INFORMED CONSENT AND HOSPICE

PATIENT NAME: _____ **DOB:** _____

I choose to receive hospice care from Arizona Professional Hospice Care Care and I acknowledge, consent and agree to the following:

HOSPICE PHILOSOPHY: I understand that the hospice program provides palliative care to meet my family/caregiver's physical, emotional and spiritual needs. I understand that the focus of the care provided is to relieve pain and symptoms and not to cure the disease. I understand that the hospice care does not include aggressive treatment.

BENEFITS OF HOSPICE CARE: Hospice care can improve my quality of life by providing understanding of the death and dying process. My quality of life can rise with the assistance of the hospice team.

RISK OF HOSPICE: I understand that some of the risks of hospice care can be: my primary care physician may not want to follow me on hospice; I cannot receive treatment for my primary diagnosis from other health care providers without the permission from the hospice company or I may revoke my hospice care. I understand that if I choose care without the permission of the hospice I may be financially obligated for payment. I further understand that hospice care is for pain and symptom management and will not cure my disease.

PATIENT AND FAMILY RIGHTS: 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.

PATIENT SATISFACTION HOTLINE: I acknowledge that I have also been advised that a toll-free patient satisfaction hotline is available. This number is answered twenty-four hours a day, seven days a week.

ALTERNATIVES TO HOSPICE CARE: alternatives to hospice care can include long-term care facilities, home care, community services (including adult day care and meal delivery) and skilled nursing facilities.

HOSPICE LEVELS OF CARE:

a. **Home Services** – I understand that hospice services are provided primarily in the home by a team of professionals and volunteers. These services are available both on a scheduled and as needed basis; on-call service is available twenty-four hours a day, seven days a week. I understand that these services will include nursing, physician care, social work, bereavement, spiritual counselors, hospice aides, volunteers, medical supplies and equipment, dietary counseling, physical, occupational and speech therapy, and medications prescribed for the relief of pain and symptoms.

b. **Respite care** - I understand that respite care is provided if my usual caregiver (such as a family member) needs a rest. During this time, I will be cared for in a Medicare-approved facility, such as a hospice inpatient facility, hospital or nursing home.

c. **General inpatient care** – I understand that the hospice program provides inpatient services in the hospital or skilled nursing facility when deemed necessary by the physician and interdisciplinary team for management of symptoms. The goal is to stabilize me and my family both physically and emotionally in order for me to return home, if possible.

d. **Continuous Home Care** – I understand that continuous home care is to be provided only during periods of physical or emotional crisis. Continuous care provides more intense care in my home environment. Continuous care is considered a short-term level of care and will be reevaluated every 24 hours.

PRIMARY CAREGIVER ROLE: I understand that the hospice team is not intended to take the place of the family, but rather to support the primary caregiver and family who are caring for me. I understand that I must make arrangements for my care when Arizona Professional Hospice Care Care is not in my home, or if my environment is unsafe. If I don't have a 24-hour caregiver available, I agree to make, in advance, appropriate arrangements for such time as my care requires 24-hour attention.

The person who has agreed to be mainly responsible for my care is _____.

ATTENDING PHYSICIAN: I understand that I or my representative have the right to choose my attending physician.

My attending physician is _____.

ADVANCE DIRECTIVES: I have received and reviewed information regarding my right to accept or refuse medical treatment and my right to execute an Advance Directive. I understand that I am not required to have an Advance Directive in order to receive medical treatment by Arizona Physicians Hospice Care. The terms of any Advance Directive that I have executed will be honored by the hospice agency to the extent permitted by law. Advance Directive is defined as a Living Will, Health Care Proxy or Medical and/or Mental Health Power of Attorney.

- ☐ I have executed an Advance Directive and provided a copy to the hospice agency.
- ☐ I have executed an Advance Directive but have not provided a copy to the agency.
- ☐ I have not executed an Advance Directive.

