Avery Care Hospice, Inc. 11030 Arrow Route, Ste 209, Rancho Cucamonga, CA 91730

INFORMED CONSENT AND TREATMENT AUTHORIZATION

This agreement is entered into by and between **Avery Care Hospice, Inc.** (hereinafter called Agency) and _____ (hereinafter called Patient). This agreement is entered into pursuant to a desire by Patient to obtain Hospice services. I request admission to Hospice and understand and agree to the following conditions:

1. I understand that the Hospice program is palliative, not curative, in the goals and treatments. The program emphasizes the relief of symptoms such as pain and physical discomfort and addresses the spiritual needs and the emotional stress which may accompany a life-threatening illness.
2. I understand I am encouraged to participate in the development and implementation of the approved plan of care and that Hospice services are not intended to take the place of care by family members or others who are important to the patient, but rather to support them in the care of the patient. With the help of hospice, the person designated the "caregiver" will provide around-the-clock care to the patient in their place of residence. If twenty-four-hour care is not available, the caregiver will arrange for another to provide it. The caregiver will also participate in decisions about the care provided to the patient. The Hospice Interdisciplinary Team supplements rather than replaces care provided by the family or Care Center Staff.
3. I accept the conditions of Hospice ad described, understanding that I may choose not to remain in the program and that Hospice may discharge me from the program if hospice care is no longer appropriate. This means there will be no further liability to me or to Hospice. I understand, however, that I may request to be readmitted at a later date. I have been able to discuss the above conditions with a member of the Hospice staff and have had my questions answered to my satisfaction.

TREATMENT AUTHORIZATION: The undersigned Patient or Patient's legally authorized representative hereby consents to any and all examinations and treatments prescribed by the Patient's physician (or hospice physician) rendered by the Agency's licensed nurses, physical therapists, occupational therapists, speech therapists, registered dietitians, social workers, spiritual counselors, home health aides and volunteers.

FINANCIAL AGREEMENT:

In consideration of the mutual promises and obligations related to treatment rendered to Patient by Agency, it is agreed as follows:

1. ***Payment Responsibility:*** It is understood that for Hospice patients, the agency assumes financial responsibility for medications and/or durable medical equipment and medical supplies related to the terminated illness, agency, in accordance with this agreement for the Patient and/or Patient's agent assumes financial responsibility for all other authorized charges. The agency in accordance with this agreement shall assist the Patient in obtaining financial assistance from third-party payers such a Medicare and private insurers.
2. ***Pharmacy Services:*** I acknowledge that I have the right to direct a pharmacist to dispense a prescription using the brand my physician prescribed instead of a generic drug product. I also understand that generic drug products generally cost less than brand name products, but the price differences vary from prescription to prescription. I hereby consent and agree that, if allowable under state law, any pharmacist who dispenses any of my prescription drugs may select a drug product that is generically equivalent to the brand prescribed by my physician, unless I submit to Hospice a written request for a brand name product.
3. ***Termination***: The agency may terminate services when in its sole medical judgment determines there is no longer any reasonable expectation that it can meet the Patient/family's needs.

MEDICARE / MEDICAL HOSPICE BENEFIT ELECTION

As a Medicare Part A or Medical beneficiary, I hereby elect **Avery Care Hospice, Inc.** as my sole provider of hospice care
Effective _____
Date (mm/dd/yy)

I understand the hospice program to be palliative, not curative in its goal and treatment, which the program emphasizes the alleviation of physical symptoms including pain, and the identification and meeting of emotional and spiritual needs that the patient and family may experience related to the terminal illness.

PATIENT:_____MR#_____Initial_____
(Last) (First)

INFORMED CONSENT AND TREATMENT AUTHORIZATION

I understand that while this election is in force, Medicare/Medical will make payments for care related to this illness on to the physician designated below and to **Avery Care Hospice, Inc.,** and that services related to this illness provided by hospitals, home health agencies, nursing homes, and any other company or agency will not be reimbursed by Medicare/Medical unless specifically ordered and authorized by Hospice. I understand the services not related to this illness will continue to be covered by Medicare/Medical along with hospice benefits.

HOSPICE SERVICES:

☐***Routine Home Care:*** I understand that hospice services are delivered primarily in the home (which may include a nursing home) provided by a team of hospice professionals, staff and volunteers. These services are available both on a scheduled basis and as needed. I understand that these services may include, as set forth in the hospice plan of care: nursing, physician care, social worker, spiritual, nutrition, bereavement counseling, home health aides, medical supplies, physical therapy, occupational therapy, speech-language therapy, and medications prescribed for relief of pain or discomfort.

☐***Inpatient Care/Inpatient Respite:*** I understand that inpatient hospice care and inpatient respite care are provided in an inpatient bed when it is deemed necessary by the hospice interdisciplinary team. I understand that hospice inpatient care is designed for short term stays with the goal of stabilizing the patient and family emotionally and physically, so the patient can return to home. I understand that inpatient respite care is designated to provide brief periods of respite for the family or primary care while the patient receives hospice care in an inpatient bed.

