True Hearts and Hands Hospice
(903) 422-8100 Central
(817) 435-9390 Southwest
(903) 494-5577 FAX

ADMISSION CONSENT

PATIENT NAME: _____ **PATIENT ID**: _____

CONSENT FOR TREATMENT: I hereby give my permission for authorized personal of your hospice to perform all necessary procedures and treatments as prescribed by my physician for the delivery of hospice care. I understand the following hospice care and services may be provided to me during the course of illness: physician, nursing, social work, therapy services, counseling services (bereavement, spiritual, dietary), hospice aide/homemaker, volunteers, durable medical equipment, pharmaceuticals, medical supplies, respite care, short term inpatient care and continuous care. I understand that I may refuse treatment or terminate services at any time and hospice may terminate their services to me as explained in my orientation. I agree and consent to the care plan. I understand that the chart below is my initial plan of care including the charges for services and the amounts that I may be responsible for paying. I will be notified by the agency each time there are changes made in my plan of treatment. I also give my permission to have my blood tested for Hepatitis B, C and HIV should a hospice employee inadvertently come in contact with my blood or body fluids.

SERVICES TO BE PROVIDED/CHARGES FOR SERVICES:

SERVICES	CHARGES	INS. PAYS	YOU PAY	SERVICES	CHARGES	INS. PAYS	YOU PAY
☐ **Routine Home Care**				☐ **General Inpatient Care**			
☐ **Inpatient Respite Care**				☐ **Continuous Care**			
☐ **Skilled Nursing**				☐ **Speech Therapy**			
☐ **Physical Therapy**				☐ **Medical Social Services**			
☐ **Occupational Therapy**				☐ **Hospice Aide/Homemaker**			

I certify that the information given by me in applying for payment under Title XVlll 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 payer made on my behalf to True Hearts and Hands Hospice. 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.

☐ **Medicare Hospice Benefit** ☐ **Medicaid Hospice Benefit** ☐ **Commercial Insurance Hospice Benefit** ☐ **Private Pay**

If I have Medicare Part A benefits, I understand the Medicare payments will be accepted as payment in full for hospice related services 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 services. If I have other insurance, I may be responsible for the co-pay, deductible and any charges that my insurance will not cover.

Special Services: I understand that, if I need hospitalization or special services not provided by hospice, I or my legal representative must make arrangements for these services. L 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 health care decisions for myself. I understand that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak for myself. I have a:

Directive to Physicians (Living Will) ☐ No ☐ Yes *(If yes, provide a copy to the agency).*
Medical Power of Attorney (MPOA) ☐ No ☐ Yes *(If yes, name and phone number of MPOA*: _____
Do-Not-Resuscitate Order ☐ No ☐ Yes **Declaration for Mental Health** Treatment ☐ No ☐ Yes

RELEASE OF INFORMATION FOR DISASTER SITUATIONS: I agree that the agency may share my protected health information with emergency official or others involved in my care to assist in disaster relief efforts. ☐ Yes ☐ No

By signing this consent, I acknowledge receipt of the admission booklet and confirm my understanding and agreement with its contents. I understand a copy of this consent 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 understand that my signature on Page 1 of this consent verifies my understanding of and agreement with all information on Pages 1 and 2.

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

_____ _____
True Hearts and Hands Hospice Representative Signature **Date**

Admission Consent Dec 2020.
1 Page each Document (Patient & Office)
Return Completed Form to Office and Leave a copy in the home