PATIENT / FAMILY INFORMED CONSENT

I choose to receive hospice care from AMEDISYS HOSPICE OF GREATER CHESAPEAKE, ***(Hospice agency to fill in appropriate legal company name)*** **referred to as "Hospice" and acknowledge and agree to the following.**

Freedom of Choice: I understand that I have the freedom to choose my hospice provider and that services will continue for as long as I remain eligible for my Hospice Medicare Benefit, Medicaid Benefit or private insurance benefit criteria. I understand that I have the right to transfer to another provider, once within each benefit period, as described in the Benefit of Election Statement, which will be provided to me in a separate document. I understand that I may elect to discontinue hospice services at any time.

Patient Information Booklet: I acknowledge receipt of the Patient Information Booklet that contains written information on the topics listed below. I acknowledge that I have had the information explained to me verbally and have had the opportunity to ask pertinent questions regarding the information provided. Topics discussed included:

- Medicare coverage of services including covered services and eligibility requirements
- Financial responsibility/authorization
- Refund policy
- Advance directives
- Medical records and privacy practices
- Privacy practices related to protected health information
- Patient/family rights and responsibilities/rights of the elderly
- Reporting of abuse, neglect, and exploitation
- Procedure for filing a grievance or complaint
- Agency staff & supervision
- Monitoring of controlled drugs policy
- Disposal of medications policy
- Agency drug testing
- Medication and treatment procedure including the patient's right to pain management & medication safety
- General home safety, falls prevention, fire safety, equipment safety
- Basic infection control
- Emergency Preparedness

Hospice Philosophy: I understand that hospice provides palliative, not curative care, to meet the physical, emotional and spiritual needs of the patient and family. I understand that hospice focuses on the relief of pain and symptoms, which may accompany a life-limiting illness.

Change in Services: I understand that I will be given a written notice, per agency policy and state regulations, prior to any reduction, discharge or referral from service, except when a medical emergency exists or when my attending physician orders admission to an inpatient facility.

Attending Physician: I understand that my chosen attending physician, in consultation with the Hospice Medical Director and other members of the Hospice Interdisciplinary Team will coordinate my Hospice care services.

My attending physician is: VIJAY ABHYANKAR, MD.

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Hospice Services: I understand hospice services will be provided by the Hospice interdisciplinary team, my chosen attending physician and providers contracted by Hospice. The Hospice interdisciplinary team consists of nurses, physicians, social workers, spiritual, bereavement and dietary counselors, home health aides, volunteers and physical, speech, occupational therapy services. Hospice services are available on a scheduled and as needed basis, twenty-four hours a day, seven days a week. Hospice services will be provided primarily as routine care at the patient's home and may also be provided in a skilled nursing facility, in an acute care hospital or inpatient hospice facility under arrangement with Hospice in accordance with the Hospice plan of care. I may choose to remain in my home during times of medical crisis under continuous care provided by the hospice staff until the crisis is resolved or a decision is made to transfer to an inpatient hospital or facility. Hospice Respite service is available in a contracted inpatient facility to provide rest period for my caregiver for a period of up to five (5) consecutive days. Hospice will make all arrangements with providers/suppliers of hospice services and supplies. Medical supplies, equipment and medications included in the hospice plan of care are also provided by Hospice, directly or through arrangement. It is the policy of this agency, or any of its subsidiaries or affiliates (Amedisys"), to provide or arrange for all hospice related services, medical appliances and supplies to the Hospice patient while under care of this agency. The undersigned agrees NOT to enter into independent agreements with third party providers for services, medical appliances or supplies while under the care of our hospice agency. If independent agreements are made contrary to this agreement, payment for those services will be the responsibility of the undersigned.

Patient and Family Role with Hospice: I understand that I may participate in making decisions regarding the type and frequency of services provided and included in the hospice plan of care. I further understand that the hospice team is not intended to take the place of the family, but rather to support the primary caregiver and family in caring for the patient. I have also been encouraged to participate with the interdisciplinary team in the development and ongoing review of my hospice plan of care. The IDT meetings will be held: EVERY OTHER WEDNESDAY

Acknowledgement to Release Information: I consent to the release of information and/or disclosure to Hospice or its affiliated entities of all or any part of my medical record by any physician, hospital or facility of which I have been a patient; to a credit check and review of my financial rating and history with any person, firm or credit bureau if I have any self-pay responsibility; and to the use of/or release of information by Hospice in accordance with federal guidelines.

Acknowledgement of Notice of Privacy Practices and General Privacy Consent: I hereby certify that I have received a copy of the Hospice Notice of Privacy Practices. I am aware and acknowledge that this notice describes how my health information may be used or disclosed. I am aware that I may direct any questions, concerns or complaints about the privacy practices to the company's Chief Privacy Officer at (225) 292-2031 or via the privacy hotline at 1-866-518-6684. By virtue of this document, am giving my consent to Hospice and/or its affiliated entities to use and /or disclose my protected health information for purposes of treatment, payment or operations, including administrative functions, quality assessment, and government and accreditation surveys. I understand that Hospice may, in the course of rendering care to me, disclose personal health information about me to my family, close friends, persons involved in my care, disaster relief agencies, and other persons identified by me as long as the information disclosed is relevant to their involvement in my care or the payment for my care. I authorize Hospice to use and disclose my individually identifiable information to report suspected abuse, neglect or domestic violence and to disclose to police for location or identification purposes, information that may pertain to death under suspicious circumstances, and/or crime on the premises. I understand that I may opt out or otherwise restrict the disclosure of my information by providing notice to the Hospice or Chief Privacy Officer.

