Hospice Benefit Election Form and Informed Consent

Patient Name _____Date of Birth _____

I consent and authorize Hand In Hand Hospice, 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 (focusing on 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.

If I am eligible for **Medicare/Medicaid**, I understand that certain **Medicare/Medicaid** payments for services related to my terminal illness are waived by electing this Hospice **Medicare/Medicaid** Benefit. Only Hand In Hand Hospice will be able to receive **Medicare/Medicaid** payment for care or services provided relative to my terminal illness (unless another hospice provides services under arrangements made by Hand In Hand Hospice).

For the time that I elect to receive Hospice care, I waive my rights to **Medicare/Medicaid** payments for services that are related to the treatment of the terminal condition for which I elected to receive hospice care, except for services provided by my attending physician if he/she is not an employee of Hand In Hand Hospice. Hand In Hand 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 Hand In Hand Hospice for all treatments and services not included in my plan of care. 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 team and documented on my plan of care.
I authorize any hospital, skilled nursing facility, physician's office, or home health agency which I am or have been a patient to disclose all or any part of my medical record to Hand In Hand Hospice or its agent to release any medical or other information about me for Medicare, Medicaid, or an insurance claim.

Third Party Insurance
I understand that hospice will bill my third party insurance. I authorize payment for services rendered by Hand in Hand Hospice. I understand that I may be billed for services not covered by third party insurance.

Acknowledging and understanding the above, I agree to and seek hospice care and hereby elect to receive the benefit(s) for which I am eligible and assign these benefits to Hand in Hand Hospice: Hospice Medicare Benefit; Hospice Medicaid Benefit; Private Insurance. A Financial Assessment will be completed for those who do not have insurance.

I elect to receive Hospice services provided by Hand In Hand Hospice and request that payment of authorized benefits begin on _____
Election Date

I acknowledge that the identified attending physician of my choice is:

_____
Primary attending physician (**print full name**)

_____ will be the primary care person responsible for _____
Family member or Nursing Facility Name — Patient Name

_____ _____
Patient/Beneficiary Signature — Medicare/Medicaid Number

(X) _____ (X) _____
Power of Attorney/Authorized Representative Signature — Relationship to Patient

I have explained the purpose of this consent/election form and services that will be provided. I have answered all questions about Hand In Hand Hospice by the patient or by responsible person(s) on behalf of the patient.

_____ _____
Hand In Hand Hospice Representative — Date

Hospice Provider Numbers: Medicare: 17-15-18 Medicaid: 100009260D

If patient is non-English speaking, individual who has interpreted consent for patient or responsible party:
Signed: _____