angels grace
HOSPICE

ADMISSION CONSENT

PATIENT NAME: _____ **PATIENT ID:** _____

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 home care/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 my hospice care without solicitation or coercion from the hospice agency.

CONSENT FOR TREATMENT: I hereby give my permission for authorized personnel of your hospice to perform all necessary assessments, 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 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. I also give my permission to have my blood tested for Hepatitis B, C and HIV should a hospice employee inadvertently come in contact with my blood or body fluids.

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 (PHI) 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.
I agree that the agency may share my PHI with emergency officials or others involved in my care to assist in disaster relief efforts. ☐ Yes ☐ No

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 payer be made in my behalf to Angels Grace Hospice. 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** ☐ **Medicaid Hospice Benefit** ☐ **Commercial Insurance Hospice Benefit** ☐ **Private Pay**

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.

CONSENT TO FILM OR RECORD: I hereby consent for the agency to record or film my care, treatment and services and allow the agency to use the photographs/recordings for their internal use, for documenting my medical condition or for insurance providers to document my condition for payment purposes.

ADVANCE DIRECTIVES: I have been made aware of my right to make health care decisions for myself and 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 made a Living Will.** ☐ **No** ☐ **Yes** (If yes, provide a copy to the agency.)
2. **I have Health Care Power of Attorney.** ☐ **No** ☐ **Yes** (If yes, write name and phone number below.)
   Name of Durable Power of Attorney/Health Care Representative: _____ *Phone:* _____
3. **I have a Do Not Resuscitate (DNR) Order/Practitioner Orders for Life-Sustaining Treatment (POLST).** ☐ **No** ☐ **Yes**

By signing this consent, I acknowledge receipt of the orientation booklet and confirm my understanding and agreement with its contents. I understand a copy of this consent 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.

_____ Patient Signature	X _____ Date	X _____ Responsible Person or Legal Guardian's Signature
_____ Hospice Representative Signature	_____ Date	X _____ Printed Name and Relationship of Person Above

☐ *Patient unable to sign due to:* _____