Admission Agreement With Stanley Jones & Associates, Inc.
For Home Care / Rehab / Outpatient Services

1. **Terms of Agreement:** By signing this agreement, I authorize provision for Stanley Jones & Associates, Inc. to provide therapy, nursing, and aide services. I understand that my services are under the direction of my physician and that Stanley Jones & Associates, Inc. is not liable for any act or omission when following physician instructions.

2. **Authorization for Release of Information:** I hereby authorize any holder of pertinent medical information to release written or oral information from my medical or school records about my history, care, examinations, assessments, or medical findings to Stanley Jones & Associates, Inc. I further authorize Stanley Jones & Associates, Inc. to release pertinent medical information orally or in writing to my physician/school personnel.

3. **Permission for Disclosure and Use of Information:** I consent to the release of my Stanley Jones & Associates, Inc. records to be reviewed by authorized representatives of Medicare/Medicaid, Medicare intermediary, and/or any third party payer for use in determining my home health benefits. I understand that I have the legal right to refuse the release of my personal and medical records now held by Stanley Jones & Associates, Inc. and that I am waiving this legal right by signing this consent. This consent shall be valid for whatever period of time is reasonably necessary for the individual/agency requesting to review my clinical records to fulfill the above described purpose(s), or until I revoke this consent in writing, such a revocation of this consent shall have a prospective effect only.

4. **Assignment of Benefits for Direct Payment to Stanley Jones & Associates, Inc.:** I authorize direct payment of Medicare, Medicaid, or third party payers to pay Stanley Jones & Associates, Inc. directly for Stanley Jones & Associates, Inc. services rendered. I also authorize for any third party payer to release any information and all information pertaining to the benefits or status of my claim to Stanley Jones & Associates, Inc. or its agent. I further authorize Stanley Jones & Associates, Inc. to release any and all information pertaining to me for benefit determination.

5. **Home Care / Patient Bill of Rights:** I have received, read, and understand the Home Care Bill of Rights. I understand that the telephone numbers for the Office of Health Facility Complaints and the Home Care Ombudsman are listed on my copy and that they will assist patient with complaints or questions regarding Minnesota Care Services.

6. **Advance Directives:** (N/A patients under age of 18) I have received the written information "Questions and Answers Regarding Minnesota Law Health Care Directives" and my questions regarding Advanced Directives were answered. I have a ___living will, ___mental health directive, ___POA, ___guardian/conservator. DNR ___yes___no. Name of person Advance Directive was reviewed with, if not client____. Establish date patient able to receive information _____________. Name of POA/Guardian______________________________ phone #___________________Address:____

7. Date verbal permission received from POA/Guardian to begin services. ________________________________

8. **Use of Loan Equipment:** I understand that if any equipment is loaned to me from Stanley Jones & Associates, Inc. or a DME supplier, it is my responsibility to be sure the item is returned in good working order.

9. **Privacy Notice:** (N/A for patients under the age of 18 and rehabilitation patients) I have received a copy of the "Home Health Agency Outcome & Assessment Information Set (OASIS) Statement of Patient Privacy Rights" and understand the content.

10. **Privacy Practices:** I have received a copy of the "Notice of Home Care Privacy Practices" and understand the content.

11. **Service Agreement:** I have had the opportunity to participate in my plan of care/service. If any changes are needed, a new agreement will be made.

12. **Medical Supplies/Therapy:** (N/A non-Medicare patients) I have received the "Notice Regarding Therapy/Medical Supplies" and fully understand its content.

13. **Payment of Fees:** Normal assessment cost is $________ and normal visit cost is __________. Your primary payer is ______________________ and will pay __________ and your secondary payer is ______________________ and will pay ________________. Your estimated out-of-pocket cost will be __________ for the assessment and __________ for each visit. SJA accepts Medicare A and Medicaid as payment in full. All unpaid balances are your responsibility; past due bills (over 30 days) may be subject to interest of 1.5% per month.

Notes: ____

____

I have read and understand the terms of this agreement and agree to abide by these terms.

Client's Signature____ Date___________________________

Client's Representative____ Date___________________________

Relationship to Client____

(This form may be signed by the patient's legal guardian or representative for one of the two reasons: 1) The client is under the age of 18, or 2) The client has cognitive barriers to understanding the content of this agreement and the Patient Rights and Responsibilities Service Agreement.)

Representative of SJA____

White to Chart Yellow to Patient

Pediatric Permission Form

I give Stanley Jones & Associates, Inc. permission to use photographs, images and/or videos of my child on their company web page or printed material to promote rehabilitation therapy and other services offered at Stanley Jones & Associates, Inc.

____

(Child's Name)

____

(Parent/Guardian Signature)

____

(Date)

STANLEY JONES & ASSOCIATES
Initial Health Assessment – Child

Client Name: ____________________________________

PAST MEDICAL HISTORY

Birth History: (Birth weight, premature or term, problem with pregnancy or delivery)

Has your child been diagnosed with or had any of the following (circle all that apply):

Allergies
Chronic ear infections
Speech language Delay
Congenital Disorder
Heart Disease
Cerebral Palsy
Seizures
Learning Disorder
Attention Disorder

Autism/Pervasive Developmental Disorder
Aspergers Syndrome
Auditory Processing Disorder
Developmental Delay
Brain Injury
Other Behavioral/Psychological Disorder
Downs Syndrome
Hearing Loss

Does your child have any other medical diagnosis? If yes please state.

