EXHIBIT A

OVERLOOK
Visiting Nurse Association

HOME CARE CONSENT

Patient Name: Shanta Driver Branch: WSP PT OVNA

I, hereby authorize Overlook Visiting Nurse Association (Overlook) to perform: *(check all that apply)*

Services:	☐ SN	☒ PT	☐ OT	☐ ST	☐ MSW	☐ CHHA	☐ PCA/HM	☐ PDN	☐ RD
Frequency:		2x/wk 4wks							

PLEASE CHECK APPROPRIATE BOX FOR EACH ITEM YOU WILL GIVE CONSENT TO OVERLOOK

I understand, acknowledge and agree to the following:

☒ **CARE/SERVICE:** I hereby consent and authorize Overlook, its agents and associates to provide care and treatment to me in my home per agency policy and/or as prescribed by my physician. A representative of this organization has explained my plan of care and all my questions have been answered satisfactorily. I understand that the treatment plan may change and, if so, these changes will be discussed with me. I further understand that I and/or my family/caregiver will receive instructions to assist with my care and that my care will therefore become my responsibility in the absence of agency staff in my place of residence. I agree to notify my physician or others providing care of any adverse reactions or other significant events relating to my health.

☒ **RELEASE OF INFORMATION:** I hereby consent to and authorize Overlook to disclose and release information contained in my clinical record to the health care providers involved in my care, third party payors, utilization review and professional standard review/accrediting organizations, regulatory review entities and any other organizations, companies, community resources, etc. that may/will assist me to meet my home care and/or health needs. I further authorize Overlook to electronically transmit OASIS data to the Center for Medicare and Medicaid Services for review and analysis.

☒ **CONSENT TO PHOTOGRAPH:** I hereby authorize Overlook to take pictures of me and the treatment being done, and authorize the release of these photographs for use to document my medical condition only. Photographs may be provided to my physician and to any of the organizations specified.

☒ **RESOURCE GUIDE:** I have received and reviewed the following patient information found inside the Resource Guide: ▪Communicating a complaint ▪Patient's Rights and Responsibilities ▪Non-Discrimination Notice ▪Statement of Patient Privacy Rights ▪Health Insurance Portability and Accountability Act of 1996 (HIPAA) ▪Advance Directives – Patient's Right to Decide ▪Do Not Resuscitate Order ▪Medicare and Your Rights ▪Overlook Published Rates for Service

☒ **LIABILITY FOR PAYMENT/ASSIGNMENT OF BENEFITS:** I certify that all information given by me to Overlook is correct to the best of my knowledge. I further understand that services provided to me by Overlook will be billed as listed below. I understand that I (or my financial guarantor) may be billed for the services received if the information given by me is incorrect, insurer refuses to pay or insurance information changes after the date below, without notifying Overlook of change.

Services to be billed to: ☒ Medicare ☐ My Insurance Company ☐ Medicaid ☐ Third party payor.
Current deductible/co-pay is: _____
☐ Directly to me (or my guarantor – specify name of guarantor or name of payors: _____

I authorize payments to be paid directly to Overlook by payors indicated above. I (or my financial guarantor) understand and agree to pay deductibles, co-payments and any amounts due after payment of benefits on my behalf by all third party payors.

If I have Medicare benefits, I understand that Medicare payments will be accepted as payment in full and I have no financial liability ***unless*** I have been notified in writing that service(s) will not be covered by Medicare and I wish to continue to receive the care or service(s).

Advance Directive – I have an Advance Directive ☐ Yes ☒ No I will provide a copy to Overlook ☐ Yes ☐ No
DNR – I have a Do Not Resuscitate? ☐ Yes ☒ No
Durable Power of Attorney – I have a Durable Power of Attorney for Medical Care ☒ Yes ☐ No Father Edwin Driver
If yes, provide name and phone number of the person designated as health care agent or attorney-in-fact.
Name: _____ Phone Number: _____

I have read this Home Care Consent and understand what I have read and what was explained to me. I agree to the terms and conditions stated above.

Additionally, I understand either party may terminate this agreement at any time.

Patient Name Shanta Driver
Client Signature Shanta Driver Date 8/28/22
Financial Guarantor Signature (if applicable) _____ Date 8/28/22
Financial Guarantor Billing Address (if applicable) _____
Overlook Representative Name/Signature Kelsey LaValle Date 8/28/22
If patient unable to sign, provide reason: _____
Kelsey LaValle, DPT

OVNA-0002

White – Medical Record Canary – Patient