PATIENT CONSENT FOR CARE AND SERVICE AGREEMENT

HOSPICE OVERVIEW:

1. The goal of hospice is to maintain quality of life through the management of pain and other symptoms when no further curative measures are planned. Hospice staff will also provide emotional and spiritual support (when requested) to me and my family and/or primary caregiver.
2. _____ will be considered my "primary caregiver." This means he/she will be the person mainly responsible for overseeing my care at home. Hospice does not take the place of the caregiver, but rather provides support to my caregiver.
3. Hospice services are provided by a team of staff specially trained in hospice care. Services for my hospice diagnosis may include: physician visits, nursing, medical equipment/supplies, medications, social workers, homemaker/health aide, dietary counseling, pastoral/spiritual counseling and volunteer. The role of each hospice team member has been explained to me.
4. Care will be provided by all team members per agreed upon schedules, but is always available 24 hours/day, by calling the Hospice agency at: (Phone) _____

LIABILITY FOR PAYMENT: I certify that all the information given by me to the organization is correct for requesting and applying for payment under Title XVIII (Medicare), Title XIX (Medicaid) of the Social Security Act and/or from any third party payer. I understand and agree to pay deductibles, co-payments, spend downs and any amount due after payment of benefits on my behalf by any and all third party payers.

I understand that services provided to me by this organization will be billed as follows:

- ❑ Medicare Hospice Benefit. Pays 100% of all care related to your hospice diagnosis and related conditions. This care is directed by your hospice team. Any services related to your hospice diagnosis of _____ must be approved by your team, or you may be held liable for the charges. This includes emergency services or hospitalizations, so please always call your hospice team first for any needs related to this diagnosis.
- ❑ Medicaid (Project 100% covered after meeting spend down and/or other requirements.)
- ❑ Medicare Advantage in VBID Program _____
- ❑ Insurance (Coverage varies with individual policy. The patient's anticipated payment amounts per visit will be provided in writing when the insurance company informs the organization of the patient's financial liability. See organization's separate Visit Rate information. ***When known at time of Admission:*** Project _____% of charges to be covered after deductible met. (Specify amounts _____).

ASSIGNMENT OF BENEFITS: I request that payment of authorized benefits be made on my behalf directly to the organization.

AUTHORIZATION FOR RELEASE OF INFORMATION: I hereby consent to and authorize the organization to release and receive information for the purposes of treatment, payment and health care operations. The exchange of information may occur between, but is not limited to, physicians, third party payers, other health care providers, and regulatory and/or accrediting reviewers.

ACKNOWLEDGEMENT OF INFORMATION: I have received verbal and written information on the following:

- Advance Directives
- Infection control
- Patients Rights and Responsibilities.
  Includes information about how to use the organization's complaint process and the state's toll free hotline
- Statement of Patient Privacy Rights and Privacy Act Statement-Health Care Records (Medicare and Medicaid patients), and/or Notice About Privacy (patients who do not have Medicare and Medicaid)
- Receipt of Notice of Privacy Practices/HIPAA
- Any cost sharing, if applicable
- Basic Home Safety
- Emergency planning related to a disruption in service

This Admission Agreement is applicable to this admission to the organization. I understand what I have read and what was explained to me and agree to the terms and conditions as above. Additionally, I understand that either party may terminate this agreement for any reason and/or at any time.

Signature of Patient or Legal Representative_____ Date_____

Signature of Witness_____ Date_____

PATIENT NAME–Last, First, Middle Initial	ID#