINISTRARME POR MI PERSONA

I _____ [patient, or patient's surrogate, or guardian, or attorney in fact's name], herein referred to as "the patient", hereby state that I have been informed of the following facts: *Yo he sido informado de:*

1. That the patient may be receiving assistance with self-administration of medication from an unlicensed person; i.e. home health aides. *Puede el pciente recibir ayuda de un personal no licenciado en la administración personal de medicamentos (Ejemplo Auxiliar de Enfermera)*

2. That the patient's home health aides are: *Las auxiliares de Enfermeras son:*

· **Not currently licensed to practice nursing or medicine**; *(No tienen licencia para practicar enfermería o medicina)*

· **Employees of our agency; and** *(Empleados de nuestra Agencia)*

· **Trained with respect to assisting with the self-administration of medication as provided in rule promulgated by the Agency for Health Care Administration.** *Estan entrenadas para ayudarlo con su propia administración de medicamentos.*

3. That our Agency encourages patients who are capable of self-administering their own medications without assistance to do so. *Nuestra Agencia le recomienda que si es capaz de administrarse sus medicamentos sin asistencia, lo haga.*

4. That our Agency, provides unlicensed personnel who, consistent with a dispensed prescription's label or the package directions of an over-the-counter medication, helps the patient, who needs assistance and whose condition is medically stable, with the self-administration of routine, regularly scheduled medications that are intended to be self-administered. *Nuestra Agencia provee personal no licenciado para ayudarlo en su administración de medicamentos que usted se puede administrar por si mismo, siguiendo las prescripciones escritas.*

5. That, for purposes of this informed consent, self-administered medications include both legend and over-the-counter oral dosage forms, topical dosage forms, and topical opthalmic, otic, and nasal dosage forms, including solutions, suspensions, sprays, and inhalers. *Este consentimiento incluye controladas y no controlados medicamentos, como oral, topical, oftalmológicas, nasal, etc.*

I _____ [patient, or patient's surrogate, or guardian, or attorney in fact's name], hereby state that I have read, and been fully informed of, the above facts and that I hereby request and consent to have home health aides assist me with my self-administered medications. *Yo certifico que leí y estoy completamente informado, y de acuerdo con la ayuda de la auxiliar de enfermera en la administración de medicamentos que puedo administrarme por mi mismo.*

Signed this the ___ day of _____, _____. *Firmado en fecha.*

_____ _____

Patient, or patient's surrogate, or guardian, or attorney in fact

(Title)

HMHC
Health Med Home Care, Inc.

CONSENT/DECLINE TO SPECIAL TREATMENTS

I HEREBY AUTHORIZE HEALTH MED HOME CARE, INC., TO RENDER APPROPRIATE SERVICES AS PRESCRIBED BY MY PHYSICIAN, OR BY ANY OTHER PHYSICIAN WHO MAY BE TREATING ME, INCLUDING ALL DIAGNOSTIC AND THERAPEUTIC TREATMENT THAT MAY BE CONSIDERED ADVISABLE OR NECESSARY IN THE JUDGMENT OF THE PHYSICIAN.
I HEREBY AUTHORIZE/DECLINE, AS BELLOW, HEALTH MED HOME CARE, INC., OR THEIR AGENTS TO PERFORM ANY WORK IN TAKING BLOOD SAMPLES FROM ME OR ADMINISTERING INJECTIONS OR INTRAVENOUS THERAPY FOR NORMAL MEDICAL PRACTICE. I HEREBY AUTHORIZE THIS WORK UNDER PHYSICIAN'S ORDERS, WHILE A PATIENT WITH YOUR ORGANIZATION.

