CARIS healthcare

ADMISSION CONSENT/ELECTION OF HOSPICE BENEFITS

PATIENT NAME: _____ **PAYER ID #:** _____

HOSPICE ELECTION EFFECTIVE DATE: _____

INSTRUCTIONS: This form is used to acknowledge receipt of our orientation booklet and confirm your understanding and agreement with its contents. Your signature on the back of this form indicates your approval.

PATIENT RIGHTS AND RESPONSIBILITIES

I acknowledge that I have been provided with a written copy of my rights and responsibilities as a patient. A hospice representative has discussed them with me and I understand them. The state hospice hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide hospice care. No employee of this agency has solicited or coerced my decision in selecting a hospice agency.

CONSENT FOR TREATMENT

I hereby give my permission for authorized personnel of your hospice to perform all necessary procedures and treatments as prescribed by my physician for the delivery of hospice care. I understand the following hospice care and services may be provided to me during the course of illness: physician, nursing, social work, therapy services, counseling services (bereavement, spiritual, dietary), hospice aide/homemaker, volunteers, durable medical equipment, pharmaceuticals, medical supplies, respite care, short term inpatient care and continuous care. I understand that hospice will supervise services provided, I may refuse treatment or terminate services at any time, and hospice may terminate their services to me as explained in my orientation. I agree and consent to the care plan.

CONSENT FOR HIV/HEPATITIS TESTING

I understand that in the event a hospice employee inadvertently comes in contact with my blood or body fluids, my blood must be tested for Hepatitis B, C and HIV (the virus that causes AIDS). These tests will be done at no cost to me.

RELEASE OF INFORMATION

I acknowledge receipt of the **Notice of Privacy Practices** and was given an opportunity to ask questions and voice concerns. I understand that the Agency may use or disclose protected health information about me to carry out treatment, payment or health care operations. The agency may release information to or receive information from insurance companies, health plans, Medicare, Medicaid or any other person or entity that may be responsible for paying or processing for payment any portion of my bill for services; any person or entity affiliated with or representing for purposes of administration, billing and quality and risk management; any hospital, nursing home or other health care facility to which I may be/have been admitted; any assisted living or personal care facility of which I am a resident; any physician providing my care; family members and other caregivers who are part of my plan of care; licensing and accrediting bodies, and other health care providers in order to initiate treatment.

RESTRICTION OF HEALTHCARE INFORMATION

Other than myself, I wish to restrict communication concerning my health status to the following person(s) only: _____

Information about my health status may be communicated to the person(s) listed above by the following means (check all that apply):

☐ face to face conversation ☐ telephone conversation ☐ telephone answering machine ☐ email

AUTHORIZATION FOR PAYMENT/ELECTION OF HOSPICE CARE

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits from Medicare, Medicaid, or other responsible payor be made in my behalf to Caris HealthCare. I understand that I am responsible for all amounts not paid by my commercial insurance. If I am a Private Pay patient, I agree to pay for all services rendered by the hospice. I have been provided a full understanding of hospice care and understand that certain benefits are waived by election of the medicare hospice benefit if applicable. I hereby elect to participate in hospice care under the following program checked:

☐ **Medicare Hospice Benefit (Section 14.1) and/or Medicaid Hospice Benefit (Section 14.2)** ☐ **Private Pay**

☐ **Commercial Insurance Hospice Benefit (Section 14.3)** ☐ **Veterans Benefits Administration (Section 14.3)**

If I have Medicare Part A benefits, I understand that Medicare payments will be accepted as payment in full for Hospice related services and I have no financial liability, unless I have been notified in writing that service(s) will not be covered by Medicare and wish to receive the care or service.

If I have other insurance, I may be responsible for the co-payment, deductible and any charges that my insurance will not cover.

Special Services: I understand that, if I need hospitalization or special services not provided by hospice, I or my legal representative must make arrangements for these services. The hospice shall in no way be responsible for failure to provide the same and is hereby released from any liability arising from the fact that I am not provided with such additional care.