ASSIGNMENT OF BENEFITS FOR MEDICARE: As a Medicare recipient, I understand that I am waiving my traditional Medicare coverage for services performed by Arizona Professional Hospice Care Care and related treatment of the terminal condition or other related condition for which hospice care was elected. If I revoke or discharge from hospice, Medicare will return me to the traditional Medicare coverage.

PATIENT AND FAMILY ROLE WITH THE HOSPICE TEAM: I understand that I am authorized by my physician to be able to identify staff thru proper ID and I have the right to join the hospice team in making the decisions about the variety, frequency and intensity of the services and techniques the hospice team will use to help me. I understand that I may review the plan of care and that I am invited to attend the hospice team meetings to discuss the services being used to assist us.

NON-DISCRIMINATION: I understand that Arizona Professional Hospice Care Care does not discriminate against other personnel, patients or other customer based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, diagnosis or source of payment.

INFORMED CONSENT AND HOSPICE ELECTION

MEDICARE HOSPICE BENEFIT: Arizona Professional Hospice Care Care will be the only provider able to receive Medicare payment for care or services of my terminal illness or any condition related to my terminal illness. Exceptions to this are: (a) Medicare will pay for physician services if my attending physician is not a hospice employee or is not receiving any payment from the hospice and (b) Medicare will pay for services provided to me by another hospice when these services have been arranged through Arizona Professional Hospice Care Care prior to services being rendered.

DOCUMENTATION: I hereby give consent and approval for Arizona Professional Hospice Care Care staff and volunteers to document my day-to-day care in the hospice medical record and care plans concerning the medical, nursing, psycho-social, religious and personal information necessary for hospice to fulfill its function.

MEDICATION, BIOLOGICALS AND MEDICAL SUPPLIES: Drugs, biological and medical supplies related to the terminal illness will be paid for by Arizona Professional Hospice Care Care for Medicare Part A patients and those whose federal state or insurance payer sources include medications and supplies as part of the hospice benefit. Generic drugs will be dispensed as available.

MEDICATION DISPOSAL: I acknowledge I have received a copy of the policy regarding use and disposal of controlled substances.

MEDICARE HOSPICE BENEFIT PERIODS: There are two initial 90-day periods followed by an unlimited number of subsequent 60 day periods. At the beginning of each period, a physician must certify that I have a terminal illness and a life expectancy of six (6) months or less if the illness runs its normal course.

DISCONTINUING HOSPICE CARE: Hospice care can be discontinued voluntarily by my consent (Revocation), by the hospice if I am no longer considered by my physician to be terminally ill, if I should go to a non-contracted facility or physician, if I should move out of our service area or discharge for cause, i.e., disruptive or abusive behavior or uncooperative with the plan of care (Discharge).

AUTHORIZATION TO RELEASE INFORMATION: I consent to the release of information and/or disclosure to Arizona Professional Hospice Care Care the portion of my medical record necessary for the provision (or continuity) of my hospice care. This includes any physician, hospital or other facility where I have been a patient. I consent to the release of information from Arizona Professional Hospice Care Care to individuals acting in an office capacity, representing governmental agencies and/or other health care providers. I understand that officials from certain governmental or accrediting agencies may contact me to obtain information concerning my medical condition and the services provided to me by Arizona Physicians Hospice Care. I hereby release and indemnify Arizona Professional Hospice Care Care from any liability and all claims pertaining to the disclosure of pertinent medical and nursing information to Medicare or other third-party providers. For the purpose of safety and continuity of care, I hereby authorize Arizona Professional Hospice Care Care to release and/or obtain medical and/or treatment information and/or billing information that may include the following information (15): (a) Confidential alcohol and/or drug abuse related information (42 CFR Sec 2. 1 ET Seq.). (b) Confidential mental health information and psychotherapy notes, (c) Confidential communicable disease related information (A.R.S. Section 36-661) and (d) Confidential HIV/AIDS related information (A.R.S. Section 36-661). I also agree that Arizona Professional Hospice Care Care may share my Personal Healthcare Information (PHI) with its affiliates: Arizona Physicians Hospice Care. The Healthcare Journey Program and/or Palliative Care Services in order to provide me with a continuum of care as needed.