Service authorization or decline:

- ☐ I authorized IV therapy
- ☐ I authorized Flu vaccine
- ☐ I authorized blood work
- ☐ I authorize vaccine of _____
- ☐ Other, explain: _____

- ☐ I decline IV therapy
- ☐ I decline flu vaccine
- ☐ I decline blood work
- ☐ I decline vaccine of _____
- ☐ I decline other _____

AUTORIZACIÓN/RECHAZO PARA RECIBIR TRATAMIENTOS ESPECIALES

YO AUTORIZO A HEALTH MED HOME CARE, INC., A QUE PROVEA LOS SERVICIOS APROPIADOS TAL COMO HAN SIDO PRESCRITOS POR MI MEDICO, O POR CUALQUIER OTRO MEDICO QUE PUEDA ESTAR TRATÁNDOME, INCLUYENDO TODOS LOS TRATAMIENTOS MÉDICOS Y DIAGNÓSTICOS QUE PUEDAN SER CONSIDERADOS RECOMENDABLES O NECESARIOS A JUICIO DEL MEDICO.
TAMBIÉN AUTORIZO/RECHAZO (segun abajo) A HEALTH MED HOME CARE, INC. Y/O A SU PERSONAL A REALIZAR CUALQUIER TAREA REQUERIDA PARA MI TRATAMIENTO COMO: OBTENER MUESTRAS DE SANGRE, ADMINISTRACIÓN DE INYECCIONES O TERAPIA INTRAVENOSA PARA LA PRACTICA MEDICA. AUTORIZO ESTO BAJO LAS ORDENES DE UN MEDICO MIENTRAS SEA PACIENTE DE ESTA ORGANIZACIÓN.

Autorización de servicios o Rechazos de los mismos:

- ☐ Yo autorizo terapia de sueros
- ☐ Yo autorizo la vacuna contra el gripe
- ☐ Yo autorizo extracción de sangre
- ☐ Yo autorizo la vacuna de _____
- ☐ Otros, explicar: _____

- ☐ Yo rechazo terapia de sueros
- ☐ Yo rechazo la vacuna contra la gripe
- ☐ Yo rechazo extraerme sangre
- ☐ Yo rechazo la vacuna de _____
- ☐ Yo rechazo otro: _____

_____ _____
Client/Patient Signature - *Firma del Paciente* Date - *Fecha*

_____ _____
Witness/Employee - *Testigo/Empleado* Date - *Fecha*

ANGELES PROTECTORES HOME HEALTH CARE INC.

Consent for Continuation of Care

I, _____, hereby authorize consent for Home Health Services to be rendered solely by ANGELES PROTECTORES HOME HEALTH CARE, INC., in the event of my hospitalization. Upon my discharge from Hospital/Outpatient center, ANGELES PROTECTORES HOME HEALTH CARE, INC., is to immediately continue providing services.

Yo, _____, autorizo a la compañia ANGELES PROTECTORES HOME HEALTH CARE, INC., a continuar brindándome los servicios de Home Health cuando sea finalizada mi estancia en el hospital o centro de rehabilitación.

_____ _____

Signature of Patient/Authorized Representative
Firma del Paciente/Representante Autorizado

Date/Fecha

_____ _____

Relationship of Authorized Representative
Relación con Representante Autorizado

Date/Fecha

_____ _____

Witness/Testigo

Date/Fecha

Angie's Home Health, Inc.

CONSENT FOR I.V. OR L.M. THERAPY ADMINISTRATION

PATIENT: _____ MR#: _____

Your physician has ordered the following medication(s) to be administered to you:

_____ ___ IV ___ IM

_____ ___ IV ___ IM

Side effects of this medication administered via this route may include:

_____

Potential Adverse reactions may include:

_____

Other risks/possible complications may include:

_____

The nature and purpose of the medication, as well as the potential side effects have been explained to me to my complete satisfaction. I have had the opportunity to have all of my questions/concerns addressed. No guarantees or assurances of any kind have been given to me or my family/guardian/care giver as the results that may be obtained.

I understand that certain lab tests may be necessary prior to and during treatment, and I hereby consent to having these tests performed.

I understand that there may be possible side effects/adverse reactions as a result of this therapy, and I release **Angie's Home Health, Inc.**, and all of its employees from any and all liability in conjunction with this therapy.

