Patient Name _____ DOB: _____

INFORMED CONSENT and ELECTION OF BENEFIT FORM

I/We, the patient and/or caregiver (hereinafter "I" refers to "I/we"), agree to admission to LifeCare Hospice (hereinafter "Hospice" refers to LifeCare Hospice"). I request that Hospice assume professional management of patient care and I understand and agree to the following conditions:

Introduction: I understand that the Hospice program is palliative, not curative, in its goals. The program emphasizes the relief of symptoms such as pain and physical discomfort and addresses the spiritual needs and emotional stress which may accompany a life-limiting illness.

Caregiver: I understand that Hospice services are not intended to take the place of care by family members or others who are important to the patient, but rather to support them in the care of the patient. With the help of Hospice, the person designated as "caregiver" will provide around-the-clock care to the patient at home. If 24 hour care is not available, the caregiver will make arrangements for 24 hour care. The "caregiver" will also participate in decisions about the care provided to the patient at home and/or in the inpatient setting.

Home Care: I understand that home care is the main focus of the Hospice program. Services are provided in the patient's place of residence by a team of Hospice staff and volunteers through scheduled visits. Consultation and visits for urgent matters and pain and symptom control are available twenty-four hours a day, seven days a week. When home is a nursing facility, I understand that care will be provided by the nursing home staff in collaboration with the Hospice professional staff and volunteers.

Choice of Care: I understand that I will have a choice about the care provided. I may review the plan of care that guides Hospice services and, if I desire, may refuse a particular treatment or service offered.

I further understand that some medical services or procedures, such as advanced cardiac life support or respirators, are not provided by Hospice. The subject of resuscitation should be discussed with the patient's physician. Other services, such as intravenous therapy, are provided only if they are determined by the Hospice Interdisciplinary Team to be necessary for the patient's comfort.

Records: I authorize Hospice to obtain copies of medical and billing records and to keep records which may include necessary information about the patient's medical condition, family and finances during the time which I am under the care of the Hospice program.

I permit the release of necessary information and medical records for purposes of providing treatment, obtaining payment for care and conducting health care operations. Hospice has established policies to guard against unnecessary disclosure of health information.

Rights/Responsibilities and Privacy Notice: I have received and reviewed the patient/family rights and responsibilities as outlined by Hospice. I have received a copy of Hospice's Privacy Notice.

Patient Name _____ DOB: _____

Medicare Part D Coordination: I have been informed that if the patient has Medicare Part D, Hospice will work with the physician to determine which medications Hospice will cover under the Medicare Hospice Benefit, which ones will be covered under the Part D plan, and which medications are determined to be no longer medically necessary and if continued, would become the financial responsibility of the patient. I will inform Hospice of all medications the patient is taking.

Preferred Drug List: I have been informed that Hospice uses a Preferred Drug List.

Opioid Disposal: I have received and reviewed Hospice's policy regarding disposal of opioid medication.

LifeCare Hospice Inpatient Unit (IPU): I understand that, if it is deemed necessary by Hospice and the attending physician, the patient can receive short-term inpatient care when pain and symptom management become impossible in the patient's home. In this circumstance, I consent to admission to the IPU and have been informed of the following:

- Introduction: The IPU is a short-term facility focused on the management of symptoms. Once symptoms are managed, the patient will be discharged to an appropriate setting for ongoing care. Hospice staff will assist with the development of the discharge plan.
- Medications: Medications for most patients in the IPU are obtained through the contracted pharmacy. I understand that I may receive a bill from this pharmacy for medications and/or co-pays that are not covered under my Hospice Benefit or additional prescription coverage. When medications are no longer in use, they will be destroyed per Hospice policy.
- Smoking: The IPU is a smoke free environment. Families and patients are permitted to smoke in designated outdoor areas. Patients must be attended and discontinue oxygen use when smoking.
- Video Cameras: Each patient room is equipped with a video camera. This closed circuit video feed is monitored at the nurses' station and is for the purpose of enhancing the safety of our patients and their families. The patient/family is welcome to turn off the camera at any time.
- Respite Care: Based on bed availability, the IPU may be able to accept an existing LCH patient who is residing in his/her home to the IPU for up to five days in order to give caregivers a break and for the patient to then return home. I know that I can discuss care options with my hospice team.

Follow-Up Care for Families: I understand that the "caregiver", others who are part of the patient's family or those who are important to the patient may choose to participate in the Hospice bereavement program. Services designed for family members and others include individual counseling, support groups, phone contacts, mailings, and memorial services.

Financial Responsibility: I have read the explanation regarding the benefits, provisions and scope of services to be offered to us. I understand that efforts will be made to recover cost of care through private insurance, Medicaid, or Medicare. However, I understand that I will not be denied admission to the program if I am not able to pay for services.

Patient Name _____ DOB: _____

Attending Physician: I understand that I can choose my attending physician and I choose:

Practioner's Name: _____ NPI: _____

Initial/mark appropriate line:

_____ **Medicare and/or Medicaid Election of Services** *(circle appropriate election)*

I elect my hospice benefit as the payment source for all services and treatment related to my terminal condition, as are arranged by Hospice. I understand that I must have prior approval from Hospice before ordering or receiving treatment, supplies, equipment, and/or other services related to my terminal condition. I understand that if I fail to get preauthorization from Hospice I may be financially responsible for any charges incurred. Medicare/Medicaid will continue to pay for care not related to the terminal condition.

_____ Commercial Insurance: I authorize payment of insurance benefits directly to Hospice.

Withdrawal/Transfer/Discharge: I understand that I may choose to discontinue hospice care at any time by signing a revocation statement, and that I may re-elect hospice care at a future time, as long as I remain eligible for hospice services. I understand that I may choose to receive hospice care from another hospice provider by informing Hospice and arranging a transfer. I understand that Hospice may discharge the patient from the program if hospice care is no longer appropriate. This means there will be no further liability to the patient or Hospice. I understand, however, that I may request to be readmitted at a later date.

I have been able to discuss the above conditions with a member of the Hospice staff and have had questions answered to my satisfaction.

Hospice services to begin on _____

_____ _____

Signature of Patient, DPOA for Health Care, or Legal Guardian Date

_____ _____

Signature of Caregiver Date

_____ _____

Signature of LifeCare Hospice Representative/Title Date

Type of Hospice Benefit: Medicare_____ Medicaid_____ Per Diem Insurance_____ Private Pay____