BLOOM HOSPICE
CONSENT and ADMISSION AGREEMENT

CONSENT AND RELEASE OF INFORMATION:
I consent to the provision of services and do authorize the staff of Bloom Hospice (BH) to provide in home services ordered by physician as noted in my Plan of Care which I participated in developing. I authorize release of information regarding my treatment including inpatient stays, testing and results and payment information to be released from my physician and/or any treatment facility to BH under HIPAA guidelines.

FINANCIAL RESPONSIBILITY: (AGENCY STAFF TO MARK BOX AND PATIENT TO INITIAL)
I understand that charges for my services are:

_____ PRIVATE PAY ONLY: (Note: Rates for Services on Holidays shall be one & one-half these rates)

Service	Rate	Freq	Service	Rate	Freq	Service	Rate	Freq
_____	$_____/_____	_____	_____	$_____/_____	_____	_____	$_____/_____	_____

☐ ____ I understand that there will be no charge for my services.

☐ _____ All my care will be paid for by _____Medicare ____Medicaid. I certify that I understand it is my responsibility to inform BH if I choose to participate in an HMO or if my Medicaid status changes. I authorize release of all records required to act on this request. I request that payment of benefits be made on my behalf.

☐ ____ BH will bill my insurance. I understand that I am responsible for any portion of my bill that my insurance does not pay. I understand my current co-pay is _____ and my deductible is _____. I request that payment of benefits be made on my behalf to Bloom Hospice. I understand that if payments are made directly to me from a third party, it is my responsibility to pay all invoices from Bloom Hospice.

☐ ____ I am responsible for paying my bill within 30 days of the invoice/statement date. I understand that I may be charged interest for any portion of my bill unpaid for more than 60 days.

INFORMATION RECEIVED:

☐____ I have received the following and had the opportunity to have my questions answered regarding: Hospice services and limitations; Eligibility criteria; Hospice Patient Rights and Patient Responsibilities; Advance Directives information and agency policy; Notice of Privacy Rights; Emergency Preparedness Training and planning related to a disruption in service; Pain Management and Symptom, Treatment and Disease Management; Management and disposal of Controlled Substances(Narcotics); Access to My Records; Basic Home and Medication Safety; Infection Control; Hours of operation and On-call availability; Contact information.

ADVANCE DIRECTIVES:

☐ Client has not made any advance directive and has no Medical Power of Attorney
☐ Client has made advance directives, location _____
☐ Client has Medical Power of Attorney, _____ph # _____State _____
☐ Client has Do Not Resuscitate order, location _____

____ I understand that if I make any new or different decisions I will notify Bloom Hospice and I agree to provide a copy of all my Advance Directives and Medical Power of Attorney authorizations.

___ I understand the services an aide can and cannot provide. I participated in the development of the aide care plan. I understand that the aide cannot provide any task that is not on the aide care plan.

___ BH staff have discussed with me and I understand the Statement of Election of Hospice Services.

___ BH staff have made me aware of my right to receive Patient Notification of Hospice Non-Covered Items, Services, and Drugs.
____ I have received the Patient Notification of Hospice Non-Covered Items, Services, and Drugs
OR
____ I do not request the Patient Notification of Hospice Non-Covered Items, Services, and Drugs

CONSENT TO PHOTOGRAPH

____I consent to have photograph(s) taken of me for identification purpose
____I consent to have photograph(s) taken of parts of my body to provide supporting documentation of my medical condition. I understand any photograph taken will be placed in my medical record.
____I understand that any photograph of me may be shared with my physician, payor source or state or federal surveyors under my HIPAA releases as stated in my admission booklet

I have read and understand both pages of this consent.

_____ ____ _____/_____
Signature Client/Legally Responsible Party Date Printed Name of Legally Responsible Party/ Relation

_____ ____ _____/_____
Signature Bloom Hospice Representative Date Printed Name & Title of Bloom Hospice Rep

Hospice Election Statement

Patient Name: _____

Hospice Agency Name: Bloom Hospice

Hospice Election

I, _____ **(Patient Name)** choose to elect the Medicare hospice benefit and receive Hospice services from Bloom Hospice **(Name of Hospice Agency)** to begin on _____ **(Start of Care Date)**.

(Note: The start of care date, also known as the effective date of the election, may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement. An individual may not designate an effective date that is retroactive.)

Right to choose an attending physician

- I understand that I have a right to choose my attending physician to oversee my care.
- My attending physician will work in collaboration with the hospice agency to provide care related to my terminal illness and related conditions.

☐ I do not wish to choose an attending physician.
☐ I acknowledge that my choice for an attending physician is:
(Please provide any information that will uniquely identify your attending physician choice.)

Physician Full name: _____

Hospice Philosophy and Coverage of Hospice Care

By electing hospice care under the Medicare hospice benefit, I acknowledge that:

- I was given an explanation and have a full understanding of the purpose of hospice care including that the nature of 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 was provided information on which items, services, and drugs the hospice will cover and furnish upon my election to receive hospice care.
- I was provided with information about potential cost-sharing for certain hospice services, if applicable.
- I understand that by electing hospice care under the Medicare hospice benefit, I waive (give up) the right to Medicare payments for items, services, and drugs related to my terminal illness and related conditions. This means 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 items, services, and drugs unrelated to my terminal illness and related conditions are exceptional and unusual and, in general, the hospice will be providing virtually all of my care while I am under a hospice election. The items, services, and drugs determined to be unrelated to my terminal illness and related conditions continue to be eligible for coverage by Medicare under separate benefits.

Hospice Election Statement

Right to Request "Patient Notification of Hospice Non-Covered Items, Services, and Drugs

- As a Medicare beneficiary who elects to receive hospice care, you have the right to request at any time, in writing, the **"Patient Notification of Hospice Non-Covered Items, Services, and Drugs"** addendum that lists conditions, items, services, and drugs that the hospice has determined to be unrelated to your terminal illness and related conditions, and that will not be covered by the hospice.
- The hospice must furnish this notification within 5 days, if you request this form on the start of care date, and within 72 hours (or 3 days) if you request this form during the course of hospice care.

Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO)

As a Medicare hospice beneficiary, you have the right to contact the Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO) to request Immediate Advocacy if you disagree with any of the hospice's determinations. The BFCC-QIO that services your area is:

BFCC-QIO Name: KEPRO

BFCC-QIO Phone Number: 1-888-317-0891

Signature of Beneficiary: _____

Date Signed: _____

☐ Beneficiary is unable to sign Reason:

Signature of Representative: _____

Date Signed: _____