INFORMED CONSENT AND TREATMENT AUTHORIZATION

This agreement is entered into by and between Encinitas Hospice Care, Inc dba Calstro Hospice San Diego (hereinafter called Agency) and ______________________________________ (hereinafter called Patient.) This agreement is entered into pursuant to a desire by Patient to obtain hospice services. I request admission to Calstro Hospice and understand and agree to the following conditions:

I acknowledge that I have been given a full explanation and have an understanding of the purpose of hospice care. Hospice care is to relieve pain and other symptoms related to my terminal illness and related conditions and such care will not be directed toward cure. The focus of hospice care is to provide comfort and support to both me and my family/caregivers.

I understand I am encouraged to participate in the development and implementation of the approved plan of care and 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 the “caregiver” will provide around-the-clock care to the patient in their place of residence. If twenty-four hour care is not available, the caregiver will arrange for another to provide it. The caregiver will also participate in decisions about the care provided to the patient. The Hospice Interdisciplinary Team supplements rather than replaces care provided by the family or care center staff. I accept the conditions of Calstro Hospice as described, understanding that I may choose not to remain in the program and that Hospice may discharge me from the program if hospice care is no longer appropriate. This means there will be no further liability to me or to Calstro Hospice San Diego. 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 my questions answered to my satisfaction.

Treatment Authorization. The undersigned Patient or Patient’s legally authorized representative hereby consents to any and all examinations and treatments prescribed by Patient’s physician (or hospice physician) rendered by the Agency’s licensed nurses, physical therapists, occupational therapists, speech therapists, registered dietitians, social workers, spiritual counselors, home health aides and volunteers.

FINANCIAL AGREEMENT

In consideration of the mutual promises and obligations related to treatment rendered to Patient by Agency, it is agreed as follows:

1. Payment Responsibility: It is understood that for Hospice patients, the agency assumes financial responsibility for medications and /or durable medical equipment and medical supplies related to the terminal illness. The Patient and/or Patient’s agent assumes financial responsibility for all other charges not authorized by the hospice. The Agency in accordance with this agreement shall assist Patient in obtaining financial assistance from third party payers such as Medicare/Medi-Cal and private insurers.

2.Pharmacy Services. I acknowledge that I have the right to direct a pharmacist to dispense a prescription using the brand my physician prescribed instead of a generic drug product. I also understand that generic drug products generally cost less than brand name products, but the price differences vary from prescription to prescription. I hereby consent and agree that, if allowable under state law, any pharmacist who dispenses any of my prescription drugs may select a drug product that is generically equivalent to the brand prescribed by my physician, unless I submit to Hospice a written request for a brand name product. **Hospice does not cover medications that are not related to the terminal diagnosis or are deemed unnecessary/ ineffective by a physician.**

3.Termination. Except for Medicare/Medi-Cal eligible Hospice Patients, the Agency upon due notice of no less than thirty days, may terminate services for lack of payment for its services. In addition, the Agency may terminate services, when in its sole medical judgment determines there is no longer any reasonable expectation that it can meet the patient/family’s needs.

Patient Name: (Last, First)	MR#:

HOSPICE SERVICES

Routine Home Care. I understand that hospice services are delivered primarily in the patient's residence (which may include a nursing home) provided by a team of hospice professionals, staff and volunteers. These services are available both on a scheduled basis and as needed. I understand that these services may include, as set forth in the hospice plan of care: nursing, physician care, social work, spiritual, nutrition and bereavement counseling, home health aides/homemakers, medical supplies, physical therapy, occupational and speech-language therapy, and medications prescribed for relief of pain or discomfort.

___________ (Initials)

General Inpatient Care/Inpatient Respite Care. I understand that inpatient hospice care and inpatient respite care are provided in an inpatient bed when it is deemed necessary by the hospice interdisciplinary team. I understand that hospice inpatient care is designed for short-term stays with the goal of stabilizing the patient and family emotionally and physically so the patient can return to home. I understand that inpatient respite care is designed to provide brief periods of respite for the family or primary caregiver while the patient receives hospice care in an inpatient bed.

___________ (Initials)

Continuous Care. I understand that continuous care (a minimum of 8 hours of care in a 24 hour period) may be provided in a patient's residence when it is deemed necessary by the hospice interdisciplinary team. I understand that continuous care is designed for short-term periods to manage acute medical symptoms with the goal of stabilizing the patient. These 8 hours do not have to be continuous; the 24 hour period starts at midnight and ends at midnight the following day. A Registered Nurse will assess the appropriateness for Continuous Care on a daily basis. If Continuous Care staff is not available due to previously identified needs of other patients, I understand Calstro Hospice will inform me when Continuous Care staff will be available.

___________ (Initials)

I understand that under the Medicare/Medi-Cal Hospice Benefit, I am entitled to hospice care, which consists of two 90-day periods and subsequent 60-day periods thereafter. The Hospice Interdisciplinary Team evaluates recertification for continuation of hospice care at the end of each benefit period.

I understand that I may revoke the hospice benefit at any time by signing a statement to that effect, specifying the date when the revocation is to be effective, and submitting the statement to Calstro Hospice prior to that date. This revocation constitutes a waiver of the right to hospice care during the remainder of the current election period.

I understand that once in each election period I may elect to receive services through a hospice program other than Calstro Hospice. Such change shall not be considered a revocation of hospice services.

The physician I have chosen to serve as my Attending Physician is:

Name:	
Address:	
Phone:	**Fax:**

In the event that my PCP is unable to follow my care while on hospice, I authorize Calstro Hospice San Diego to utilize their Medical Director as my following physician. ___________ (Initials)

Patient Name: (Last, First)	MR#:

PATIENT RIGHTS

As a **Calstro Hospice** Patient, you have the right to:

1. Be informed of your rights and responsibilities in a language and manner which you understand.
2. To exercise your rights as a patient of the hospice.
3. Be fully informed, as evidence by your written acknowledgement of your appointed representative, of these rights and of all rules and regulations governing patient conduct, prior to or at time of admission.
4. To have your property and person treated with respect.
5. Make informed decisions regarding proposed and ongoing care and services.
6. Choose whether or not to participate in research, investigational or experimental studies, or clinical trials.
7. Have grievances regarding treatment or care that is or fails to be furnished and the lack of respect for property by anyone who is furnishing services on behalf of the hospice; and to not be subjected to discrimination or reprisal for exercising his/her rights.
8. Confidentiality of information, privacy, and security.
9. Be involved in the care planning process.
10. Be fully informed by a physician of your medical condition, unless medically contraindicated, and to be afforded the opportunity to participate in your medical treatment, and choose your attending physician.
11. Be informed and receive written information concerning our policies on advance directives, including a description of applicable State law.
12. Have an appropriate assessment and management of your pain and other symptoms.
13. Be fully informed, prior to or at time of admission, of services available through the hospice program, and related charges, including services not covered under Titles XVIII or XIX of the Social Security Act.
14. Refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.
15. Be advised of what hospice services are to be covered under the hospice benefit.
16. Receive information about the scope of services that the hospice will provide and specific limitations on those services.
17. Be assured confidential treatment of personal and clinical records and to approve or refuse their release to any individual outside the hospice, except in the case of transfer to another health facility, or as required by law or third-party payment facility.
18. Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of your property.

PATIENT RESPONSIBILITIES

As a **Calstro Hospice** patient, you have the responsibility to:

1. Remain under a doctor's care while receiving hospice services.
2. Inform the hospice of advance directives or any changes in advance directives, and provide the hospice with a copy.
3. Cooperate with your primary doctor, hospice staff and caregivers by providing information, following instructions and asking questions.
4. Advise the hospice of any problems or dissatisfaction you have with the care provided.
5. Notify the hospice of address or telephone number changes or when you are unable to keep appointments.
6. Provide a safe home environment in which care can be given. Conduct such that if the patient's or staff's welfare or safety is threatened, service may be terminated.
7. Obtain medications, supplies and equipment ordered by your physician if they cannot be obtained or supplied by the hospice
8. Treat hospice personnel with respect and consideration.
9. Sign the required consents and releases for insurance billing, and provide insurance and financial records as requested.
10. Accept the consequences for any refusal of treatment or choice of non-compliance.
11. Advise the agency of any problem or dissatisfaction with our care, without being subject to discrimination or reprisal. The Hospice shall investigate all grievances; document the existence of the complaint and findings. Findings will be communicated to the patient/family.