DESCRIBE ANY AREAS OF CONCERN FOR THERAPY:

Feeding/Nutrition:

Do you have any concerns regarding feeding/swallowing? (Food allergies, difficulty swallowing, gagging, drooling, trouble breathing while eating)

How do you currently feed your child?

What are your child's favorite foods? What type of foods does your child refuse?

How does your child indicate that he/she is hungry?

Speech and Communication:

What does your child do when he/she needs help with something?

What happens if you cannot figure out what your child is asking for? What is his/her response?

Does anyone in your family talk for your child and/or interpret his/her gestures and speech?

Can people outside of your family understand your child's speech?

What is the primary language spoken at home? What is your child's primary language?

Sensory:

Does your child demonstrate any of the following?

Avoid getting messy	Dislike being touched
Dislike bathing	Dislike hair cutting/nail cutting
Irritated by certain clothing	Have trouble being close to others
Dislike many food items	Sensitive to touch around the mouth

SOCIAL EMOTIONAL:

Does your child play independently?
Does your child demonstrate frequent mood changes?
Does your child separate easily from you?
Does your child have difficulty changing activities?
Does your child play with other children?
Is your child easily frustrated?

Is there any additional information that would help us to better understand your child?

CURRENT HEALTH STATUS:

Immunization Status (Up-to-date): ____

Prosthesis/Orthosis: Glasses ____ Hearing Aids ____ Splints ____
Upper Extremity ____ Lower Extremity ____
Ambulation Aids: Walker ____ Cane ____ Crutches ____ Wheelchair ____

Special Equipment: Tumbleform ___ Prone/Supine Stander ___
Communication Device ___ Positioning Device ___
Transferring Equip. ___ Toileting Equip. ___
Dressing Equip: ___ Other ________________

FAMILY AND HOME STRUCTURE:

Family structure (Family size, special parenting situations)

Primary Caregiver(s): Parent(s)______ Daycare provider _____ Other _____

Occupation, employer, working hours and days of parents/caregivers:
Father ____
Mother ____
Other ____

Day Care Provider: (Name, address, and phone number) ___________________
____

COMMUNITY RESOURCES (Describe assistance received from family, nursing agency, PCA, babysitter, parent group, advocate, social services, church, other respite)

School based services: PT ___ OT ___ ST ___ Educational ___
Name of School ___________________________________ Grade ____
Days and Times ____

o

DEVELOPMENTAL SCREENING

	Independent	Needs Help
Bathing		
Brushing Teeth		
Combing Hair		
Dressing		
Buttoning		
Tie Shoes		
Eating		
Utensils		
Drinking		
Toileting		
Mobility		
Communication		
Behavior		

CHILD PROTECTION STATEMENT

Client is vulnerable by nature of age less than 18.

Parent Signature: ____

RN/Therapist Signature: _____________________________ Date: _________

Insurance Information/Verification

Name ____
Last First Middle

Date of Birth : ________________________

Subscriber Name: ____________________ Insurance Carrier: ___________________

Member ID: _________________________ Group ID: __________________________

Insurance Company mailing address: ____

Insurance Company phone number: ____

Medical Assistance Number: ____

List any secondary insurance: ____

Insurance Notice:

- All caregivers are expected to know and understand their coverage and benefits for therapy services. You can verify your benefits by calling the phone number on your insurance card and speak with a representative. It is very important to understand your coverage and any "exclusions" or "limitations" to therapy benefits.
- Please remember that your insurance policy is between you and your insurance company. Benefits quoted are only an estimate and are not a guarantee of payment.
- In the event your insurance chooses not to pay for services, you are ultimately responsible for all charges.
- By signing below, you agree that you are informed of your insurance benefits/coverage and you understand your out of pocket responsibility.

____
Parent or Legal Guardian Date

____
Stanley Jones and Associates Inc. Representative Date

I certify that information given by me in applying for payment under Title XVIII of Social Security of for benefits under the Veteran's Administration, Worker's Compensation, Medical Assistance, or private insurance company is correct. I understand that if I do not provide accurate information I may be responsible for all or part of charges.

Medication Profile

Patient Name: ______________________________________
Allergy to Meds: ______________________________________
Precautions related to meds: ______________________________________

Medications

Date Drug Identified	Initials	Medication: Dose, Route, Frequency	Date D/C'd	Initials

Signatures: ______________________________________

____

Stanley Jones & Associates, Inc.
Therapy Services

Pediatric Client Data Record

Client Information:

Client Name:____
Last First Middle Initial

Sex:_________________ Date of Birth:____________________

Parent(s) Name(s):____

Street Address:____

City, State, Zip:____

Phones:

Home:________________________________ Other:________________________________

Dad work:_____________________________ Dad cell:_____________________________

Mom work:____________________________ Mom cell:____________________________

Other:

Responsible Party: (same as above or indicate name, address, and phone)

____

____

Referring Doctor:____

Clinic Affiliate:____