I, _________________________________, hereby consent to participate in and be admitted to care by High Peaks Hospice (HPH). I hereby consent and authorize HPH, its staff and associates to provide care and services to me, as prescribed by my physician and in accord with HPH policy, in my home or other residence. I understand that:

1. The goal of hospice care is not to cure my terminal illness. The goal of hospice care is to improve and maintain quality of life, to the extent possible, through the management of pain and other symptoms when no curative measures are possible or planned. The HPH team will provide physical, psychosocial, spiritual and emotional support as needed to me, my family and primary caregiver(s).

2. Hospice services are provided by the HPH team specially trained in hospice care. Services may include medical, nursing, social work, hospice aides, spiritual counseling, bereavement, medications, durable medical equipment, supplies and other services related to my terminal illness.

3. HPH team will work with my attending physician (Name) ______________________ in providing my care and ensuring that I am as comfortable as possible. My family/caregiver(s) and I will participate in care planning and decisions.

4. My care will be based on my individual needs and those of my family/caregiver(s). Hospice care will usually be provided by scheduled visits, but assistance is available 24 hours a day, 7 days a week, as needed. Frequency of visits is based on need as determined by the HPH team. RN will Visit ________________, LPN will Visit ________________, HA will visit ________________, SW will visit ________________, Chaplain will visit ________________, Volunteer Will Visit ________________________________

5. I want (Name(s)) ______________________________ to be considered my “primary caregiver(s)”. This will be the person(s) mainly responsible for seeing to my daily care and needs. The HPH team does not take the place of the caregiver(s). HPH team supports and supplements me and my family/caregiver(s). I and my family/caregiver(s) will be responsible for my day-to-day care. I agree to cooperate fully with the HPH team in applying for assistance programs or privately arranging for additional care if needed.

6. While I am enrolled in HPH’s program, the HPH team will manage my care whether I am receiving care in my home, or in a hospital, nursing home, or other facility. Short stay inpatient care is available for management of significant, uncontrolled symptoms or respite care need. Inpatient stays must be authorized by HPH staff.
and be provided at facilities with which HPH contracts. HPH will not be responsible for hospital stays, emergency room visits, medical testing or other procedures not arranged by HPH staff. Medicare and my insurance providers may not pay for such visits, tests and procedures while I am on hospice care.

7. The HPH medical record will contain information about me, my family and my primary caregiver(s). This information is private and confidential and every effort will be made to maintain that confidentiality. However, I authorize HPH to disclose and release information contained in my HPH medical record for the purpose of treatment, payment, and healthcare operations. I also authorize HPH to disclose information about me with appropriate family members and the caregiver(s) I choose.

8. This consent may be withdrawn at any time by revoking my consent for care in writing. The effective date of such a revocation may not be prior to the date that it is signed. If my condition improves or I otherwise become ineligible for hospice services, I will be discharged by HPH.

I have received an explanation of the services to be provided by the HPH team, my involvement with the plan of care, and how changes will be made if needed.

___ (Initials)

Acknowledgement of Information: I have received verbal and written information in a language I understand on the following which can be found in the Admission Packet, given to me upon admission to HPH services.

- **Advance Directive.** I understand that HPH’s policy is to respect my choices and to avoid discrimination based on whether or not I have an Advance Directive or a “Do Not Resuscitate (DNR)” directive. I also understand that HPH does not, as an agency, provide extraordinary life prolonging measures such as Cardiopulmonary Resuscitation (CPR).
- **Patient/Family Bill of Rights** and **Your Responsibilities as a Patient.** This includes information about how to use HPH’s complaint process and NY State’s toll free hotline.
- **Notice of Privacy Practices:** This document provides information on use of and how to obtain access to medical information held by HPH
- **Care Information:** Includes information on basic care, medication storage/disposal, infection control, safety and many other resources. ___ (Initials)

**Liability for Payment:**

I certify that all the information given to HPH by me is correct for requesting and applying for payment under Title XVIII (Medicare), Title XIX (Medicaid) of Social Security Act and/or from any third party payer. I understand and agree to pay any deductibles, co-payments, spend downs and any amount due after payment of benefits on my behalf by any and all third party payers.
I □ am  □ am not a participating member of a Health Maintenance Organization (HMO). If not and I enroll in an HMO I will immediately notify HPH.

I understand that services provided to me by HPH will be billed as follows (Choose what applies):
□ Medicare fee for service – not HMO (estimate 100% covered)
□ Medicaid (estimate 100% covered after meeting spend-down and/or other requirements)
□ Other insurance or HMO (coverage varies with individual policy). Any anticipated payments for services will be provided in writing when the insurance company informs HPH of the participant’s financial liability. Estimate amount you will be liable for at time of admission__________ to cover__________ (deductible/co-pay/per diem)
□ Private Pay. Unassisted cost ________________. The patient or responsible party is responsible for the timely payment of all charges. If assistance is needed, complete a Financial Assistance Eligibility form. _____ (Initials)

**Assignment of Benefits:** I request that payment of authorized benefits be made on my behalf directly to HPH. _____ (Initials)

**Authorization for Release of Information:** I hereby consent to and authorize HPH to release and receive information for the purpose of treatment, payment and healthcare operations. The exchange of information may occur between, but is not limited to: physicians, insurance carriers, other health care providers, community resources and regulatory and/or accrediting reviewers. I also authorize my physician and other healthcare providers to provide appropriate medical records to HPH. _____ (Initials)

This admission and care consent is applicable to this admission to HPH services. I understand what I have read or have had read to me, and what was explained to me, and agree to the terms and conditions as above. I have been advised of my rights and responsibilities. All services provided by HPH have been explained to me and I have had ample opportunity to ask questions. My initials above, (_____Initials), indicate that I have read or have had read to me, understand and agree to each of the statements in this consent form.

____________________________________________________  __________________________
Signature of Patient (Unless declared incapacitated)   Date

____________________________________________________  __________________________
Signature of Agent/Representative/Caregiver               Relationship to Patient

____________________________________________________  __________________________
Printed Name of Agent/Representative/Caregiver           Witness

**For HPH Use:**
Capacity: □ Yes  □ No  Documented by Physician: □ Yes  □ No
Health Care Proxy/Power of Attorney (HCP/POA): □ Yes  □ No  Documentation: □ Yes  □ No