I hereby give my consent for the administration of this therapy by **RN, Angie's Home Health Care, Inc.**, as ordered by my physician.

_____

Patient/Guardian Signature/Date

_____

RN Signature/Date

Gentle Care Home Health, LLC.

SUPERVISION CONSENT

I, _____, authorize **Gentle Care Home Health,LLC.** to perform in home supervision.

The supervisory visit will be conducted as follow:

- ❑ every _____ for non-Medicare/Medicaid patients (according patient's direction) and approval). I accept to pay supervisory visits. Charge per visit is $ _____.
- ❑ once (1) every month, or _____, for Medicaid Patient with personal care only (non-skilled)
- ❑ 14 days cycle for Medicare / Medicaid patient with Skilled Services
- ❑ other, specify _____.

Patient's Signature: _____ Date: _____

CONSENTIMIENTO PARA SUPERVISION

*Yo, _____ autorizo a **Gentle Care Home Health,LLC.** a realizar supervisiones en mi casa.*

Las siguiente visita de supervision sera conductada:

- ❑ *cada _____ para pacientes que no tiene Medicare/Medicaid (de acuerdo la aprobacion del paciente). Yo accepto pagar la visita de supervision. Los cargos por visita son $ _____.*
- ❑ *1 vez al mes, o _____ para pacientes de Medicaid con cuidado personal solamente.*
- ❑ *cada 14 dias para pacientes de Medicaid/Medicare con cuidado de Enfermera.*
- ❑ *otro, especifique _____.*

Firma de paciente: _____ Fecha: _____

Happy Heart Home Health Care, Inc

Consent for Home Visit by Joint Commission Surveyor(s)

Happy Heart Home Health Care, Inc. is committed to providing the highest quality of care possible to its patients. To demonstrate that commitment, we are seeking accreditation by the Joint Commission on Accreditation of Healthcare Organizations, a nationally recognized quality review organization. As part of the accreditation process, field representatives (also called surveyors) of the Joint Commission must observe the care provided to patients in their home.

We are asking for your assistance by allowing one or two representatives of the Joint Commission to come with our staff member(s) to your home and observe the care and services we provide to you. Your participation is purely voluntary. Refusal to allow the surveyor to visit your home will not affect the care or services we provide to you in any way.

By signing this document, you agree to allow one or two representative(s) of the Joint Commission on Accreditation of Healthcare Organizations to accompany our staff during a visit in your home. You agree to allow this individual to observe the care and services provided to you or your family member by our staff while in the home and to ask questions about the care and services you are receiving from our home care organization.

Happy Heart Home Health Care, Inc. *está comprometido a proveer la mayor calidad en el cuidado de la salud de nuestros pacientes. Para demostrar este compromiso, estamos buscando acreditarnos con La Comisión Unida de Acreditación a las Organizaciones del Cuidado de la Salud (Joint Comission), una organización de revisión, de calidad reconocida nacionalmente. Como parte del proceso de acreditación, los representantes (también llamados inspectores) de Joint Commission tiene que observar el cuidado brindado a los pacientes en sus casa.*

Estamos solicitando su asistencia para que uno o dos representantes de Joint Commission visiten su casa con uno de nuestros empleados par observar el cuidado y servicios que le proveemos. Su participación es voluntaria. El rechazo de que el supervisor visite su casa, no afecta en ninguna manera el cuidado o los servicios que le ofrecemos.

Con la firma de este documento usted autoriza que uno o dos representantes de Joint Commission acompañen a nuestros empleados a una visita a su casa. Usted esta de acuerdo con que esta persona observe el cuidado y los servicios que le proveen a usted o su familia nuestros empleados, y le pregunten acerca de estos servicios.

_____ _____

Signature/*Firma* Date/*Fecha*

_____

Print name of patient or family member/*Imprima el nombre del Paciente/Familiar*

HOME CARE SERVICES PROVIDER

Telemonitoring Informed Consent Form
(continued)

Patient informed consent for _____ (Telemonitoring system)

I give permission to the staff of _____ (agency name) to provide home telemonitoring services to me. _____ has explained the details of these services to me.