PHI/HIPAA: I have been given the information to explain PHI and HIPAA related to the release of medical information needed for my care.

EMERGENT CARE: I agree to call my hospice nurse before going to the hospital or emergency room. I understand that hospice is available to assist me 24 hours a day, 7 days a week.

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. I acknowledge receipt of the information of pages 1 and 2. My signature on page one of this form verifies that the information on pages 1 and 2 has been verbally explained to my understanding and agreement.

NOTICE OF ELECTION: In acknowledgement and understanding of the above, I elect the Medicare hospice services with Arizona Professional Hospice Care Care to begin on: _____ (Election Date)

_____	_____	_____
Patient Signature	Date	Responsible Person or Legal Guardian Signature

_____	_____	_____
Hospice Representative Signature	Date	Printed Name and Relationship of Person Above

- Patient unable to sign due to: _____

AUTHORIZATION FOR PAYMENT AND FINANCIAL RESPONSIBILITY

PATIENT NAME: _____ **DOB:** _____

CHARGES/PATIENT RESPONSIBILITY

Arizona Professional Hospice CareCare accepts payment for services from Medicare, Medicaid, worker's compensation, private insurance or private pay. Depending on my policy, my hospice coverage may have limits. My policy may also require a co-payment for hospice care. Arizona Professional Hospice CareCare will notify me and/or my family or guardian of any charges I may be responsible for prior to my admission to hospice care. Arizona Professional Hospice CareCare rates and charges are available upon request. Arizona Professional Hospice CareCare will bill Medicare and Medicaid on my behalf. Arizona Professional Hospice CareCare accepts Medicare assigned payment as payment in full as long as I meet the Medicare guidelines for hospice services. If any services are ordered that are not covered by Medicare, Arizona Professional Hospice CareCare will notify me before these services are rendered. After Arizona Professional Hospice CareCare submits their bill to Medicare, I may receive a Medicare Summary Notice (MSN). This is not a bill. Medicare and most insurance' reimburse hospice on a per day basis for hospice care.

ASSIGNMENT OF INSURANCE BENEFITS

I understand that services provided to me by Arizona Professional Hospice CareCare will be billed to the following:

☐ **Medicare** ☐ Medicaid

☐ My Insurance Company: _____
Insurance Company Phone: _____
Insured's Name: _____ Phone: _____
Policy Number: _____ Group Number: _____

☐ Other Third Party Payer/Insurance Company Name: _____
Insurance Company Phone: _____
Insured's Name: _____ Phone: _____
Policy Number: _____ Group Number: _____

☐ Directly to Me or My Guarantor: _____
Address: _____
Phone: _____ Fax: _____

AUTHORIZATION FOR PAYMENT

Uninsured/Underinsured: I understand that the decision to accept me into Arizona Professional Hospice CareCare program will not be based solely upon my ability or inability to pay for hospice services. Social Services will assist in the application for community and government assistance as needed.

Insurance Coverage: Medicare will cover 100% of hospice care associated with the primary diagnosis. Private insurance coverage may include limited services and may have co-insurance/deductibles. I will be notified in writing if restrictions or out-of-pocket expenses are expected.

Non-covered Services: I understand that the non-covered services will be explained to me and my family/caregiver before the service is provided. I understand that I am responsible for the charges not covered. The following services are not covered under the Medicare/Medicaid hospice benefit: (a) Prescription drugs obtained without authorization from hospice; (b) Admission to a non-contracted facility (hospital, nursing home, etc.); (c) Emergency room visit without prior authorization; or (d) Resuscitative measures performed by emergency personnel (911).

Assignment of Benefits for Commercial Insurance: Under the terms of my policy, I hereby authorize reimbursement to be paid directly to Arizona Physicians Hospice Care. A copy of this authorization can serve as the original. I hereby authorize Arizona Professional Hospice CareCare to release my full information to my insurance company (including copies of my medical/billing records) relative to the service provided. A copy of these records can also serve as the original document.