PHOTOGRAPHY/VIDEOGRAPHY CONSENT

I give consent for my photograph and/or video to be used. Beneficiary/Patient or Representative Initials_____

I do not wish for my photograph and/or video to be used for any purpose. Beneficiary/Patient or Representative Initials_____

ADVANCE DIRECTIVES

I understand that the Federal Patient Self-Determination Act of 1990 requires that I be made aware of my right to make health care decisions for myself. I understand that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak for myself.

1. **I have an Advance Directive.** ☐ **No** ☐ **Yes** *(If yes, provide a copy to the agency.)*
2. **I have appointed a Health Care Agent.** ☐ **No** ☐ **Yes** *(If yes, write the name and phone number of the person listed in the Advance Directive as my Health Care Agent.) Name:* _____

_____ *Phone #:* _____

My signature on the back of this form indicates my approval and understanding.

CARIS healthcare

ADMISSION CONSENT/ELECTION OF HOSPICE BENEFITS

(CONTINUED)

PATIENT NAME: _____ **PAYER ID #:** _____

INFORMED CONSENT

I ACKNOWLEDGE/UNDERSTAND THE FOLLOWING:

I understand the nature of the hospice care available through the Medicare Hospice Benefit and am aware that all treatment will focus on comfort (palliative) rather than cure (curative) or life prolonging. Treatment will be for management of symptoms and to provide comfort for my terminal illness . The focus of my care will be to maintain me in my home rather than in a hospital.

I understand that I and/or my caregiver will participate in developing the plan of care along with the hospice team composed of a physician, nurse, medical social worker, spiritual counselor and other disciplines that may be necessary.

I waive the right to all other benefits under the Medicare Program while I am receiving hospice benefits. Only Caris HealthCare will be able to receive Medicare payment for care of services provided to me for my terminal illness or any other condition related to my terminal illness.

Medicare will make payment for unlimited hospice days; however, the days are broken into three benefit periods to be used in this order. These periods are as follows:

First Benefit Period	-	90 days
Second Benefit Period	-	90 days
Subsequent 60 day Period	-	Unlimited as long as beneficiary meets requirement for benefit.

My medical condition will be reviewed and updated as changes occur but at intervals of no more than every fourteen days and also prior to each benefit period for Hospice appropriateness by my physician and the hospice team.

I understand that I may be responsible for five (5) percent of the reasonable cost up to a maximum of $5.00 for each outpatient individual prescription for my terminal illness and can be charged up to five (5) percent of payment made by Medicare for a respite care day. Medicare regulations require Caris HealthCare to notify me of this. Caris HealthCare is not currently asking patients/families to incur this cost. Should it become necessary, Caris HealthCare will give me 30 days notice in advance of implementation.

I understand that I can use standard Medicare in the usual manner to pay the bill for:

1. My doctor, if he/she is not an employee of this hospice.
2. Treatment of a condition unrelated to my terminal illness.

I understand that I can revoke this benefit at any time and resume regular Medicare coverage and that I must sign the revocation statement the day I revoke. I know I will lose any hospice days remaining in the benefit period in which I revoke. If I do not notify Caris of my decision to revoke, I may be responsible for medical expenses that might be incurred.

I understand that I may transfer my hospice care to another Hospice Program once during each election period.

Physician Role: I understand that the Hospice Medical Director in consultation with the Interdisciplinary Team (IDT) will coordinate my hospice services. My attending physician is part of the IDT. I understand that I or my representative have the right to choose my attending physician. The physician I choose as my attending physician is:

Name	NPI#	Phone
_____	_____	_____

Acknowledging/understanding the above, I authorize Medicare Hospice Benefit coverage to begin on: _____.

Month/Day/Year

I understand a copy of this consent form shall be as valid as the original and shall remain in effect until I am discharged from the agency. I also understand that I may revoke this consent in writing at any time.

_____ Beneficiary or Representative Signature	_____ Date
_____ Relationship of Legal Representative to Beneficiary	
_____ Hospice Employee Signature	_____ Date

☐ Patient unable to sign due to: _____

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_____	_____
Beneficiary or Representative Signature	Date
_____	
Relationship of Legal Representative to Beneficiary	
_____	_____
Hospice Employee Signature	Date

☐ Patient unable to sign due to: _____