MIDDLESEX
HOSPICE AND PALLIATIVE CARE

ADMISSION CONSENT

PATIENT NAME:_____ **HOSPICE ELECTION EFFECTIVE DATE:** _____

ADDRESS: _____

INSTRUCTIONS: This form is used to acknowledge receipt of our Orientation Booklet and confirm your understanding and agreement with its contents. Your signature below indicates your approval.

PATIENT RIGHTS & 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 health hot line 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. No employee of this agency has solicited or coerced my decision in selecting a hospice.

CONSENT FOR TREATMENT

I hereby give my permission for authorized and personnel of Middlesex Hospice and Palliative Care to perform all necessary procedures and treatments as prescribed by my physician for the delivery hospice care. I understand that I may refuse treatment or terminate services at any time and the hospice may terminate their services to me as explained in my orientation. I agree and consent to the home care plan and payment as outlined in this admission booklet.

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 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, 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.

AUTHORIZATION FOR PAYMENT

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 payor be made in my behalf to Middlesex Hospice and Palliative Care. 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:

☐ **Hospice Medicare Benefit (Section 10.1)**

☐ **Commercial Insurance Hospice Benefit (Section 10.2)** ☐ **Private Pay**

If I have Medicare Part A benefits, I understand that Medicare payments will be accepted as payment in full 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.

CONSENT TO FILM OR RECORD

I hereby consent for the agency to record or film my care, treatment & 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.

SPECIAL SERVICES

I understand that, if I need hospitalization or special services not provided by hospice, I or my legal representative mst 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.

ADVANCE DIRECTIVES

I understand that the Federal Patient Self-Determination Act of 1990 requires that I be made aware of my right to make healthcare decisions for myself. I understand that I may express my wishes in a document called an Advance Directive (Living Will/Appointment of a Health Care Agent) 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)*

Patient Statement of Living Will: _____

2. I have designated an Attorney-In-Fact for Health Care Decisions ☐ **No** ☐ **Yes**

*(if yes, write the name & phone number of the person given power of attorney)*_____

_____	_____	_____
Patient's Signature	Date	Responsible person or Legal Guardian Signature
_____	_____	_____
Witness Signature/Agency Representative	Date	Printed Name & Relationship of Person above

☐ *Patient unable to sign due to:*_____