Authorization: I authorize Arizona Professional Hospice CareCare to be paid directly for my care. If for any reason I receive monies from insurance companies for services rendered by Arizona Physicians Hospice Care, it is my responsibility to release this money to Arizona Physicians Hospice Care. I understand that I may be responsible for co-payments and any other charges that my insurance company may not cover. It is my responsibility to review my insurance company regarding rates and services covered by my policy. I understand that I am responsible for any charges that my insurance company does not cover. If I am a private pay patient, I agree to pay for all services receive from Arizona Professional Hospice CareCare I realize that if I do not comply, I will be subject to legal action and responsible for reasonable legal fees.

I hereby certify that the information I have provided to Arizona Professional Hospice CareCare in order to submit for payment under Title XVIII or Title XIX of the Social Security Act is accurate to the best of my knowledge.

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

REQUEST FOR MEDICAL RECORD INFORMATION

PATIENT NAME: _____ **DOB:** _____

MCN #: _____ **SSN #:** _____

1. This Medical Record Information is in effect from _____ to _____.
   I hereby authorize (name of facility): _____ to release medical record information to the Medical Director of Arizona Professional Hospice CareCare allowing them to better manage my care.

2. This Medical Record Information is in effect from _____ to _____.
   I hereby authorize (name of facility): _____ to release medical record information to the Medical Director of Arizona Professional Hospice CareCare allowing them to better manage my care.

I hereby authorize the release of the medical information checked and/or listed below:

- ☐ Complete Health Care Record(s)
- ☐ History and Physical Examination
- ☐ Minimum Data Set
- ☐ Laboratory Reports
- ☐ Medical/Treatment Records
- ☐ Pathology Reports
- ☐ Discharge Summary
- ☐ Progress Notes
- ☐ Care Plans
- ☐ Dental Records
- ☐ Photographs, Video Tapes, Digital or Other Images
- ☐ X-Ray Reports
- ☐ Transcribed Reports
- ☐ Billing Statements
- ☐ Emergency Care Records
- ☐ Consultant Reports
- ☐ Nurse's Notes

☐ Other: _____

☐ Other: _____

☐ Other: _____

I hereby authorize Arizona Professional Hospice CareCare to release medical record information to the following:

_____

_____

I authorize the release of photocopies of my medical records, which may include the following:

- ☐ Confidential HIV-related information (as defined in A.R.S. Section 36-661).
- ☐ Confidential Communicable disease-related information (as defined in 42 C.F.R. Section 2.1 ET Seq on Consent).
- ☐ Confidential mental health diagnosis and/or treatment information.

I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing that I notify Arizona Professional Hospice CareCare in writing to that effect. I understand that a photocopy or facsimile of this authorization is considered acceptable in lieu of the original.

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

INFORMED CONSENT FOR PSYCHOTROPIC MEDICATIONS

PATIENT NAME: _____ DOB: _____

What is a psychotropic medication? A psychotropic medication is prescribed by a physician or Advanced Nurse Practitioner (ANP) for the treatment of symptoms of psychosis or other mental or emotional conditions. The medication is used to exhibit an effect on the central nervous system in order to treat a psychiatric or emotional condition. When treating symptoms, they are used to help influence, modify and or improve an individual's behavior, cognition or affective state.