Authorization to obtain and release information

I give permission to the staff of _____ (agency name) to obtain any and all clinically necessary information on where care has or will be provided to me.
I also give permission for the staff of _____ (agency name) to release any clinically necessary information about my health to any individuals that have been or might be involved in my care.

Authorization to collect, analyze, store, and share outcome data

I give permission to the staff of _____ (agency name) to collect, analyze, store, and share outcome data from the care I receive and that this may include health information. I understand that my health information may need to be shared with others inside and outside _____ (agency name), and if so, none of this data will identify me. I understand that occasionally, when required by law, information about me may be shared with others that reveal my identity.

I understand that individuals who are either directly or indirectly involved in my care for the purposes of treatment, billing, and daily operations may review my health information and records.

I understand that I have the right to see my data by written request to _____ (agency name).

I also understand that I have the right to refuse the staff of _____ (agency name) to collect, analyze, store, and share my data at any time. By refusing this will not affect my usual _____ (agency name) health care but will prevent me from participating in the telemonitoring program.

HOME CARE SERVICES PROVIDER

Telemonitoring Informed Consent Form
(continued)

Authorization to capture video images during a telemonitoring visit

I authorize the staff of _____ (agency name) to take photographs or images of me. These photographs or images will be kept confidential and only used for my care and treatment.

Patient Responsibilities

1) I understand that the staff of _____ (agency name) will be helping my ordering physicians, not replacing them. I agree to provide accurate answers about my conditions, medications, and treatments. I recognize that if I do not answer truthfully or use the equipment as instructed that this may result in serious harm happening to me.

2) I understand that while the equipment is in my home I will follow the instructions given to me by the staff _____ (agency name) about its care. If the equipment becomes damaged I will notify the staff of _____ (agency name) immediately: ( ) _____ - _____. (agency phone number)

I have read and understand the above information and consent to participate. I agree that the equipment will be returned to _____ (agency name) when my participation in this program is over.

_____ _____
Patient Signature Date
(Power of Attorney may sign if patient deemed unable)

_____ _____
Witness Date

MAXMED, INC.

INTRAVENOUS THERAPY CONSENT

Patient/Client Name: _____ MR: _____

Patient/Client/Responsible Party is to initial each paragraph which is relevant to the treatment.

	I have been informed of the purpose and possible complications in intravenous therapy. I consent to the administration of this treatment in the home by the Maxmed, Inc. RN as ordered by the physician.
	I understand that service from Maxmed, Inc. is on a part-time/intermittent basis.
	I agree that my caregiver and/or I will assume responsibility for the care of the Intravenous in the absence of the Maxmed, Inc. Nurse.
	I have been instructed how to care for the intravenous and how to seek assistance between nursing visits.
	I consent to the administration of Intravenous Medication as ordered by my physician. I have been informed of possible side effects and complications.
	I consent to the insertion of intravenous needles as required to administer my intravenous therapy. I have been informed of possible side effects and complications.
	I have been informed that Maxmed, Inc. has specific policies relating to the care I will receive. These provisions include the termination of service at my or my family's request, the request of my Physician, or by the decision of Maxmed, Inc.
	I agree to abide by the terms and policies of Maxmed, Inc.

I hereby acknowledge that I have read and understand the above consents and that I have received a copy of this consent.

_____ _____

Patient/Client Signature Date

_____ _____

Witness' Signature Date

CONSENTIMIENTO PARA TRATAMIENTO DE HERIDAS, Y/U OTROS TRATAMIENTOS

1. Por la presente autorizo al Dr./Dra. _____ o a sus asociados o asistentes a realizar en el paciente indicado en este formulario el siguiente tratarniento de heridas, y/u otros tratamientos: desbridamiento de herida; remoción de tejido muerto, biopsia, aplicación de tejidos vivos humanos reestructurados en un laboratorio, xenoinjertos, injertos pequeños y aloinjertos.

