HOSPICE & HOMECARE OF RENO COUNTY

HOSPICE CONSENT TO TREAT and
Acknowledgement of Review and Receipt

Patient Name:_____

Date of Birth:_____

To Hospice & HomeCare of Reno County, I hereby give my **permission** for authorized personnel to perform all necessary procedures and treatments as prescribed by my physician for the delivery of hospice care.

_____

Signed: Patient / Authorized Representative

☐ I acknowledge that I have been provided with information about the services covered under the **hospice benefit**, the scope of services the agency will provide and any limitations on those services.

☐ I acknowledge that I have been made aware of my rights as a patient receiving care and understand these rights and responsibilities. I have been given a copy of the **Patient Rights and Responsibilities**, as well as **Advance Directive** information per Kansas Statutes and Federal requirements.

☐ I acknowledge that the agency provided and reviewed with me my right and the procedure to voice **complaints and/or grievances**.

☐ I acknowledge that the agency provided and reviewed with me procedures to follow if care, treatment or services are disrupted by a **natural disaster or emergency**.

☐ I further acknowledge that I have been made aware of the agency's policy and procedure regarding **management and disposal of controlled drugs**. I have been given a copy of the Management and Disposal of Controlled Drugs Policy and Procedure.

☐ As required by the HIPAA Privacy Regulations I have received a copy of the **Notice of Privacy Practices**.

☐ I hereby give my permission for authorized personnel of the agency to use **photography** as deemed reasonable and necessary for the delivery and documentation of hospice care. I understand the photos will become a part of the medical record.

☐ I authorize the agency to release to or receive from hospitals, physicians, or other agencies involved in my care all **medical records** and information pertinent to my care.

☐ I certify that the **information** given by me for payment under TITLE XVIII, TITLE XIX of the Social Security Act, other insurance policy or responsible payer is correct.

☐ I authorize **release of all records required for payment** for services rendered. I request that payment of authorized benefits from Medicare, Medicaid, or other responsible payer be made on my behalf to the named Certified Hospice Agency. I agree to pay for any services not covered by insurance.

_____ I acknowledge review of all of the statements listed above.

DATE_____ WITNESS_____

(Form expires two years from date of signature)