



Ameristar Home Healthcare

Ameristar Home Healthcare, LLC utilizes a secure electronic medical charting system to document all patient visits. In the event that the electronic system is temporarily unavailable or inoperable, staff will obtain required patient signatures using this paper form.

By signing below, you acknowledge that a staff member from Ameristar Home Healthcare conducted a visit at your residence on the date and time indicated. If you do not agree with the date or time of the visit, please do not sign this form and contact our office immediately at (614) 489-7272 for clarification.

Thank you for your understanding and cooperation

Patient/Client Name: _____

Supervision

HHA Present? _____ Yes _____ No

Follows the patient care plan _____ Yes _____ No

Is the Patient/Client satisfied with the care/services? _____ Yes _____ No

Appears competent when providing services _____ Yes _____ No

Complies with infection prevention and control? _____ Yes _____ No

Reports client needs/conditions to supervisor in a timely manner? _____ Yes _____ No

Good personal grooming habits.? _____ Yes _____ No

Adheres to the dress code.? _____ Yes _____ No

Uses proper body mechanics.? _____ Yes _____ No

Honors patient's rights? _____ Yes _____ No

HHA Signature: _____

I, _____, received a home health visit by the discipline indicated
(Patient Name)

below on (date) _____ Time in: _____ Time out: _____

SN/Sup visit _____ SOC _____ Recert/Sup _____ ROC _____

Patient Signature: _____ Date: _____

Clinician Signature: _____ Date: _____