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| **Aurora Adult Day Care LLC** |
| **Address: 1330 S Potomac St, Suite #118,Aurora, CO 80012** |
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**AURORA ADULT DAY CARE PROGRAM**

Participant Name: Start Date: \_\_\_\_\_\_\_\_\_

Services Agreement

I would like to be a participant in Life Adult Day Care Program. I have received an explanation of the services that will be provided to me, a facility tour, and understand that I have the right to participate in activities of my choosing.

Agreed Upon Days and Times of Attendance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorization for Release of Information

I hereby consent and authorize the Agency to release and receive information for the purposes of treatment, payment, and health care operations. The exchange of information may occur between, but is not limited to, physicians, third party payers, other health providers, and regulatory and/or accrediting reviewers

Statement to Permit Payment for Home Health Services

I hereby request that payment of authorized adult day program services be made on my behalf to the Agency.

I understand that agency will bill MedicaidPrivate PayInsurance Co.:

Patient for the services being provided to me by the Agency. I understand that I will be responsible for the following amount:

Acknowledgements

I have received verbal and written information on the following, and have had the information explained to me:

1. Participant Handbook

Facility rules

1. Emergency Preparedness, Infection Control and Safety Education
2. Facility Tour
3. Orientation to policy and procedures

Advance Directives

I have an Advance Directive Yes No

If yes, I have the following Living Will Medical Durable Power of Attorney Do Not Resuscitate Order

Other Advanced Directives Yes No Explain

Copy obtained Yes No Name and phone number of MDPOA

I would like more information on Advanced Directives: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that I have read and agree with the information on this document and have been provided a copy for my records. I have participated in the formation of my plan of care.

*Patient Signature or responsible party Date*

*Staff Signature Date*