PO Box 238 Hayden, ID 83835 Tel. (208) 967-4771 Fax (208) 683-8101

PATIENT CONSENT TO OSFS *Care Connect* Services

Patient Name: _____ *Date of Birth*: _____

On Site for Seniors offers a 'hybrid' concierge membership model of healthcare practice, which allows access to specialty care and enhanced services not normally covered by health insurance and/or Medicare. Participating patients, facilities or agencies pay a small monthly fee. The patient's medical insurance is still billed for normally covered services rendered by our practice. By allowing insurance and/or Medicare to help offset the expense of healthcare delivery, OSFS is able to keep the monthly membership fee to a modest amount. Schedule A (attached) describes your unique membership benefits and responsibilities.

I hereby voluntarily authorize the rendering of such care, including diagnostic procedures and medical treatment, by authorized agents and employees of *On Site for Seniors, Inc*. **(OSFS)** or their designees, as may in their professional judgment be deemed necessary or beneficial in fact to face consultation or via video conferencing (telemedicine).
I understand that this Consent form will be valid and remain in effect from the date of signature, as long as I receive services from *On Site for Seniors*. A new consent will be obtained if I am discharged and subsequently return for services. I understand that I have the right to give or refuse consent to any proposed procedure or treatment at any time during its performance.

1. Use and Disclosure of Protected Health Information (PHI): I consent to OSFS's use of PHI, results of my medical history and physical examination, and wound images obtained during the course of my specialty care treatment and stored in the OSFS Electronic Health Records system for purposes of education, research, quality assessments and improvement activities, and development of proprietary clinical process. My PHI may be disclosed by OSFS to third parties who have executed a Business Associate Agreement. Disclosure of my PHI shall be in compliance with the privacy regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I specifically authorize use and disclosure of my PHI by OSFS and business associates for purposes related to treatment, payment, and health care operations. If I wish to require a restriction to how my PHI may be used or disclosed, I may send a written request for restriction to OSFS at PO Box 238, Hayden, Idaho 83835. If the PHI is owned by another entity, OSFS will direct my request to the appropriate party.

2. Advanced Directives: *(*select only one)*

☐ I have formulated Advanced Directives (living will, health care surrogate declaration, durable power of attorney for finances and for healthcare) and request that these directives govern my course of care, in as much as possible under state or federal laws. I understand that it is my responsibility to provide OSFS with a copy of my Advance Directives and that those directives will not govern my course of care until they have been filed in my medical record.

☐ I do not have Advanced Directives to include with my health care record at this time, but I understand it is my right to make decisions regarding my course of treatment, including the executing of Advanced Directives.

3. Patient Identification and Picture/Video Images: I understand and consent that images (digital, film, etc.) may be taken by the care specialist of me, including surrounding anatomic features (e.g. trunk, face etc.). The purpose of these images is to monitor the progress of treatment and ensure continuity of care. I further agree that my healthcare provider, referring physician, the care specialist or other treating physicians may receive communications, including these images, regarding my treatment plan and results. The images are considered protected health information and will be handled in accordance with federal laws regarding the privacy, security and confidentiality of such information. I understand that OSFS will retain the ownership rights to these images, but that I will be allowed access to view them or obtain copies according to state and federal law. I understand that these images will be stored in a secure manner that will protect privacy and that they will be kept for the time period required by law. Images that identify me will only be released and/or used outside of OSFS upon written authorization by me or my legal representative.

4. Wound Care Services *(if applicable)*:

1) Benefits of Wound Care Treatment: Benefits of wound care treatment include: enhanced wound healing and reduced risks of infection and amputation.

2) Risks/Side Effects of Wound Care Treatment: Wound care treatment may cause side effects and risks including, but not limited to, infection, ongoing pain and inflammation, potential scarring, possible damage to blood vessels, possible damage to surrounding tissue, possible damage to nerves, bleeding, allergic reaction to topical and injected local anesthetics or skin prep solutions, removal of healthy tissue and prolonged healing or failure to heal.

3) General Description of Wound Care Debridement: As part of my wound care treatment I may require debridement of my wound. Debridement means the removal of dead or unhealthy tissue from a wound to promote healing. Dead tissue on the wound delays healing, increases the risk of infection, increases drainage and causes odor. This procedure is usually done at the bedside or in the clinic using sterile instruments. This procedure is usually not painful. If it is painful, numbing medicine may be applied to reduce discomfort. I understand that during the course of treatment, multiple wound debridements may be necessary and that all debridement will be performed by an authorized practitioner.

4) Risks/Side Effects of Wound Debridement: The risks or complications of wound debridement include, but are not limited to: potential scarring, possible damage to blood vessels or surrounding areas such as organs and nerves, allergic reactions to topical or injected local anesthetics or skin prep solutions, bleeding, removal of healthy tissue, infection, ongoing pain and inflammation, and failure to heal. I specifically acknowledge that the healthcare provider, referring physician or the wound care specialist have explained: (1) that bleeding after debridement may cause rapid deterioration of my already compromised condition, (2) that drainage of an abscess or debridement of dead tissue may result in spread of bacteria and bacterial toxins into the bloodstream and hereby cause serious infection, and (3) that debridement will make the wound larger due to the removal of dead tissue from the edge of the wound.

