



Patient Name _____ Patient Number _____
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Hospice Benefit Election Form

Consent For Care/Service

I consent and authorize the organization, its agents and associates to provide care and treatment as prescribed by my physician and per program policy. I have received an explanation of the services to be provided. I understand that hospice services are palliative (*pain and symptom control, emotional and spiritual support*) in nature and not intended to cure my terminal condition and this has been fully explained to me. I understand that certain Medicare services relating to my terminal illness are waived by electing this Hospice Medicare Benefit which has been fully explained to me. Hospice will pay for care which is related to my terminal illness and within my plan of care as developed with Hospice staff. I understand that it is my responsibility to seek pre-approval from Hospice for all treatments and services not included in my plan of care.

Authorization For Release of Information

I 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 reviewers.

Payment

I understand that services provided to me by this organization will be billed as follows and that I request that payment of authorized benefits be made on my behalf directly to the organization:

- Medicare (Project 100% covered)
- Medicaid (Project 100% covered after meeting spend down)
- Insurance (Coverage varies with individual policy)
- Non-reimbursable (Some or all charges will be covered by Hospice Foundation)

Acknowledgement of Information

I have received verbal and written information on the following:

- Advance Directives
- Patients' Rights and Responsibilities
- Summary Notice of Privacy Practices
- Basic Home Safety
- Emergency planning related to a disruption in service
- Infection Control
- Drug Disposal
- Payment information specific to insurance, if any.

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. I understand that I may discontinue hospice care at any time by signing a written statement which can be obtained from any Hospice personnel, and understand that I will lose any remaining days in that benefit period. I also understand that I may transfer to another hospice program once during a benefit period without loss of days."

EFFECTIVE DATE OF BENEFIT: _____

_____	_____	_____	_____
Patient or Authorized Representative	Date	Hospice Staff	Date