Which drugs are considered "psychotropic" for the purpose of informed consent? The term psychotropic medication or drug for purposes of informed consent includes the following categories:

- Anti-anxiety agents
- Anti-psychotics or neuroleptics
- Antidepressants
- Agents to control mania or depression, e.g., mood stabilizers
- Sedatives, hypnotics or other sleep promoting medications
- Psychomotor stimulants

A Physician or Advance Nurse Practitioner has prescribed the following psychotropic medication(s):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

The following information has been reviewed with me:

- The diagnosis and target symptoms for the medication
- The possible results of not taking the medication
- The possibility that the medication record may need to be adjusted
- The possible benefits/intended outcome of the medication
- The possible risk and side effects
- The possible alternatives
- My right to actively participate in my treatment
- My right to voluntarily withdraw consent for medication

STATEMENT OF CONSENT

I consent to the use of the above listed psychotropic medication(s). The nurse has reviewed the information on this form, and I give consent voluntarily and without coercive or undue influence. I understand that this consent may be revoked at any time by me. I understand that this consent is valid until the consent is withdrawn or the physician or ANP has discontinued any of the above listed medications.

_____	_____	_____
Patient Signature	Date	Responsible Person or Legal Guardian Signature

_____	_____	_____
MD/FNP-C/RN Signature	Date	Printed Name and Relationship of Person Above

COVID-19 LIABILITY WAIVER

PATIENT NAME: _____ DOB: _____

I acknowledge the contagious nature of the Coronavirus/COVID-19 and that the CDC and many other public health authorities still recommend practicing social distancing.

I further acknowledge that Arizona Physician Hospice Care has put in place preventative measures to reduce the spread of the Coronavirus/COVID-19.

I further acknowledge that Arizona Physician Hospice Care cannot guarantee that I will not become infected with the Coronavirus/Covid-19. I understand that the risk of becoming exposed to and/or infected by the Coronavirus/COVID-19 may result from the actions, omissions, or negligence of myself and others, including, but not limited to, salon staff, and other salon clients and their families.

I voluntarily seek services provided by Arizona Physician Hospice Care and acknowledge that I am increasing my risk to exposure to the Coronavirus/COVID-19. I acknowledge that I must comply with all set procedures to reduce the spread while attending my appointment.

I attest that:

* I am not experiencing any symptom of illness such as cough, shortness of breath or difficulty breathing, fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell.
* I have not traveled internationally within the last 14 days.
* I have not traveled to a highly impacted area within the United States of America in the last 14 days.
* I do not believe I have been exposed to someone with a suspected and/or confirmed case of the Coronavirus/COVID-19.
* I have not been diagnosed with Coronavirus/Covid-19 and not yet cleared as non-contagious by state or local public health authorities.
* I am following all CDC recommended guidelines as much as possible and limiting my exposure to the Coronavirus/COVID-19.

I hereby release and agree to hold Arizona Physician Hospice Care harmless from, and waive on behalf of myself, my heirs, and any personal representatives any and all causes of action, claims, demands, damages, costs, expenses and compensation for damage or loss to myself and/or property that may be caused by any act, or failure to act of the salon, or that may otherwise arise in any way in connection with any services received from Arizona Physician Hospice Care.

I understand that this release discharges Arizona Physician Hospice Care from any liability or claim that I, my heirs, or any personal representatives may have against the salon with respect to any bodily injury, illness, death, medical treatment, or property damage that may arise from, or in connection to, any services received from Arizona Physician Hospice Care. This liability waiver and release extends to the salon together with all owners, partners, and employees.

_____	_____	_____
Patient Signature	Date	Responsible Person or Legal Guardian Signature
_____	_____	_____
Hospice RN/Physician Signature	Date	Printed Name and Relationship of Person Above

TELEMEDICINE CONSENT FORM

PATIENT NAME: _____ DOB: _____

PURPOSE: The purpose of "Telemedicine Consent Form" is to obtain your consent to participate in telemedicine consultation in connection with the following procedure(s) and/or services.

NATURE OF TELEMEDICINE CONSULT: During the telemedicine consultation:

1. Details of your medical history, examinations, x-rays, and test will be discussed with other health professionals through the use of interactive video, audio, and telecommunication technology.
2. A physical examination of you may take place
3. A non-medical technician maybe present in the telemedicine office/clinic to aid in the video transmission.
4. Video, audio and/or photo recordings may be taken of you during the procedure(s) or service(s)

MEDICAL INFORMATION & RECORDS: The medical information related to history, records and tests of the patient will be discussed during the telemedicine appointment with video and audio. All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information for this telemedicine interaction to researchers or other entities shall not occur without your consent.