2. Dr/Dra._____ me ha explicado en su totalidad la naturaleza y propósito del tratamiento de heridas y/u otro tratamiento y además me ha informado de los beneficios esperados y las complicaciones (por causas conocidas o desconocidas), molestias y riesgos que pudieran surgir, como también las alternativas posibles al tratamiento propuesto, incluyendo no tratamiento y que este tratarniento de heridas y/o otro tratamiento podria incluir la aplicación local de un factor de crecimiento de cicatrización de herida para mejorar la cicatrización. Se me ha brindado la oportunidad de hacer preguntas y todas las que he formulado han sido respondidas en su totalidad y satisfactoriamente.

3. Todo órgano o tejido removido puede ser examinado y retenido por el **Instituto de Curas de Heridas y Dermatologia** y su filial autorizada por motivos médicos, cientificos o educacionales y dichos tejidos o partes pueden ser desechados según las prácticas acostumbradas.

4. Reconozco que no se me han otorgado garantias o seguridades concernientes a los resultados que se procura obtener por el tratamiento de heridas y/o otro tratamiento.

5. Por la presente doy mi consentimiento para que se tomen fotografias, grabaciones en cinta, grabaciones de video y/o otras peliculas del paciente nombrado, en conexión con los servicios médicos y otros servicios que el paciente está recibiendo. Además doy mi consentimiento al Equipo de Tratarniento de Heridas a formular preguntas sobre mis problemas médicos y sociales. Los videos son utilizados para efectos educativos solamente. Dichas fotografias, cintas grabadas, cintas de video, películas y/o historias podrían ser publicadas, exhibidas, mostradas o utilizada por el Equipo de Tratarniento de Heridas y sus filiales autorizadas por cualquier motivo relativo a educación médica, conocimientos, investigación y/o publicidad médica que el Equipo de Tratamiento de Heridas y sus filiales autorizadas estimen apropiadas. Entiendo que ni el paciente indicado ni los miembros de la familia del paciente serdn identificados por sus nombres en conexión con cualquier uso público de estos materiales.

6. Otorgo mi consentimiento como una contribución voluntaria y renuncio a todos los derechos que pudíera tener, a regalías u otro tipo de compensación por el uso indicado.

7. **ENTIENDO QUE EL CUMPLIMIENTO DE LAS RECOMENDACIONES DE MI DOCTOR ES UN FACTOR PRIMORDIAL EN MI CURACION. UNA VEZ QUE HAYA ACORDADO UN TWO DE TRATAMIENTO, COOPERARE EN LA MEDIDA DE MIS POSIBILIDADES CON EL PLAN DE TRATAMIENTIO Y SI NO LO PUDIERA HACER, INFORMARE A MI DOCTOR 0 ENFERMERO/A QUE MI PARTICIPACION EN ESTE PROGRAMA PODRIA DARSE POR TERMINADA SI NO CUMPLO CON LAS RECOMENDACIONES DE MI MEDICO.**

8. Confirmo que he leído y comprendido totalmente lo manifestado anteriormente y que todos los espacios en blanco han sido llenados antes de yo firmar. He tachado todos los pdrrafos que no corresponden a mi caso.

_____ _____ _____ _____
(FIRMA DEL PACIENTE) (FIRMA DEL TESTIGO) (FECHA) (HORA)

Debe obtenerse la firma del paciente salvo que éste es un menor no emancipado menor de 18 años 0 no tiene las facultades pare firmar.

Si el paciente no tiene las facultades para dar su consentimlento o para ejercer su derecho a negarse, y/o es menor de edad, completar lo siguiente:

El Paciente no tiene las facultades para dar su consentimiento debido a: _____

_____

_____ _____ _____ _____
(FIRMA DEL REPRESENTANTE) (RELACION) (FECHA) (HORA)

_____ _____ _____
(FIRMA DEL TESTIGO) (FECHA) (HORA)

CERTIFICACON DEL MEDICO:

NOMBRE DEL MEDICO: _____

Certifico por la presente que he explicado la naturaleza, objeto, beneficios, riesgos y/o alternativas al tratamiento de heridas propuesto, Y/o otros tratamientos y me he ofrecido a responder cualquier preguntas y las he respondido en su plenitud. Asimismo, creo que el paciente/familiar/apoderado entiende perfectamente lo que he explicado y respondido.