5. Financial Responsibility: I understand that regardless of my health insurance coverage, I am responsible for any amount not covered by insurance. I authorize medical information about me to be released to any payor and their respective agent to determine benefits or the benefits payable for related services.

6. Assignment of Benefits:

If services are not covered by a facility or private agreement, I hereby assign all rights and privileges and authorize payment directly to OSFS for any services covered by insurance filed on my behalf or on the behalf of the person for whom I am duly authorized to sign for insurance benefits. I agree this assignment is primary to any assignment given after this date including any cost relative to attorney fees. I also understand that I am financially responsible to OSFS for charges not covered by this assignment or not paid on a timely basis from an insurance company.

7. Guarantee of Payment:

Unless covered by a facility or other private agreement, I agree to be responsible to OSFS for charges resulting from services rendered at their prevailing rates. I agree all bills are due in full upon demand. Should I fail to honor this agreement, I agree to pay any collection cost or attorney fees resulting from the collection of my accounts. No granting of extensions, indulgences or forbearances to the patient or any responsible party and no delays or lack of diligence on the part of OSFS in enforcing any rights shall in any manner release the undersigned liability except as designated by the provider and/or OSFS Board. I agree that OSFS is not party to any disputed claim or peer-review decision which affects payment of any claim filed on my behalf and that upon request for payment from OSFS, I agree to pay any outstanding balance **unless services are covered by another facility or private agreement**. I hereby assign all medical benefits to which I am entitled to my physician/provider for services rendered to me.

Medicare Assignment/Signature on File:

I request that payment of authorized Medicare benefits be made either to me or on my behalf directly to On Site for Seniors, Inc. for any service furnished to me by the physician/provider/staff. I authorize On Site for Seniors, Inc. to release information to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits or the benefits payable for related services.

Signature: _____ *Date*: _____

I hereby acknowledge that I have read and agree to the contents of this Consent. I agreement that my medical condition has been explained to me by my healthcare provider or referring physician. I agree that the risks and benefits to treatment and management services that I will undergo have been discussed with me by the care specialist. I understand the nature of my medical condition, the risks and benefits of treatment, and the consequences of failure to seek or delay treatment for any conditions. I have read this Consent or had it read to me and understand the contents herein. I have had the opportunity to ask questions of the care specialist and have received answers to all of my questions. I understand I can contact the care specialist at **(208) 967-4771** if I have any further questions regarding management of my healthcare.

By signing below, I consent to (1) the care and treatment and services described in this document and orally by my healthcare provider, referring physician or the care specialist; (2) the creation of images to record my condition; and (3) to the transfer of health information protected by HIPAA between my healthcare provider, referring physician, the care specialist or other treating physicians or parties involved in my health care.
I have reviewed and agree to the ***Care Connect*** Membership fee schedule (attached). I agree to abide by the ***Care Connect*** Policies and Responsibilites of Membership per *On Site for Seniors.*

_____ _____ _____
Patient or Legal Representative *Signature* *Relationship* *Date*

_____ _____
Witness Signature (if approved verbally or signed with a "mark") *Date*

I acknowledge that I have had the opportunity to review and agree with the **Privacy Policy Statement** of OSFS:

_____
Patient or ***Legal Representative*** *Signature*

****** In the event the Consent is not signed by patient, the undersigned acknowledges that they have the legal right to sign this document. ******

_____ _____ _____
Legal Guardian or Legal Representative *Printed Name* *Date*

Schedule A --- OSFS *Care Connect* Services

Membership in OSFS ***Care Connect*** services includes the following enhanced medical services beyond what traditional medical insurance covers to improve your overall quality of life and peace of mind:

- Timely appointments with your specialist.
- Direct access to your Physician/Provider through personalized, private messaging services.
    - You (or your designated caregiver or family member) may send HIPPA-secure messages to your provider for non-emergency questions and requests.
- Physician/Provider coordination of tests, treatments, specialist referrals and consultations.
- Telehealth visits (*real time audio-video visits)* for routine or special urgent care needs allow same-day, efficient and comfortable follow up of medical needs.
    - Your monthly membership includes 1 telehealth visit per month (not cumulative)
    - Additional telehealth visits are available for $30 per fifteen minutes.
- Access to teleheath equipment "kit" and training to accomplish video visits.
    - Direct video connection over a computerized, HIPAA-secure internet service
    - 24-hour check-out of portable equipment from *On Site for Seniors* is available without charge to members who do not have personal devices that can support the video visits.
    - For members with personal devices that can support the video visits, up to 1 hour of training will be included to demonstrate and educate on connecting through OSFS telehealth.
- Personalized annual health conference with family/friends of your choice to review health status and personal goals to decide on your best plan of care. The conference is scheduled at a mutually agreed upon time. Conference may include persons wishing to participate using a video connection or conference call connection.
- If you are hospitalized, your On Site Physician/Provider will review your hospital care plan and coordinate after-hospital care for a smooth return to home.
- Access to personal *Your Path Guide* (health coaching) through On Site for Seniors *(optional)*
- Access to memory strengthening program: *High-Tech/High-Touch* service & training (*optional)*

Membership Fee: *$40.00 per month with minimum of 3 month membership*.
Membership automatically renews at monthly intervals after the initial three months.
One month notice of separation is required to end the agreement.

**** Note: OSFS Care Connect Membership fees are **waived** for residents of facilities that have Healthcare Support Services Agreements with On Site for Seniors ****