ACCESS: The patient accepts that he/she needs access to PC, laptop, or mobile device and a good internet connection in order to have an efficient telemedicine appointment.

CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risk associated with the telemedicine consultation, and all existing confidentiality protections under Federal and State Law apply to information disclosed during this telemedicine consultation.

RIGHTS: You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

DISPUTES: You agree that any dispute received from the telemedicine consult will be resolved in Arizona, and that Arizona law shall apply to all disputes.

RISK, CONSEQUENCES & BENEFITS: You have been advised of all the potential risk, consequences and benefits of telemedicine. Your health care doctor/practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented. On this form and the telemedicine consultation. All your questions have been answered, and you understand the written information provided above.

By signing this form,

- I understand that all the laws that are protecting my privacy of medical history or information are also applied to telemedicine practices.
- I understand that I can withdraw the consent at any time and that will not affect any of my future treatment procedures.
- I accept that I authorize health care professionals and use telemedicine for my treatment and diagnosis.

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

I REFUSE TO PARTICIPATE IN A TELEMEDICINE CONSULTATION FOR THE PROCEDURE(S) AND SERVICE(S) DESCRIBED ABOVE.

_____	_____	_____
Patient Signature	Date	Responsible Person or Legal Guardian Signature

EMERGENCY/DISASTER/EVACUATION PLAN - PATIENT

Name: _____ D.O.B.: _____

Address: _____ Telephone: _____

Physician Name: _____ Telephone: _____

In the event of an emergency or natural or man-made disaster, and to facility appropriate evacuation, transportation and care, the patient plans to:

Remain in the home

Evacuate to home of family member or friend with assistance of family and/or caregiver.

Name: _____ Phone: _____

Address: _____

Evacuate with assistance of Arizona Professional Hospice Care to arrange for non-emergency transportation, contact the patient's out-of-home emergency contact and help to locate an available:

Motel/Hotel Shelter Special needs shelter Non-emergency inpatient admission

Evacuate with assistance of emergency officials. Call 911 for emergency transportation.

If evacuation is needed, notify Arizona Professional Hospice Care. Select all special needs:

Patient has restricted mobility: (Select level of mobility)

Bedbound Chair/wheelchair bound Ambulatory with assistance: Maximum Moderate Minimum

Patient requires lifesaving equipment: (Select all that apply)

Insulin requiring diabetic. Insulin administered by: Injection Pump (type: _____)

Insulin type, dose and frequency: _____

Oxygen at ____ liters/minute via: Nasal Cannula Mask Tracheal Liquid Concentrator Cylinder

Requires oxygen continuously Requires oxygen intermittently: hours per day: _____

Portable oxygen cylinder available Portable battery-operated oxygen concentrator available No portable oxygen available

Ventilator dependent: (type: _____)

Ventilator settings: Respiratory rate: _____ Tidal volume: _____ FiO2: _____ PEEP: _____

Ventilator is portable with back-up battery Ventilator is not portable

CPAP: _____cm H2O

BiPAP: IPAP: _____cm H2O EPAP: _____cm H2O

BiPAP ST: IPAP: _____cm H2O EPAP: _____cm H2O Respiratory rate: _____

Suction Machine:	Suction machine is portable with back-up battery	Suction machine is not portable
Infusion Pump:	Infusion pump is portable with back-up battery	Infusion pump is not portable
Enteral Pump:	Enteral pump is portable with back-up battery	Enteral pump is not portable
Apnea Monitor:	Apnea monitor is portable with back-up battery	Apnea monitor is not portable

Other medical needs:

Wound Care: _____

Intravenous medications: _____

Tube feeding: _____

Other: _____

Other special needs:

