

Your physician has or may recommend health services to assist you (or your child) when discharged from the hospital. You may choose who provides services for you. We encourage you to consult with health care providers before making your selection. The following checked health services have been or may be ordered by your physician.

Home Services

- HME (home medical equipment)
- Home Health (e.g., nursing & therapies)
- Home Hospice
- Home IV Therapy

Facility Based Services

- IV Therapy Clinic
- Long-Term Acute Care Hospital
- Skilled Nursing Facility (SNF)
- Acute Rehab
- Hospice In-Patient Services
- Behavioral Health
- Other \_\_\_\_\_

We maintain a list of providers who offer the services you need and you are welcome to review the list. You may choose any provider on the list, or you may choose any other available provider that you know. A provider's name on the list is not an indication of Intermountain Healthcare's or the hospital's endorsement. The hospital however does endorse the quality and services of Intermountain providers. Intermountain Healthcare owns this hospital and other providers of post-hospital care (for example, Intermountain Healthcare Hospice, Intermountain Healthcare Home Care, Intermountain Healthcare Rehabilitation Services, Intermountain Healthcare Skilled Nursing, Intermountain Healthcare Behavioral Health).

Your insurance company's preferred provider is: \_\_\_\_\_  
(If you do not choose a preferred provider, you may be responsible for all or part of the bill.)

Your physician has recommended the following provider: \_\_\_\_\_

If you have no other preference for a particular provider, do you want to use an Intermountain provider?

- Yes
- No

Indicate your final selection below:

\_\_\_\_\_

By signing below, you do the following:

1. Acknowledge that your selection of a provider of Home Medical Services is freely made;
2. Authorize the release of information (for example, history and physical, discharge summary, lab reports) deemed necessary for discharge planning to facilitate the continuation of your treatment by the service provider; and
3. Release Intermountain Healthcare from all legal liability that may arise from the release of such information. (Alcohol and drug treatment records are protected by federal regulation 42 CFR, Part 2.)

Patient/Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Hospital Representative \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Repeat admissions for ongoing conditions with no change in service provider:

I certify that I have been provided a choice for post-hospital services and have selected the service provider listed above for continued service.

Patient Initials: \_\_\_\_\_ Hospital Representative Initials: \_\_\_\_\_ Date: \_\_\_\_\_

PATIENT STAMP:



**PATIENT CHOICE FORM**