CONSENT TO PHOTOGRAPH

The undersigned Patient or Patients Legally authorized representative hereby consents Calstro Hospice Inc., the attending physician, or other designated person (s) to take photographs of me for the following identified reasons:

1. Photographs of me for identification purposes.
2. Photographs of appropriate parts of my body in order to provide supporting documentation of my medical condition and to accurately monitor my condition.

_____________(Initials)

Patient Name: (Last, First)	MR#:

Procedures for Making Complaints:
If you have a complaint regarding the services you have received from Calstro Hospice, please contact the **Director of Patient Care Services** at 866-568-6462.
Additionally, you also have the right to file a complaint against Calstro Hospice San Diego by contacting the Department of Health Services by phone or by mail. The Department of Health Services office hours are Monday-Friday, 8:00am–5:00pm, except holidays. Department of Health Services contact information is as follows depending on the county: Department of Health Services **(San Diego County)** 1600 Pacific Highway, Room 206, San Diego CA 92101. 619-515-6555.

___________ (Initials)

Calstro Hospice San Diego is also accredited by **The Joint Commission** which is an agency that ensures that healthcare organizations provide quality care under national standards. If you would like to file a complaint with The Joint Commission in regards to patient safety and quality of care you may do so online at:
https://jcwebnoc.jcaho.org/QMSInternet/IncidentEntry.aspx
Via Email: complaint@jointcommission.org
By Phone: 1-888-354-9203
By Mail:
Office of Quality and Patient Safety
The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, Illinois 60181

All patients, regardless of race, religion, age, gender, sexual orientation, disability (mental or physical), color, ancestry, communicable disease, or place of national origin have the right to receive the same quality of care and to have access to the hospice resources they need to meet their health care needs.

MEDICARE/MEDI-CAL HOSPICE BENEFIT ELECTION
As a Medicare Part A or Medi-Cal beneficiary, I hereby elect Calstro Hospice as my sole provider of hospice care effective (date)_______________________________.
I understand that by electing hospice care under the Medicare Hospice Benefit, I am acknowledging that I understand the palliative rather than curative nature of hospice care, as it relates to my terminal illness and related conditions. I understand that by electing hospice care under the Medicare Hospice Benefit, I am waiving (give up) all rights to Medicare payments for services related to my terminal illness and related conditions and I understand that while this election is in force, Medicare will make payments for care related to my terminal illness and related conditions only to the designated hospice and attending physician that I have selected. I understand that services not related to my terminal illness or related conditions will continue to be eligible for coverage by Medicare; however, I also understand that services unrelated to my terminal illness and related conditions are exceptional and unusual hospice should cover all care related to my terminal illness and related conditions needed under the hospice election. and

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.

☐ I elect to receive the "**Patient Notification of Hospice Non-Covered Items, Services, and Drugs"**
Initials_______ Date________
(**Hospice**: Please provide the beneficiary with the addendum. Must be signed and dated accompanying the election statement.)
☐ I decline to receive the "**Patient Notification of Hospice Non-Covered Items, Services, and Drugs"**
Initials________ Date________

Patient Name: (Last, First)	MR#:

ADVANCE DIRECTIVES

I have been provided the following information regarding advance directives.

- ❑ Informed of my rights to formulate an Advance Directive.
- ❑ I am not required to have an Advance Directive in order to receive medical treatment by any healthcare provider but understand that cardiopulmonary resuscitation (CPR) will not be performed by hospice staff.
- ❑ The terms of any Advance Directive that I have executed will be followed by any healthcare provider and my caregivers to the extent permitted by law.
- ❑ **The patient has an Advance Directive:**
  - ❑ Power of Attorney for Health Care
  - ❑ Living Will

Name and Address of Agent:

....

