1st Nurse Registry
2215 N. Military Trail, Suite O, West Palm Beach FL 33409
Phone: (561) 948-2010 Fax: (561) 948-2012
Email: office@1stnurseregistry.com

Consent Form

PATIENT/CLIENT NAME: _____ DATE: _____

- Consent to receive services - I hereby authorize 1st Nurse Registry to render appropriate home care services to the patient/client named above. I understand an appropriate level of home care personnel will provide such care. I recognize and agree that I have the right to refuse treatment or terminate services at any time by notifying the 1st Nurse Registry office. In addition, 1st Nurse Registry may terminate service by notifying me of termination and the reason.

- Authorization for emergency medical services- At any time while receiving services from1st Nurse Registry, and in the event of any medical emergency, I authorize 1st Nurse Registry or its employees/contractors to provide or obtain such medical treatment as they deem advisable under the circumstances, and I agree to assume sole responsibility for all charges for such treatment.

- Release of medical Records - I hereby consent and request that copies, if necessary, of my prior medical records be delivered to 1st Nurse Registry to establish or continue my home care plan.

  I hereby authorize 1st Nurse Registry to release copies of my medical records or reports or such portions or summaries thereof as may be relevant, to other health care providers or regulatory or accrediting bodies for the purpose of continuing and coordinating my home care plan and for quality assurance, survey and accreditation purposes.

- Vehicle Release-I agree to notify 1st Nurse Registry, in advance, and I understand that I must receive written authorization from the 1st Nurse Registry office, before any 1st Nurse Registry employees/contractor may operate my automobile or transport me in a 1st Nurse Registry employee's/contractor's automobile understand and agree that it is my responsibility to maintain automobile liability insurance at the minimum level established by the state covering my automobile and authorized drivers, including1st Nurse Registry employees/contractors, should I permit a 1st Nurse Registry employee/contractor to operate my automobile. I understand and agree that 1st Nurse Registry does not provide insurance coverage under any circumstances for any damages to my automobile, bodily injury or damage to property resulting from the use of my automobile by 1st Nurse Registry employees/contractors hereby release 1st Nurse Registry and its employees/contractors assigned to me, and hold 1st Nurse Registry Care and such employees/contractors harmless and indemnify them from any claim, liability, or cause of action for any injury to my person (including death), bodily injury to a third party, or property damage resulting from the use of an automobile (whether or not owned by me) if operated by a 1st Nurse Registry employee/contractor. Whether or not prior authorization from the 1st Nurse Registry office has been obtained.

- Statement of Patient Bill of Rights- I certify that I have read, received a copy, and understand the Patient Bill of Rights which has been explained to me orally by a representative of 1st Nurse Registry.

- Patient rights on Advance Directives
  (Please check the appropriate boxes)-I certify that I ❒ have executed ❒ have not executed a Living Will
  I certify that I ❒ have executed ❒ have not executed a Durable Power of Attorney/Health Care Proxy.
  Name: _____ Telephone # _____

I authorize 1st Nurse Registry to receive a copy of any of the above documents. The documents are located at or with Home Care.

I certify that I have been instructed about, received a copy of, and understand the patient Rights on Advance Directives which was explained to me orally by a representative of 1st Nurse Registry.

Assistance with Medications- I have been informed by 1st Nurse Registry that I may be receiving assistance with self-administration of medication from an unlicensed person (excluding narcotics).

Credit Card

❒ I hereby authorize payment through my (Circle one) MasterCard Visa Discover Card Security Code: _____
Name on card: _____ Card # _____ Expiration date: _____

Billing Address of Card:

_____

for services and/or supplies provided by 1st Nurse Registry. I understand I am personally and financially responsible for payments if the information provided by me is invalid or payment is not authorized by the credit card company. I further understand that this credit card must be presented for imprint and signature verification.

Signature:_____ Date: _____

_____
Patient's/Client's Initials