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Patient Self-Determination Act: I have received verbal and written information about Advance Directives, my right to accept or refuse medical treatment, applicable state law, my rights under state law and other information necessary to make decisions about advance directives and my care in accordance with the Patient Self-Determination Act of 1990.

Patient has executed:

Living Will ..... ☒ **Yes** ..... ☐ **No**

Medical Power of Attorney ..... ☐ **Yes** ..... ☐ **No**

DNR ..... ☐ **Yes** ..... ☐ **No**

Consent to Photograph: – I consent to the photography of any wound(s) I may have, and agree that any photographs will become a part of my permanent medical record. I further consent that these photographs to be used to inform or collaborate with my physician(s) and wound care specialists. I also consent to the use of these wound photographs and wound assessment/documentation, "voided of any personal identifying information" for statistical, research, marketing, and/or educational purposes.

Receipt of information: Hospice services have been explained to me; I have been given the opportunity to ask questions I have concerning the hospice program of care; and my questions have been answered to my satisfaction and have received copies of consents and the written material to my satisfaction.

Consent To Treat: I give my consent and authorize representatives/employees of this agency to render timely and appropriate palliative health care services to me. Not withstanding any of the foregoing, I hereby reserve the right to refuse services or treatment at any time upon giving verbal notification to the hospice office or field staff. Further, I understand this agency reserves the right at all times to cease providing services to me, by giving verbal or written notification, and stating the reason for the same. I have been informed of the services to be provided to me by this hospice, and the proposed plan of care. The proposed plan of care is initially provided according to my physician's orders, and is subject to change as my condition changes and/or as specifically ordered by my physician and/or hospice medical director. I also consent to and authorize hospice representatives to contact me or my family by phone, fax or e-mail after the termination of hospice services for clinical follow-up or operational purposes.

HOSPICE FINANCIAL AUTHORIZATION

I, as patient and/or responsible party, certify that the information given by me in applying for payment under Title XVIII and Title XIX of the Social Security Act, my private insurance and/or any other third party payer is correct. I hereby assign to Hospice any and all benefits for services rendered under the terms of any insurance policy, Title XVIII and Title XIX of the Social Security Act, and/or other payment arrangement and hereby individually obligate such payor(s) to pay Hospice in accordance with the standard and customary charges incurred during my period of treatment. I, and/or my responsible party, understand that:

- I authorize release of all records required to act on this request and authorize payments to be made on my behalf.

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- I accept responsibility for any services, medications, procedures, treatment or hospitalizations not preauthorized by Hospice. If Hospice does not have knowledge of or give authorization for services rendered for treatment of my terminal illness, I may be held financially responsible for all related charges.
- I acknowledge receipt of the hospice rates/fee schedule if required by state statute.
- I understand that I will be notified of changes in my funding status, verbally and in writing, within 15 days, if state requires such notification.
- I am responsible for any co-payments, deductible, non-covered services required by my insurance benefit, state Medicaid program or other payer.

Insurance Coverage

Listed below is the estimated charges and insurance coverage based on verification of coverage and discussion with your insurance plan(s)/program for hospice services:

Primary: ☒ Medicare ❒ Medicaid ❒ Private Insurance ❒ Patient ❒ Other _____

Secondary: ❒ Medicare ❒ Medicaid ❒ Private Insurance ❒ Patient ❒ Other _____

Tertiary: ❒ Medicare ❒ Medicaid ❒ Private Insurance ❒ Patient ❒ Other _____

Estimated Charges

Hospice Services	Charges/Rates	Insurance Allowable	My Estimated Liability
Routine Care	$207.00/d	100%	none
Continuous Care	$52.00/h	100%	none
Respite Care	$211.00/d	100%	none
General Inpatient Care	$917.00/d	100%	none
Nurse	$176.10	100%	none
MSW	$247.70	100%	none
Counselor	$ 1.00	100%	none
Hospice Aide	$100.35	100%	none
Physical Therapy	$227.37	100%	none
Speech Therapy	$255.13	100%	none
Occupational Therapy	$228.87	100%	none
Dietician	$176.10	100%	none

I agree to pay $ NONE per month toward my share of the costs listed above.

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Financial Responsibility

Insurance and Other Payers: Hospice will submit a claim to my insurance company (if applicable), but this submission does not relieve me of financial responsibility for services and products provided by Hospice should the claim be denied or paid in accordance with the estimate(s) listed above.

Medicare/Medicaid Recipients: I understand that if I am eligible for Medicare or Medicaid Hospice program, that Medicare or Medicaid reimbursement is accepted as payment in full for the amounts allowable. My responsibility for these programs is limited to:

- The co-pay and/or share of cost required by some state programs (listed above).
- Services you request which are not covered. These services include:

No non-covered services requested.

I understand Hospice has contractual agreements with hospitals, nursing homes, ambulance transportation, radiology, and laboratory services. Hospice has provided me with a list of contracted providers and I understand while under Hospice care if I go to other healthcare providers, Hospice must be notified.

I acknowledge receipt of the aforementioned information as indicated by my signature.

Patient/ Authorized Representative Signature	Relationship	Date
X [signature]	SPOSE	9-19-16
If signed, by Authorized Representative list reason patient cannot sign: dementia		
Hospice Representative Signature [signature]	Title	Date 9-19-16

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