_____ _____
(FIRMA DEL MEDICO) (FECHA)

Wound Healing & Dermatology Institute
1333 Coral Way. Suite 200
Miami, Fl 33145

CONSENT FOR WOUND CARE, AND/OR OTHER TREATMENT(S)

1. I hereby authorize Dr. _____ or his associates or assistants to perform upon the named patient the following wound care, or other treatments: describe wound, removal of dead tissue, biopsy, application of bioengineered human living tissue, xenografts, pinch grafts allografts.

2. Dr. _____ has fully explained to me the nature and purpose of the wound care or other treatment and has also informed me of the expected benefits and complications (from known and unknown causes), attendant discomforts and risks that may arise, as well as possible alternatives to the proposed treatment including no treatment, and that this wound care and/or other treatment may include local application of wound healing growth factor to improve healing. I have been given the opportunity to ask questions and all my questions have been answered fully and satisfactorily.

3. Any organs or tissues removed may be examined and retained by the **Wound Healing & Dermatology Institute** authorized affiliate for medical, scientific, or educational purposes and such tissue or parts may be disposed of in accordance with accustomed practice.

4. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the wound care, and/or other treatment.

5. I hereby consent that photographs, tape recordings, videotapes and/or other films may be taken of the named patient in connection with the medical and other services which the named patient is receiving. I further consent that a history of the patient's social and medical problems may be taken by the Wound Care Team. Videotapes are used for educational purposes only. Such photographs, tape recordings, videotapes, films and/or histories may be published, shown, exhibited or otherwise used by Wound Care and its authorized affiliates for any purpose of medical education, knowledge, research and/or medical publicity which the Wound Care Team and its authorized affiliates may deem proper. I understand that neither the named patient nor members of the patient's family will be identified by name in connection with any public use of these materials.

6. I grant this consent as a voluntary contribution and I waive any and all rights the named patient may have to royalties or other compensation with any such use.

7. I UNDERSTAND THAT MY COMPLIANCE WITH MY DOCTOR'S ORDERS IS A MAJOR FACTOR IN MY HEALING. ONCE I HAVE AGREED TO A COURSE OF TREATMENT, I WILL COOPERATE WITH MY TREATMENT PLAN TO THE BEST OF MY ABILITY, AND, IF I CANNOT, I WILL INFORM MY DOCTOR OR NURSE CASE MANAGER. I UNDERSTAND THAT MY PARTICIPATION IN THIS PROGRAM CAN BE TERMINATED IF I DO NOT COMPLY WITH MY DOCTOR'S ORDERS.

8. I confirm that I have read and fully understand the above and that all blank spaces have been completed prior to my signing. I have crossed out any paragraphs above that do not pertain to me.

_____ _____ _____ _____
(SIGNATURE OF PATIENT) (SIGNATURE OF WITNESS) (DATE) (TIME)

The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incompetent to sign.

If patient is unable to consent or is a minor, complete the following:

Patient is unable to consent because: _____

_____

_____ _____ _____ _____
(SIGNATURE OF REPRESENTATIVE) (RELATIONSHIP) (DATE) (TIME)

_____ _____ _____
(SIGNATURE OF WITNESS) (DATE) (TIME)

PHYSICIAN'S CERTIFICATION:

NAME OF PHYSICIAN:_____

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to the proposed wound care, hyperbaric oxygen treatment and/or other treatments; and have offered to answer any questions and have fully answered such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

_____ _____
(PHYSICIAN'S SIGNATURE) (DATE)

Wound Healing & Dermatology Institute
1333 Coral Way. Suite 200
Miami, Fl 33145