....

Copy Received: ❑ Yes ❑ No

- ❑ **The patient does not have an Advance Directive**

RELEASE OF PATIENT RECORDS/ NOTICE OF PRIVACY PRACTICES

I understand that Calstro Hospice may need to obtain medical records and related information from hospitals, nursing homes, physicians, pharmacies, home health agencies, insurance companies, health care benefit plans, or others in order to assure continuity of care and proper reimbursement. I authorize the above persons and entities to release to Calstro Hospice and its representative medical records and related information necessary to be helpful to the provision of hospice care. I also authorize Calstro Hospice and its representatives to release medical records and related information to others for the purposes of my health care, administration and management of my health care (including utilization review), or processing and obtaining payment for services and supplies rendered to me. I understand and agree that these authorizations specifically include my permission and consent to release any information regarding a diagnosis of AIDS or results of Human Immunodeficiency Virus (HIV) tests to the extent permitted by law. A photocopy of this authorization shall be as valid as the original.

RECEIPT OF INFORMATION

Hospice services have been explained to me; I have been given the opportunity to ask any questions I have concerning the hospice program of care, and my questions have been answered to my satisfaction. I have been provided the following materials:

- ♦ A copy of patient's rights & responsibilities
- ♦Written materials explaining a patient's legal rights to accept or refuse medical treatments and to prepare an advance directive for health care
- ♦Information regarding sentinel events

ACKNOWLEDGEMENT

I acknowledge and agree to the terms and conditions described in the following documents:

❑ Informed Consent and Treatment Authorization ❑ Financial Agreement ❑ Pt Rights & Responsibilities
❑ Medicare/Medi-Cal Hospice Benefit Election ❑ Advance Directives ❑ Notice of Privacy Practices
❑ Patient Notification of Hospice Non-Covered Items, Services, and Drugs ❑ Consent to Photograph

Patient's Signature: **Date:**

If Patient is unable to sign, state reason:

Name (print)& Signature of legally authorized representative (if applicable): **Relationship:**

Employee: Signature: Discipline:
(Last, First)

Patient Notification of Hospice Non-Covered Items, Services, and Drugs Example

Date of Request _________________

(Hospice must furnish this addendum within 5 days if requested at the time of hospice election and within 72 hours if requested during the course of hospice care.)

Diagnoses Related to Terminal Illness and Related Conditions (hospice is responsible to cover all items, services and drugs):

1.	**4.**
2.	**5.**
3.	**6.**

Diagnoses Unrelated to Terminal Illness and Related Conditions:

1.	**4.**
2.	**5.**
3.	**6.**

Non-covered items, services, and drugs determined by hospice as not related to my terminal illness and related conditions:

Items/Services/Drugs	Reason for Non -coverage

Note: The hospice makes the decision as to whether or not conditions, items, services, and drugs are related for each beneficiary. This addendum should be shared with other healthcare providers from which you seek items, services, or drugs, unrelated to your terminal illness and related conditions to assist in making treatment decisions.

Right to Immediate Advocacy

As a Medicare beneficiary you have the right to appeal the decision of the hospice agency on items not be covering because the hospice has determined they are unrelated to the individual's terminal illness and related conditions. You have the right to contact the Medicare Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) for immediate assistance. You can all your QIO at : LIVANTA LLC 1-(877) 588-1123 if you have questions

Acknowledgment of non-covered items, services, and drugs not related to my terminal illness and related conditions The purpose of this addendum is to notify beneficiary (or representative), in writing, of those conditions, items, services, and drugs the hospice will not be covering because the hospice has determined they are unrelated to the individuals terminal illness and related conditions. I acknowledge that I have been given a full explanation and have an understanding of the list of items, services and drugs not related to my terminal illness and related conditions not being covered by hospice. Signing this addendum (or its's updates) is only acknowledgment of receipt of the addendum (or its updates) and not necessarily agreement with the hospice's determinations.

____ _________________________

Signature of Beneficiary/Representative **(Date Signed)**

☐ Beneficiary is unable to sign -Reason: ____

____ _________________________

Witness signature **(Date Signed)**