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

CONSENT AND ELECTION OF HOSPICE MEDICARE BENEFITS

PATIENT NAME: _____ **PATIENT ID**: _____ **SOC Date:** _____

INFORMED CONSENT

I acknowledge/understand the following:

I understand the nature of the hospice care available through the Medicare Hospice Benefit; that all treatment will focus on comfort (palliative) rather than cure (curative) or life prolonging treatment. Treatment will be for management of symptoms and to provide comfort for my terminal illness. The focus of my care will be to maintain me in my home or facility rather than in a hospital.

I understand that I or my representative have the right to choose my attending physician.
My attending physician is _____ NPI #: _____

Address: _____

I understand the following:

- That I and/or my caregiver will participate in developing the plan of care along with the hospice team composed of a physician, nurse, medical social worker, spiritual counselor, volunteer and other disciplines that may be necessary.
- I wave the right to all other benefits under the Medicare Program while I am receiving hospice benefits. Only True Hearts and Hands Hospice will be able to receive Medicare payment for care or services provided to me for my terminal illness or any other condition related to my terminal illness.
- During the time I receive Hospice care, I waive my rights for those services covered under traditional Medicare benefit, specifically related to my life-limited illness.
- It is my responsibility to seek pre-approval from my Hospice for all treatments and services not included in my plan of care: Emergency room visits, hospital admissions, Chemotherapy or radiation treatments, Physician services rendered other than by my personal physician or Hospice Medical Director.
- Medicare will make payment for unlimited hospice days; however, the days are broken into three benefits periods to be used in this order. The periods are as follows: 1st benefit period – 90 days 2nd benefit period - 90 days Subsequent 60-day periods – Unlimited as long as beneficiary meets requirement for benefits. Prior to the beginning of each benefit period my medical condition will be evaluated for continued hospice appropriateness by my physician and the hospice interdisciplinary group.
- I understand that I may be responsible for five (5) percent of the reasonable cost up to a maximum of $5.00 for each outpatient individual prescription for my hospice-related illness and can be charged up to five (5) percent of individual respite care.
- I understand that I can use standard Medicare in the usual manner to pay the bill for:
    - My doctor, if not an employee of this hospice.
    - Treatment of a condition unrelated to my terminal illness. (See above)
- I understand that I can revoke this benefit at any time and resume regular Medicare coverage. I know I will lose any hospice days remaining in the benefit period in which I revoke.
- I understand that I may transfer my hospice are to another Hospice Program once during each election period.

I have been provided the opportunity to discuss concerns and ask any questions I may have regarding the above information. I have had the opportunity to review the information with my family, primary caregiver and advisors to my satisfaction.

Signature of Beneficiary or Legal Representative:	Date Signed:
Relationship to Patient:	
Hospice Witness Signature	Date Signed: