ZEPHYR HOSPICE

INFORMED CONSENT FOR HOSPICE CARE

Patient Name____ MRN ________________

I choose to receive hospice care from Zephyr Hospice and acknowledge and agree to the following:

Hospice is a comprehensive program established to provide supportive and palliative care to patients who have a diagnosis with a life limiting illness. Support and education is provided to the family and/or primary caregiver concerning their physical, emotional and spiritual needs. A written and individualized plan of care is utilized to assess ongoing patient and family needs and goals.

Hospice provides palliative, not curative care to meet the physical, emotional, and spiritual needs of the patient and family. I understand that hospice services are provided primarily as Routine Home Care at the patient's residence by an interdisciplinary team of professionals and volunteers. Hospice services are available both on a scheduled and as needed basis, twenty-four hours a day and seven days a week.

Hospice services are provided by an Interdisciplinary Team which includes nursing services, physician care, social work, home health aides, volunteers, dietary counseling, physical, occupational, and speech therapy. The Interdisciplinary Team establishes, develops, revises, and supervises the plan of care with my input under the direction of the Hospice Medical Director. Medical supplies, durable medical equipment, and medications are prescribed for the relief of pain and symptom management related to the diagnosis are also provided.

Hospice provides inpatient services when it is deemed necessary by the hospice team and the attending physician as authorized by Medicare, Medicaid, or Commercial Insurance Carrier. Short term inpatient care is appropriate when skilled observations and interventions are required for acute symptom control to stabilize the situation and return the patient to the home setting. Respite care is offered to relieve caregiver stress. Both are provided in a hospice contracted facility. Continuous care may be authorized in the home in lieu of inpatient care.

The hospice team is not intended to take the place of the family, but rather support the primary caregiver/family in the care of the patient. I understand I may join the hospice team in making decisions about my care while on the hospice program. The Plan of Care is regularly reviewed and I or my caregiver, on a scheduled basis, may join the IDG conference to discuss the care and services.

If I choose to seek services or treatment related to my hospice diagnosis that have not been specifically ordered and authorized by my Hospice Team as part of my Plan of Care, I may be held financially responsible for all costs incurred.

Patient has executed and Advanced Directive ____Yes ____No

ACKNOWLEDGEMENT OF INFORMATION

I have received verbal and written information on the following:

- *Advance Directives.* In addition, I understand that the organization's policy is to respect individual choice and to avoid discrimination based on whether or not I have an Advance Directive or a Do Not Resuscitate (DNR) directive.
- *Patient Rights and Responsibilities.* This also includes information about how to use the organization's complaint process and the state's toll-free hotline.
- *Statement of Patient Privacy Rights and Privacy Act Statement-Health Care Records* (Medicare and Medicaid patients), and/or *Notice About Privacy* (patients who do not have Medicare and Medicaid).
- *Basic Home Safety.*
- *Emergency planning related to a disruption in service.*
- *Infection control.*
- *Biomedical Waste.*

I have received a copy of **Zephyr Hospice Notice of Privacy Practices.** Hospice services have been explained to me; I have been given the opportunity to ask questions concerning the hospice program of care; my questions have been answered and I have received copies of consents and written materials.

____

Signature of Patient or Legal Representative | Date

____

Legal Representative's Name (Please Print) | Relationship

____

Zephyr Hospice Representative | Title

Management and Disposal of Controlled Drugs for Patients and Families

Dear Hospice Patient/Family:
We are providing you this policy to assist you in storing your controlled (e.g., narcotic) medications:

Storage:

- Store tablets and liquids at room temperature, in a cool dry place, away from heat or light. May store in the bathroom in medication cabinet. Store suppositories in the refrigerator, if required.
- Medications stored in refrigerator should be stored away from food items, with proper labeling.
- Keep all medications out of reach of children and/or persons with altered mental status.
- Follow specific guidelines for storage and handling given by the pharmacy.
- Consider using a locked box to store controlled medicine to prevent this medicine from being stolen or taken by anyone other than the patient.

- In order for Hospice employees to dispose of controlled substances, Hospice must:
  - Investigate state regulations to ensure compliance with the most stringent requirements.
  - Revise policies and procedures to the current regulations, as applicable.
  - Educate staff on updated procedures and responsibilities.
  - Update materials provided to the patient and family regarding Hospice's written policies and procedures on the management and disposal of controlled drugs.
- Disposal of controlled substances:
  - Take unused, unneeded or expired prescription drugs out of their original container and throw them in the trash.
  - Mixing prescription drugs with an undesirable substance, such as used coffee grounds or kitty litter, and putting them in impermeable, non-prescript containers, such as empty cans or sealable bags, will further ensure the drugs are not diverted.
  - Flush prescription drugs down the toilet only if the label or accompanying patient information specifically instructs doing so.
  - Take advantage of community pharmacy take-back programs that allow the public to bring unused drugs to a central location for proper disposal. Some communities have pharmaceutical take-back programs or community solid-waste programs that allow the public to bring unused drugs to a central location for proper disposal. Where these exist, they are a good way to dispose of unused pharmaceuticals.
  - The FDA advises that the following drugs be flushed down the toilet instead of thrown in the trash:

Abstral Tablets	**MS Contin**
Actiq(fentanyl citrate)	**Naloxone Hydrochloride**
Arymo ER	**Nucynta ER**
Avenza Capsules (morphine sulfate)	**Onsolis**
Belbuca	**Opona**
Buprenorphine Hydrochloride	**Oxecta**
Butrans Transdermal Patch	**Oxycodone Hydrochloride**
Daytrana Transdermal Patch (methylphenidate)	**OxyContin Tablets** (oxycodone)
Diastat//DiastatAccudial	**Percocet** (Oxycodone and Acetaminophen)
Dilaudid Tablets and Liquid	**Percodan**
DuragesicTransderm System (Fentanyl)	**Reyataz Capsules** (atazanavir sulfate)
Embeda ER	**Suboxone**
Exalgo ER	**Targiniq ER**
Fentora Tablets	**Vantrela ER**
Hysingla ER	**Xartemis XR**
Iviza Capsules (morphine sulfate)	**Xtampa ER**
Meperidine HCl Tablets and Oral Solution	**Xyrem**(Sodium Oxybate)
Morphine Sulfate	

Note: Patients should always refer to printed material accompanying their medication for specific instructions.

This policy has been discussed with me.

______________________________ ______________________________

Patient/caregiver Signature Date Hospice Nurse or Physicians Signature/Date

MEDICARE/MEDICAID BENEFIT ELECTION

As a Medicare Part A or Medicaid beneficiary, I request that the Medicare/Medicaid benefit be made available to me through Zephyr Hospice. I understand that hospice is palliative, not curative, as it relates to the illness for which I am being admitted. I understand that while this election is in force, Medicare/Medicaid will make payments for care related to the illness for which I am being admitted only to Zephyr Hospice and to the physician I designate as my attending.

I also understand that other health care providers (hospitals, home health agencies, nursing home, other physicians, or any other agency, including another hospice as long as Zephyr Hospice is my designated hospice provider) will not be reimbursed for services related to this illness unless specifically authorized in advance by the Zephyr Hospice Interdisciplinary Team. I understand this hospice benefit includes benefit periods. The first two benefit periods are (90) days; the third and each subsequent period is (60) days and continues indefinitely as long as my condition warrants hospice services. I understand that I may change Hospice Providers once in each benefit period without loss of days in that period. I understand that service I may receive to treat a condition not related to this illness will continue to be covered by Medicare/Medicaid in addition to hospice benefits. I understand that I may revoke this election at any time by signing a revocation statement. I understand that the Medicare/Medicaid hospice benefit provides for the following services:

- Intermittent skilled nursing care
- Home Health aide service
- Physician consultation
- Spiritual counseling
- Bereavement service
- Counseling including dietary
- Medical Social Services
- Trained volunteers
- 24 hour on-call services

Additional services are provided as needed for palliative care as they relate to my hospice Diagnosis:

- Supplies, equipment and prescriptions
- Homemaker services
- Short term inpatient care
- Continuous Crisis Care
- Respite Care
- Therapy Services (Physical, Occupational, Speech)

Transfer from ______________________ Hospice to Zephyr Hospice (if applicable) Date: ______________

Attending Physician Is: ____

I acknowledge I have been given opportunity to ask any questions I have about hospice care and that my questions have been answered to my satisfaction. I acknowledge that I have read, understand, and agree to the Medicare/Medicaid Hospice Benefit Election and acknowledge I have selected the Attending physician.