Communication barriers: _____ Language barrier: _____

Intellectual disability: _____ Special diet: _____

Other: _____

_____	_____	_____
Patient Signature	Date	Responsible Person or Legal Guardian Signature
_____	_____	_____
Hospice RN/Physician Signature	Date	Printed Name and Relationship of Person Above

PATIENT NOTIFICATION OF HOSPICE NON-COVERED DRUGS/SERVICES/ITEMS

PATIENT NAME: _____ DOB: _____

Purpose: The purpose of this form is to notify the hospice beneficiary (POA/Representative) of those conditions, items, services, and drugs the hospice will not be covering because the hospice has determined they are unrelated to the beneficiary's illness and related conditions.

Hospice Coverage and Right to Request "Patient Notification of Hospice Non-Covered Items, Services, and Drugs

I acknowledge that I have been provided with information about my financial responsibility for certain hospice services (drug copayment and inpatient respite care). I understand that I have the right to request at any time, in writing, the "Patient Notification of Hospice Non-Covered Items, Services, and Drugs" addendum that lists the items, services, and drugs that the hospice has determined to be unrelated to my terminal illness and related conditions that would not be covered by the hospice.

I acknowledge that I have been provided information regarding the provision of Immediate Advocacy through the Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO) if I disagree with any of the hospice's determinations and I have been provided with the contact information for the BFCC-QIO that services my area.

_____ **Initials** I **elect** to receive the "Patient Notification of Hospice Non-Covered Items, Services, and Drugs

_____ **Initials** I **decline** to receive the "Patient Notification of Hospice Non-Covered Items, Services, and Drugs

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

PHOTOGRAPH CONSENT

PATIENT NAME: _____ **DOB:** _____

I hereby consent to the organization taking photographs or videos of myself during the course of my care.

The photographs(s) or video will be for internal purposes (such as quality reviews, education, etc.) to supplement written documentation about my medical condition, and/or for the payer of my services (Medicare, Medicaid and/or other insurance) to assist with coverage/payment decisions.

I understand that any photographs taken will be placed in my clinical record and that duplicate originals/copies may be forwarded to the payer(s) of my services and/or my physician if requested and as determined by the organization.

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

Patient unable to sign due to: _____

PATIENT / FAMILY HANDBOOK

Patient Name: _____ DOB: _____

I have received the Patient & Family Handbook, which includes information on:

- Advance Directives
- Type of care and services you provided
- Medication disposal policy
- Copy of Consent Forms
- Provider/Agency Information
- Department of Health and Medicare Guidelines
- Telemedicine

I have received information on all the following and agree to:

- Universal Precautions
- Patient Bill of Rights
- Explanation of Benefits and Consents
- Infection Control

Release of information:

I have been given and I have read Arizona Professional Hospice CareCare Notice of Privacy Practices. I understand that in order to provide my care and treatment and to receive payment for these services, Arizona Professional Hospice CareCare will seek my personal health information, maintain records of this information and may disclose this information to others. I agree that Arizona Professional Hospice CareCare may obtain my medical information from and may release my medical information to my health care providers, including home care agencies, hospitals, nursing homes, and physicians, and to my insurers.

_____	_____	_____
Patient Signature	Date	Responsible Person or Legal Guardian Signature

_____	_____	_____
Hospice Representative Signature	Date	Printed Name and Relationship of Person Above

IMPORTANT NOTICE TO OUR PATIENTS

Patient Name: _____ DOB: _____

As required by HIPPA, all patients who receive health care services must:

1. Receive or at least be offered the attached "Notice of Privacy practices" Form; and

2. Sign the "Acknowledgement" Form and return it for our records.

Please note that the attached Notice is not a consent form that must be read in full and signed before treatment can be provided; rather, the Notice provides our Patients with a summary description of (1) how our office will use and disclose medical and billing information for legitimate business purposes, and (2) how our Patients can exercise their rights with regard to this medical information. These notices are similar to the ones that the general public received from their banks and other financial institution.

Please sign the Acknowledgement Form below and return it for our records. Thank you very much.

