SKIRBALL HOSPICE

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www.skirballhospice.org

INFORMED CONSENT TO TREATMENT, AUTHORIZATION TO PAY, AND RELEASE OF INFORMATION

TREATMENT AUTHORIZATION: I request admission to Skirball Hospice and elect to receive Hospice services. I authorize and consent to any and all examinations and treatments prescribed by my physician (or Hospice physician) rendered by Skirball Hospice physicians, nurse practitioners, licensed nurses, social workers, spiritual counselors, hospice aides, volunteers, registered dietitians and physical, occupational and speech therapists.

In doing so, I understand and agree to the following:

I understand the hospice program to be palliative, not curative in its goals and techniques; that the program emphasizes the relief of physical symptoms including pain; and that the hospice team identifies and attempts to meet the emotional and spiritual needs of the patient and family, related to the terminal illness and related conditions for which the patient is being admitted.

Routine Home Care: I understand hospice services are delivered primarily in the home (which may include a nursing home or assisted living facility) provided by a team of hospice professionals, staff and volunteers. These services are available both on a scheduled basis and as needed. I understand that these services may include, as set forth in the hospice plan of care: nursing care, physician care, social work, spiritual, nutrition and bereavement counseling, hospice aides, medical supplies, physical therapy, occupational and speech-language therapy and medications prescribed for relief of pain or discomfort.

General Inpatient & Respite Care: I understand general inpatient hospice care and inpatient respite care are provided in an inpatient setting when it is deemed necessary by the hospice interdisciplinary team. I understand hospice inpatient care is designed for short-term stays with the goal of acute pain and symptom management, which cannot be provided in another setting with the goal of returning home. I understand inpatient respite care is designed to provide brief periods of respite for the family or primary caregiver while the patient receives hospice care in an inpatient setting.

Crisis Care (Continuous Care): I understand that crisis care - meaning extended visits (a minimum of 8 hours of care in a 24-hour period) may be provided in a patient's home or community when it is deemed necessary by the hospice interdisciplinary team. This extended care is designed for short-term periods to manage acute medical symptoms or a family crisis with the goal of stabilizing the patient's condition or family situation and then returning to Routine Home Care.

CAREGIVERS: I understand that Skirball Hospice does not provide 24-hour caregivers. I understand I am responsible for having a caregiver provide care to me in my place of residence at my own expense. If a family member or other person is not able to provide such

care, I can choose to hire a caregiver at my residence or move to a facility to receive such care. The caregiver may also participate in decisions about the care provided. The Hospice interdisciplinary team supplements rather than replaces care provided by the family or designated caregiver.

PLAN OF CARE: I am encouraged to participate in the development and implementation of the hospice interdisciplinary plan of care.

MEDICATIONS: I understand that the pharmacist that fills my prescriptions may select the drug product in the hospice formulary that is generally equivalent to the brand name prescribed by my physician. I understand that if my physician believes the generic form would not be effective, the brand medication will be provided. I understand that if I choose another vendor, medications, equipment and supplies not provided by hospice through its vendors or authorized by hospice, I am financially responsible for those charges.

PHYSICAL THERAPY: I acknowledge that I have received a copy of form NTC 12-01 from the Physical Therapy Board of California.

CONSENT TO PHOTOGRAPH: I authorize Skirball Hospice to photograph the patient and documents and to use such photographs for medical documentation and insurance purposes. This consent is subject to cancellation by written notice from the undersigned except to that extent that action has been take.

REVOCATION: I understand I may revoke the hospice benefit at any time by signing a statement to the effect, specifying the date when the revocation is to be effective and submitting the statement to Skirball Hospice prior to that date. This revocation constitutes a waiver of the right to hospice care during the remainder of my current election period.

TRANSFER: I understand that once in each election period I may choose to receive services through a hospice program other than Skirball Hospice. Such change shall not be considered a revocation of hospice services. It will be considered a transfer.

RECERTIFICATION: I understand that under the Medicare Hospice Benefit, I am entitled to hospice care, which consists of two 90-day periods and subsequent 60-day periods of unlimited duration. At the end of each benefit period, the hospice interdisciplinary team evaluates the patient condition for recertification and for continuation of hospice care. I accept the conditions of Skirball Hospice as described to me, understanding I may choose not to remain in the hospice program and that hospice may discharge me from the program if hospice care is no longer medically appropriate. I understand however, that if my medical condition changes, I may request to be readmitted at a later date.

