

**HOSPICE OF WARREN COUNTY
ADMISSION SERVICE AGREEMENT**

Patient Name _____ **Case #** _____

CONSENT FOR CARE/SERVICE

I, or my representative, agree to accept responsibility for participation in the hospice program and grant permission for agency representatives to carry out a plan of care as ordered by my physician and as per agency policy. An agency staff member has explained my plan of care; and all of my questions have been answered satisfactorily. I understand that the treatment plan may change; if so, these changes will be discussed with me. I also understand that I and/or my family/caregiver will receive instructions to assist with my care and that my care will therefore become my responsibility in the absence of agency staff in my home. I agree to notify my physician or others providing care of any adverse reactions or other significant events relating to my health.

RELEASE OF INFORMATION

I hereby authorize release of any and all information concerning my hospital (or other) confinement and treatment to Hospice of Warren County. I also consent to and authorize the agency to disclose and release information contained in my clinical record to the health care providers involved in my care, third party payers, utilization review and professional standards review organizations, regulatory review entities, and any other organizations, companies, community resources, etc. that may/will assist me to meet my health care needs. I authorize the agency to fax medical records to the above organizations and entities when necessary.

ASSIGNMENT OF BENEFITS AND LIABILITY FOR PAYMENT

I certify that all information given by me to the agency is correct. I further understand that services provided to me by this agency will be billed to the following and hereby AUTHORIZE PAYMENT directly to Hospice of Warren County.

Medicare Medicaid My insurance company (specify) _____

Directly to me or my guarantor Another third party payer (specify) _____

My insurance benefits have been explained to me, I understand and agree to pay deductibles, co-payments and any amounts due after payments of benefits on my behalf by any and all third party payers.

ADVANCE DIRECTIVE FOR HEALTH CARE

I have been given a verbal explanation and written information regarding advance directives from the agency. I understand that it is the policy of the agency to respect individual choice and to avoid discrimination based on whether or not I have an advance directive.

I DO DO NOT have an advance directive. I WILL WILL NOT provide a copy to the agency.

The patient Bill of Rights and Responsibilities has been reviewed with me and I have received a copy.

ACKNOWLEDGEMENT OF RECEIPT: Warren General Hospital Notice of Privacy Practices:
I have received Warren General Hospital Notice of Privacy Practices.

This agreement applies only to this admission to the hospice program. I understand what I have read and what was explained to me. I agree to the terms and conditions stated above. Additionally, I understand either party may end this agreement at any time.

SIGNATURES/DATES

_____/_____/_____
Patient/Representative **Date** _____/_____/_____
Agency Representative **Date**