



PATIENT CONSENT FORM

This form is designed to make sure you have the information you need to make an informed decision about being treated by Enlighten Infant Home Care LLC and to voluntarily consent to treatment. Our staff will be happy to provide you with any additional information you may need in order to provide us with your informed consent.

Please sign the signature page at the end of this document to acknowledge your consent.

1. **Consent to Treatment.** I, the undersigned personal representative of patient (“Personal Representative”), consent to the below-named patient (“Patient”) being treated by employees, independent contractors, and/or agents of Enlighten Infant Home Care LLC (“Enlighten”) within Patient’s place of residence. Patient’s treatment will involve appropriate services performed within the servicing health care professional’s scope of practice, which may include, but are not limited to, phototherapy, bilirubin tests, weight calculations, and vital sign tests. I authorize the provision of treatment to Patient by Enlighten and its nurses and other clinical personnel. I acknowledge that I may be required to sign additional consent forms for certain treatments as a way of confirming that I have received all the information I need to make an informed decision about the treatment of Patient.
2. **Use of Independent Contractors.** The nurses and other clinical personnel providing treatment to Patient are independent contractors of Enlighten and are not employees, agents, or representatives of Enlighten. I understand that independent contractors are solely responsible for the care and treatment provided to Patient and are not controlled by Enlighten or its employees. I agree that Enlighten shall not be liable for the acts or omissions of any such independent contractors.
3. **No Guaranteed Outcome.** I am aware that the practice of medicine is not an exact science and that treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made as to the outcome and/or result of any treatment or examinations provided to Patient. I am aware that, while routinely performed without incident, there may be material risks involved with the treatment and services Patient receives or supplies and equipment Patient uses as part of Patient’s treatment.
4. **Risks.** I acknowledge that any supplies, devices, or other goods sold or given to Patient, including but not limited to phototherapy equipment and eye protectors, are provided “as is” and that Enlighten, its authorized representatives, and its independent physician contractors and other healthcare professionals and clinical staff disclaim any express or implied warranties related thereto. I acknowledge that Enlighten shall in no way be responsible for any misuse of or accidents occurring when using these supplies, devices, or other goods.
5. **Special Services.** I understand that, if Patient needs hospitalization or other special services not provided by Enlighten, I must make arrangements for these services. Enlighten shall in no way be responsible for failure to provide the same and is hereby released from any liability arising from the fact that Patient is not provided with such additional care.
6. **COVID-19 Consent.** I understand that certain infections, including but not limited to COVID-19 and influenza, are extremely infectious and are spread through person-to-person contact. Enlighten closely monitors outbreaks of these infections within the communities it services. However, given the nature of these infections, I understand there is an inherent risk of infection associated with the in-home services that Enlighten provides. I hereby acknowledge and assume the risk described herein, and I give express permission for Enlighten and its employees, independent contractors, and agents to proceed with treatment of Patient.

7. Patient Responsibilities. I acknowledge that Patient has certain responsibilities as a Patient and that I, as the personal representative of Patient, have those same responsibilities. I acknowledge responsibility for following the treatment plan recommended by the practitioner primarily responsible for Patient's care. This may include following the instructions of physicians, nurses, or other clinical personnel as they carry out the coordinated plan of care, implement the responsible practitioner's orders, and enforce any applicable policies. I am responsible for keeping Patient's appointments and, when unable to do so for any reason, for notifying Enlighten within a reasonable time as dictated by Enlighten policy. I acknowledge I am responsible for any adverse actions resulting from my refusal to follow the specific instructions of doctors, nurses, or other clinical personnel.
8. Right to Refuse Treatment. I understand that, absent emergency or extraordinary circumstances, no treatment will be performed upon Patient without the opportunity to confer with a physician or other health care professional about Patient's treatment. I have the right to consent or to refuse consent to any proposed plan of treatment. I acknowledge that I am responsible for any adverse actions resulting from my refusal of treatment.
9. Patient Information. I agree to provide, to the best of my knowledge, any information requested by Enlighten, including but not limited to Patient's family and medical history and financial and payment information. I agree that any and all information provided to Enlighten is and will be true, correct, and complete. I hereby agree to indemnify and hold harmless Enlighten from any and all loss, costs, expenses, taxes due, penalties, interests, and attorney's fees that are incurred as a result of any misrepresentations, omissions, or untruthful, incomplete, or erroneous statements made on Patient's behalf.
10. Personal Property. I understand that Enlighten is not responsible for any personal property or valuables damaged, lost, stolen, or otherwise harmed during the treatment of Patient.
11. Consent to Photograph. I authorize Enlighten and its employees, independent contractors, and agents to photograph or otherwise take images of Patient and/or parts of Patient's body for purposes of identification, treatment, payment, and healthcare operations. Any photographs or other images taken will become part of Patient's medical record. Enlighten will not use, release, or disclose such photographs or images for any other purpose without my specific written authorization.
12. Payment; Default. I understand that Enlighten does not accept private insurance or other third-party payors, with the sole exception of Medicaid. In consideration of the services to be provided to Patient, I acknowledge that I am solely responsible for paying all charges, deductibles, and/or co-insurance amounts associated with such services that are not covered by Medicaid, if applicable. I agree to make payments according to Enlighten's credit terms. I understand that if I do not pay such charges within 120 days of receipt of an invoice, I will be considered to be in default of payment. In the event I should default on any of the above charges, I agree to pay all reasonable costs of collection, including reasonable attorney's fees as might be allowed by law, regardless of whether the account is referred to a collection agency or an attorney for collection.
13. Assignment of Benefits. On behalf of Patient, I irrevocably assign and transfer any and all rights provided by Medicaid directly to Enlighten or its authorized representatives who provide services to Patient. I understand and acknowledge that, if Patient is covered under Medicaid, it is my responsibility to provide Enlighten with the name of the plan, name and phone number of Patient's primary care physician or pediatrician, confirmation of eligibility under the plan, and any other relevant information. I acknowledge that Medicaid may not cover certain services and that it is my responsibility to verify that Patient has coverage for these charges. I understand that it is my responsibility to pursue resolutions for benefit reductions or non-payment and that Enlighten is not responsible for filing any claims or collecting any benefits on Patient's behalf. I also understand that Enlighten is not responsible for negotiating a settlement on a disputed claim.
14. Notice of Privacy Practices. I acknowledge that I received a copy of Enlighten's Notice of Privacy Practices and that I read and understood it. I understand that I have certain rights to privacy regarding my PHI. I also understand that Enlighten can and will use my PHI for purposes of treatment, payment, and health care operations. The Notice explains in more detail how Enlighten may use and share my PHI for other purposes. Enlighten Infant Home Care LLC has the right to change the Notice from time to time, and I can obtain a current copy of the Notice by contacting the Privacy Officer.

[SIGNATURE PAGE TO FOLLOW]

I certify that I have read the above consent or have had it read to me and fully understand it. I believe I have adequate knowledge on which to base information consent. I fully understand what I am signing and hereby consent to the above.

Patient Name (Print)

Date

Personal Representative Name (Print)

Personal Representative Relationship to Patient

Personal Representative Signature

OFFICE USE ONLY:

_____ Personal Representative refused to sign

_____ Patient is unable to sign because Patient (i) is under 14 years of age; (ii) has never been married, is not pregnant, is not a parent, or has not graduated from high school; and (iii) does not have a parent or guardian to sign on their behalf.