FINANCIAL RESPONSIBILITY: I understand that Skirball Hospice assumes financial responsibility for medications, durable medical equipment and medical supplies related to the terminal illness, approved by the hospice and provided by a hospice approved vendor. I understand I am responsible for the cost of care for my terminal illness if I seek care beyond what is considered medically necessary by the hospice interdisciplinary group and documented on my plan of care.

AGREEMENT TO PAY: If I am a Medicare or Medi-Cal Beneficiary, I understand that when I elect the hospice benefit, I thereby waive General Medicare coverage related to my hospice diagnosis and accept hospice care for my hospice diagnosis.

I understand that while this election is in force, my insurance carrier will make payments for care related to this diagnosis. Services related to the hospice diagnosis provided by hospitals, home health agencies, nursing homes and any other company or agency will not be

reimbursed by my insurance carrier unless specifically ordered and authorized by Skirball Hospice.

I understand the services not related to this diagnosis will continue to be covered by my insurance carrier along with hospice benefits. I understand that payment/coinsurance/deductible amounts for items not related to my terminal illness will remain my responsibility.

PAYMENT AUTHORIZATION

I, hereby authorize ❒ Medicare ❒ Medi-Cal ❒ Other: _____ to pay directly to Skirball Hospice for _____ any insurance or government benefits to which I may be entitled to under the terms of my insurance coverage with the above mentioned insurance carrier, such amount not to exceed the coverage for services rendered. I agree to pay the amount not covered by insurance (this could include deductibles, co-pays, plan percentages, example 80/20). If I cancel my insurance and/or sign into a different insurance, I will notify Skirball Hospice. If my insurance is cancelled or terminated and I do not notify Skirball Hospice, I will be responsible for charges incurred past that date.

_____	_____	_____
Insured Name	Subscriber Number	Social Security Number

ADVANCE DIRECTIVES

I have been informed verbally and in writing of my rights concerning Advanced Directives including:

- I have the right to formulate an Advance Directive.
- I am not required to have an Advance Directive in order to receive medical treatment by any healthcare provider.
- The terms of any Advance Directive that I have executed and disclosed to Skirball Hospice will be followed to the extent permitted by law.

❒ The patient does not have an Advance Directive
❒ The patient has an Advance Directive:
  ❒ Power of Attorney for Health Care
  ❒ Living Will

Name of Agent: _____
Address of Agent:
_____
_____

POLST (PHYSICIAN ORDERS FOR LIFE SUSTAINING TREATMENT)

❒ The patient has a POLST
  ❒ Check if POLST completed with hospice election.

RELEASE OF PATIENT RECORDS

I understand Skirball Hospice may need to obtain medical records and related information from hospitals, nursing homes, physicians, pharmacies, home health agencies, insurance companies, health care benefit plans or others in order to assure continuity of care and proper reimbursement for services. I authorize the above persons and entitles to release to Skirball Hospice and its representatives medical records and related information necessary for the provision of hospice care. I also authorize Skirball Hospice and its representatives to

release medical records and related information to others for the purposes of my health care, administration and management of my health care (including utilization review) or processing and obtaining payment for services and supplies rendered to me. I understand and agree that these authorizations specifically include my permission and consent to release any information regarding a diagnosis of AIDS or results of Human Immunodeficiency Virus (HIV) tests to the extent permitted by law. A photocopy of this authorization shall be as valid as the original.

I have been able to discuss the conditions described and written with this document and the patient handbook with a member of the Hospice staff and have had my questions answered to my satisfaction.

I acknowledge I have received a copy of the Skirball Hospice Patient Information Handbook which includes a detailed listing of Patient Rights and Responsibilities, Notice of Privacy Practices and information on reporting complaints or grievances.

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322
www.mbc.ca.gov

ACKNOWLEDGEMENT

I acknowledge and agree to the terms and conditions described herein:

_____	_____	_____
Patient or Representative Signature	Relationship to Patient	Date

If patient unable to sign, state reason:_____

Name of Legal Representative (if applicable): _____

Address of Legal Representative (if applicable):_____

_____	_____	_____
Hospice Representative Name/ Credential	Signature	Date

Patient Name (Last, First)	MR#