CONSENT AND RELEASE

Client Name: _____ DOB: _____

Address: _____ Social Security No._____

Request for Admission and Consent to Care and Service
I request admission to the program and give my permission for authorized personnel to perform all necessary non-medical care included in my service delivery plan of care.

My home care will consist of non-medical services; provided by non-medical staff that may include personal care and/or support services. I understand that coverage of all visits or shifts cannot be guaranteed and that all reasonable effort will be made by West Genevieve Home Care to provide services.

Authorization to Release Information
I authorize the release of information by any acute care facility, skilled nursing facility, home health agency, or physician's office in which I have been a client and authorize those individuals to disclose for review or photocopying any or all parts of my clinical record. I authorize West Genevieve Home Care to release verbal and written information about my status to other professionals involved in my care and to third party payers requesting documentation to obtain reimbursement for my care. I understand that all reasonable attempts will be made to keep my client record confidential and that additional information will only be release with my written permission.

Release of Rights Regarding; Notes and/or photographs relating to the lifestyle and events associated with West Genevieve Home Care.

I hereby grant West Genevieve Home Care the right and permission to copyright and use, reproduce, distribute, display, broadcast and published by audio, video, photographic or written production over by me in their marketing and advertising materials in any medium; the right to prepare derivation works therefrom; and the right to administer all copyright in the work in the name of West Genevieve Home Care or its related entities. I waived any rights to inspect or approved the materials or to lay any claim or benefits derived from them.

Assignment of Benefits
I consent to and authorize payment from my medical insurer, which would otherwise be payable to me, to be made directly to the above-named provider. I understand and agree that I am personally responsible for paying any outstanding balance on my bill that is not paid by my medical insurer. If my medical insurer either pays me directly or declines coverage for all of my bill, for whatever reason, I agree to be responsible for paying the entire bill. I further understand that payment-in-full is due upon receipt of my bill.

Time and one half is charged for the six national holidays. One and one-half percent interest per month is charged on all accounts past due over 30 days. All court costs and legal fees incurred for the collection of a delinquent account will be the obligation of the client.

Client's Rights and Responsibilities

I have read my rights and responsibilities or have had them read to me and I understand them.

The undersigned hereby does release and forever discharge West Genevieve Home Care and any of its employees, for himself, his family, and his heirs, executors and administrators of and from all manner of actions, cause and cause of action, and any claims for liability whatsoever, in law of equity, which the undersigned has or which may accrue in the future by reason of any damage, loss, injury or suffering which may arise either indirectly or directly from engagement and use of a West Genevieve Home Care employee(s). This includes the driving of the client, any member of his family or non-member either in a vehicle owned by the undersigned or a vehicle owned by West Genevieve Home Care employee. The undersigned further acknowledge receipt of lawful consideration for this release.

Notice Regarding Payment Responsibility

I have received this notice and have been advised on the information contained within.

I certify that I have read and received pages 1 and 2 of this consent and Release form and that I am the client (or am duly authorized as the client's agent to execute the above) and agree to the terms and conditions.

_____ _____

Signature of Client or Authorized Representative Date

_____

Relationship to Client

_____ _____

Signature of Witness Date

If client did not sign, please state the reason:

If the client in under 18 years of age, and is not an emancipated minor under state law, or is not mentally competent, the following paragraph must be completed:

Because the above referenced client is unable to consent the care by the above-named provider, as he or she is a minor and is not emancipated or is not mentally competent, the undersigned, as _____ (relationship to the client) hereby agrees to be responsible for authorizing the client's care. The undersigned further agrees to be responsible for and to guarantee payment of the full amount of all the above-named provider's charges incurred by the client beginning on the date appearing next to the undersigned signature.

_____ Date:_____

Signature of Responsible Person

_____ Date:_____

West Genevieve Home Care
General Manager or Authorized Agent