ACKNOWLEDGEMENT FORM

I hereby acknowledge that I have received (or was at least offered) a current copy of Provider's Privacy Notice.

_____	_____	_____
Patient Signature	Date	Responsible Person or Legal Guardian Signature

_____	_____	_____
Representative Signature	Date	Printed Name and Relationship of Person Above

STATE OF ARIZONA
PREHOSPITAL MEDICAL CARE DIRECTIVE (DO NOT RESUSCITATE)
(IMPORTANT – This document must be on paper with orange background)

GENERAL INFORMATION AND INSTRUCTIONS: A Prehospital Medical Care Directive is a document signed by you and your doctor that informs emergency medical technicians (EMTs) or hospital emergency personnel not to resuscitate you. Sometimes this is called a DNR – Do Not Resuscitate. If you have this form, EMTs and other emergency personnel will not use equipment, drugs, or devices to restart your heart or breathing, but they will not withhold medical interventions that are necessary to provide comfort care or to alleviate pain. **IMPORTANT:** Under Arizona law a Prehospital Medical Care Directive or DNR must be on letter sized paper or wallet sized paper on an orange background to be valid.

You can either attach a picture to this form, or complete the personal information. You must also complete the form and sign it in front of a witness. Your health care provider and your witness must sign this from.

1. My Directive and My Signature:

In the event of cardiac or respiratory arrest, I refuse any resuscitation measures including cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of advanced cardiac life support drugs and related emergency medical procedures.

Patient (Signature or Mark): _____ Date: _____

PROVIDE THE FOLLOWING INFORMATION: **OR**

My Date of Birth _____
My Sex _____
My Race _____
My Eye Color _____
My Hair Color _____

ATTACH RECENT PHOTOGRAPH HERE

HERE

2. Information About My Doctor and Hospice (if I am in Hospice):

Physician: _____ Telephone: _____

Hospice Program, if applicable (name): _____

3. Signature of Doctor or Other Health Care Provider:

I have explained this form and its consequences to the signer and obtained assurance that the signer understands that death may result from any refused care listed above.

Signature, Licensed Health Care Provider: _____ Date: _____

4. Signature of Witness to My Directive:

Note: At least one adult witness OR a Notary Public must witness the signing of this document. The witness or Notary Public CANNOT be anyone who is : (a) under the age of 18; (b) related to you by blood, adoption, or marriage; (c) entitled to any part of your estate; (d) appointed as your representative; or € involved in providing your health care at the time this form is signed.

I was present when this form was signed (or marked). The patient then appeared to be of sound mind and free from duress.

Signature: _____ Date: _____

CONSENT FOR PALLIATIVE CARE

Patient Name: _____ MCN#: _____

I, _____, hereby consent to the palliative care consultation with Arizona Professional Hospice Care.

I also acknowledge and consent to the following:

1. The Arizona Professional Hospice Care team will teamwork with my primary care physician to manage pain and control symptoms, as well as provide emotional and spiritual support to me and my family.
2. I understand that Arizona Professional Hospice Care compliments my right to make choices for my health care and services including choices related to foregoing resuscitation and other life-sustaining measures. I further understand that if I have not made my wishes known to Arizona Professional Hospice Care, and/or in the absence of a DNRO, trained Arizona Professional Hospice Care staff will initiate basic life support resuscitation should I experience cardio-pulmonary arrest.
3. I have received a copy and understand the Arizona Professional Hospice Care Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Arizona Professional Hospice Care and of my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.
4. I understand that if I am to receive the full benefits of palliative care it is important to make my needs and concerns known to the Arizona Professional Hospice Care team. I agree to actively participate in my plan of care.
5. I understand that the palliative care medical record will contain information about me and my family. The medical records will be kept confidential.
6. I understand that when appropriate, the Arizona Professional Hospice Care staff may discuss Hospice Care with me and my family.

I authorize Arizona Professional Hospice Care consultation to begin on _____
(Start of Service date)

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