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Signature of Patient or Legal Representative　　　Date

____

Legal Representative's Name (Please Print)　　　Relationship to Patient

____

Patient Name　　　MR #

Effective Date of Medicare Hospice Benefit Election: ______________________

HOSPICE PATIENT'S BILL OF RIGHTS/RESPONSIBILITIES

Patient Name____ **ID#**_____________

Hospice patients have a right to be notified in writing of their rights and responsibilities in advance of receiving care and to exercise those rights. The patient's family or guardian may exercise the patient's rights when the patient is incapacitated. Hospice providers have an obligation to protect and promote the patient's rights, including the following:

Patients have a Right to Dignity and Respect

Hospice patients and their formal caregivers have a right to not be discriminated against based on race, color, religion, national origin, age, sex, sexual preference or handicap. Furthermore, patients and caregivers have a right to mutual respect and dignity, including respect for property. Hospice staff is prohibited from accepting personal gifts and borrowing money or items from patients.

Patients have the right to:

- Exercise your rights and be protected from discrimination or reprisal for exercising your rights.
- Have your cultural, psychosocial, spiritual and personal values, beliefs and preferences respected.
- Receive information about the services covered under your Hospice benefit.
- Be treated with respect and have your property treated with respect.
- To have complaints investigated made by the patient, patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for patient's property by anyone furnishing services on behalf of Hospice. You will not be subject to discrimination for doing so. Hospice must document both the existence of the complaint and the resolution of the complaint.
- Voice complaints without fear of discrimination or reprisal for having done so. If you have a complaint, please call our office and ask for the Hospice Administrator.
- Be advised of the telephone number and hours of operation of the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
    - You have the right to be advised of the availability of the CHAP hotline number. The number is 1-202-862-3413. The hours of operation are 8am to 6pm Monday - Friday. The purpose of the hotline is to receive complaints or questions about Hospice and to lodge complaints concerning the implementation of advance directives. The hotline also receives complaints about advance directives.
    - Know about the disposition of such complaints.
    - Refuse to participate in investigational, experimental, research or clinical trials.
    - Be notified in advance about the care that is to be furnished, any changes to the care to be furnished, the types (disciplines) of the caregivers who will furnish the care and the frequency of the visits that are proposed to be furnished.
    - Choose an attending physician.
    - Receive information about the services covered under your Hospice benefit.
    - Receive information about the scope of services that Hospice will provide and any specific limitations of Hospice services.
    - Be free from mistreatment and mental, physical, sexual and verbal abuse, neglect and exploitation, including injuries of unknown source and misappropriation of patient property by anyone.
- Be advised in advance of the right to participate in developing the Hospice care plan and in planning changes in care before the change is made.
- Be informed of rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.
- Be informed of policies and procedures for implementing advance directives, including a description of applicable state law. You have the right to receive advance directives information prior to or at time of the

first home visit, before care is provided. Also. any limitations if Hospice cannot implement an advance directive on the basis of conscience.

- Receive care without condition on, or discrimination based on, the execution of advance directives.
- Refuse care or treatment without fear of reprisal or discrimination and in accordance with law and regulation. If you are not legally responsible, your surrogate decision maker may refuse on your behalf as permitted by law.
- The patient's family or the person appointed pursuant to state law to act on the patient's behalf may exercise the patient's rights when the patient has been adjudged incompetent under state law by a court of proper jurisdiction. If a state court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with state law may exercise the patient's rights to the extent allowed by state law
- Confidentiality of your medical record as well as information about your health, social and financial circumstances and about what takes place in your home.
- Expect Hospice to release information only as required by law or authorized by the patient and to be informed of procedures for disclosure.
- Access, request an amendment to and receive an accounting of disclosures regarding your own health information as permitted under applicable law, and be advised of Hospice's policies and procedures regarding disclosure of clinical record. I acknowledge that I have received my HIPAA Privacy Notice.
- Receive effective pain management and symptom control for conditions related to terminal illness.
- Respect of personal dignity, privacy and security.
- Have Hospice accommodate your right to pastoral and other spiritual services.
- Effective communication.
- To be informed of the extent to which payment may be expected from Medicare, Medicaid, any other federally funded or aided program known to Hospice or any other payor known to Hospice.
- To be informed of any charges that will not be covered by Medicare.
- To be informed of the charges for which the patient may be liable and to receive this information, orally and in writing, before care is initiated and within 30 calendar days of the date Hospice becomes aware of any changes.
- To have access upon request to all bills for service the patient has received, regardless of whether the bills are paid out-of-pocket or by another party.
- To be admitted by Hospice only if it has the resources needed to provide the care safely and at the required level of intensity, as determined by a professional assessment. Hospice with less than optimal resources may nevertheless admit the patient if a more appropriate provider is not available, but only after fully informing the patient of Hospice's limitations and the lack of suitable alternative arrangements.

