Client Responsibilities

You have the responsibility:

1. To provide complete and accurate information to the best your knowledge about your present complaints and past illnesses, hospitalizations, medications, allergies and other matters relating to your health.

2. To remain under a doctor's care while receiving skilled agency services.

3. To notify the agency of any perceived risks, or unexpected changes in your condition (e.g. hospitalizations, changes in plan of care, symptoms, pain, homebound status, change in physician, etc.)

4. To follow the plan of care and instructions and accept responsibility for the outcomes if you do not follow the care, treatment, or service plan.

5. To carefully consider any decision to refuse care and to understand the full extent of the consequences in relation to current health problems.

6. To ask questions when you do not understand about your care, treatment, and service, or other instruction about what you are expected to do.

7. To notify agency of the existence of, and any changes made to, an advanced directive.

8. To notify the agency if your Medicare or other insurance coverage changes or if you decide to enroll in a Medicare or private HMO or hospice.

9. To promptly meet your financial obligations and responsibilities as agreed upon with the agency.

10. To comply with the recommendations of the professional involved in my care once goals and objectives have been agreed upon.

11. To provide a safe and cooperative environment for care to be provided (such as keeping pets confined, not smoking, or putting weapons away during your care).

12. To notify the Home Health Department if I am unable to be at home for a scheduled visit at least one day in advance of the visit.

13. To treat those individuals assigned to my care with respect and consideration

14. To tell the agency of any problems, concerns, or dissatisfaction with the services provided.

I have received verbal and written instruction on my Client's Rights and discussed any questions I had with my Home Health Provider. I understand my Rights and Responsibilities as a Lee County Health Department client. I have received a copy of the Lee County Health Department policies on: Client Discharge and Client Transfer. I acknowledge my receipt of the LCHD Notice of Privacy Practices.

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Date Signature of Client/Guardian