Patients have the responsibility to:

- Properly use and dispose of controlled substances and biologicals.
- Use and maintain equipment and supplies provided by Hospice.
- Follow responsibilities that have been outlined in your IDG plan of care.
- Follow infection control procedures that are relevant to your care.
- Notify Hospice of any perceived risks in your care or unexpected changes in your condition, e.g., changes in the plan of care, symptoms to be reported, etc.
- Provide a safe environment for care.
- Notify Hospice if the visit schedule needs to be changed.
- Notify Hospice of the existence of, and any changes made to, advance directives.
- Notify Hospice of any problems or dissatisfactions with the services provided.
- Follow instructions and express any concerns you have about your ability to follow and comply with proposed IDG plan of care or course of treatment. Hospice will make every effort to adapt the plan to your specific needs and limitations. If such changes are not recommended. Hospice will inform you of the consequences of care alternatives.

- Ask questions about care or services when you do not understand your care or what you are expected to do.
- Provide feedback about service needs or expectations.
- Follow Hospice rules and regulations concerning patient care and conduct.
  - Provide accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters related to the patient's health.
  - Know that in the event of an emergency that disrupts Hospice's services to patient, that Hospice will make every effort to visit or telephone patient. However, if patient has a medical emergency and is not able to contact Hospice, the patient should access the nearest emergency medical facility.
  - Ask questions about care or services when you do not understand your care or what you are expected to do.
  - Show respect and consideration for Hospice's personnel and property.
  - Meet financial commitments agreed upon with Hospice promptly.
  - Understand and accept consequences for the outcomes if the care and services or treatment plans are not followed.

______________________________________ ____________

Patient Signature *Date*

______________________________________ ____________

Representative Signature (If patient not able to sign) *Date*

______________________________________ ____________

Hospice RN or Physician Signature *Date*

Note: One copy to Hospice patient record and one copy to patient

Zephyr Hospice

Consent to photograph

Name: ____

I ___________________________________ hereby authorize Zephyr Hospice LLC, to use personal photographic material for the purposes listed below:

- Photographs of appropriate parts of my body (specifically for the treatment of wounds) in order to provide supportive documentation of my medical condition. I understand that these photographs will become the property of Zephyr Hospice and be placed in and remain part of my medical record.
- Photographs of me for identification purposes. I understand that these photographs will be om ether property of Zephyr Hospice and be placed in and remain part of my medical record.
- Photographs of me for news and /or educational purposes. I understand that these photographs will become the property of Zephyr Hospice and be placed a and remain part of my medical record.

____

Signature of Patient POA Date

____

Signature of Zephyr Hospice Representative Date

ZEPHYR HOSPICE

FINANCIAL AUTHORIZATION ASSIGNMENT OF BENEFITS

Beneficiary Information (Patient)				
Last Name:	First Name:	M.I.	Gender: M/F	
DOB:		SSN:		
Address: Street	Apt. No.	City:	State:	Zip:
Contact Phone #:		Secondary Phone #:		
Comments:				
Insurance Provider Information:				
Insurance Company:		Insurance Phone #:		
Member ID #:		Group ID #		
Claims Address: St.	Suite No:	City:	State:	Zip:
Policy Holder:		Employer:		
Contact Person:		Relationship:		
Insured SSN:		Employer:		
Employer Address St.:	Suite No:	City:	State:	Zip
Comments:				

Assignment of Benefits

I hereby authorize that payment be made directly to Zephyr Hospice for health insurance benefits otherwise payable to me in connection with the provisions of Zephyr Hospice services. I understand and agree that I am responsible for any co-pay/deductibles deducted from my carrier.

____

Signature of Patient or Legal Representative Date

____

Legal Representative's Name (Please Print) Relationship

____

Zephyr Hospice Representative Title

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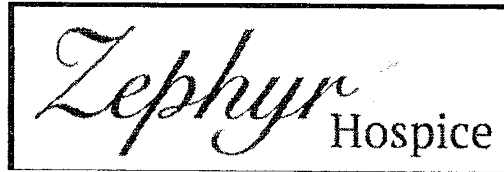

Livanta is a Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO). BFCC-QIOs are responsible for medical case review, which supports the rights of people on Medicare. These rights include protecting you when you get health care and making sure you get the health care services the law says you can get. BFCC-QIOs can help you if you have a concern about the care you have been receiving or if you want to request a review (appeal) of your discharge from a health care facility.

HELPLINE: 877-588-1123

TTY: 855-887-6668

FAX: 855-694-2929

Hospice Coverage and Right to Request

"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_________

I decline to receive the "Patient Notification of Hospice Non-Covered Items, Services, and Drugs" Initials_________ Date_________