☐***Continuous Care:*** I understand that continuous care (1 minimum of 8 hours of care is a 24 hour period) may be provided in a patient's home when it is deemed necessary by the hospice interdisciplinary team. I understand that continuous care is designated for short-term periods to manage acute medical symptoms with the goal of stabilizing the patient.

I understand that under the Medicare/MediCal Hospice Benefit, I am entitled to hospice care, which consists of two 90-day periods and subsequent 60-day periods of unlimited duration. The Hospice Interdisciplinary Team evaluates recertification for continuation of hospice care at the end of each benefit period.

I understand that I am responsible for the cost of care for my terminal illness if I seek care beyond what is considered medically necessary by the hospice interdisciplinary group and documented on my plan of care.

I understand that I may revoke the hospice benefit at any time by signing a statement to that effect, specifying the date when the revocation is to be effective and submitting the statement to Hospice prior to that date. This revocation constitutes a waiver of the right to hospice care during the remainder of the current election period.

I understand that once in each election period I may elect to receive services through a hospice program other than Avery Care Hospice, Inc. such change shall not be considered a revocation of hospice services.

PATIENT:_____MR#_____Initial_____
(Last) (First)

INFORMED CONSENT AND TREATMENT AUTHORIZATION

I have been providing the following information regarding advance directives:

☐ Informed of my rights to formulate an Advance Directive.

☐ I am not required to have an Advance Directive in order to receive medical treatment by any health care provider.

☐ The terms of any Advance Directive that I have executed will be followed by any health care provider and my caregivers to the extent permitted by law.

The patient has an Advance Directive:

☐ Power of Attorney for Health Care

☐ Living Will

☐ The patient does not have an Advance Directive.

Name and Address of Agent:

_____

_____

_____

Copy received: ☐ Yes ☐ No

RELEASE OF PATIENT RECORDS:

I understand that **Avery Care Hospice, Inc.** may need to obtain medical records and related information form hospitals, nursing homes, physicians, pharmacies, home health agencies, insurance companies, health care benefit plans, or others in order to assure continuity of care and proper reimbursement. I authorize the above persons and entities to release to **Avery Care Hospice, Inc.,** and its representative's medical records and related information necessary to be helpful to the provision of hospice care. I also authorize **Avery Care Hospice, Inc.,** and its representatives to release medical records and related information to others for the purposes of my health care, administration, and management of my health care (including utilization review), or processing and obtaining payment for services and supplies rendered to me. I understand and agree that this authorization specifically includes my permission and consent to release any information regarding a diagnosis of AIDS or the results of Human Immunodeficiency Virus (HIV) tests to the extent permitted by law. A photocopy of this authorization shall be as valid as the original.

RECEIPT OF INFORMATION:

Hospice services have been explained to me in a manner and language understood by me; I have been given the opportunity to ask any questions I have concerning the hospice program of care, and my questions have been answered to my satisfaction. I have been provided with the following materials:

☐ A copy of Patient's Rights

☐ Written materials explaining a patient's legal rights to accept or refuse medical treatments and to prepare an Advance Directive for health care.

RECEIPT OF ACKNOWLEDGEMENT:

I have received, acknowledged and agreed to the terms and conditions described in the following documents:

☐ Informed Consent and Treatment Authorization
☐ Medicare/Medical Hospice Benefit Election
☐ Notice of Privacy Practices
☐ Patient/Family Hospice Information
☐ Financial Agreement
☐ Advance Directives
☐ Compliant and Grievance Program

_____ _____

SIGNATURE OF PATIENT **DATE**

IF PATIENT UNABLE TO SIGN, STATE REASON: _____

_____ _____

SIGNATURE OF LEGALLY AUTHORIZED REPRESENTATIVE (If Applicable) **DATE**

_____

NAME AND ADDRESS OF LEGAL REPRESENTATIVE (PRINT) (If Applicable)

_____

HOSPICE CARE REPRESENTATIVE

PATIENT:_____MR#_____Initial_____

(LAST) (FIRST)

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: https://qioprogram.org/locate-your-qio or call **1-800-MEDICARE (1-800-633-4227)**. TTY users can call **1-877-486-2048**.

☐ I elect to receive the **"Patient Notification of Hospice Non-Covered Items, Services, and Drugs" Initials**_____
Date_____
(Hospice: Please provide the beneficiary with the addendum. Must be signed and dated accompanying the election statement.)

☐ I decline to receive the **"Patient Notification of Hospice Non-Covered Items, Services, and Drugs"**
Initials_____ **Date**_____

Note: *The hospice makes the decision as to whether or not conditions, items, services, and drugs are related for each patient. As the patient or representative, you should share this list and clinical explanation with other healthcare providers from which you seek items, services, or drugs, unrelated to your terminal illness and elated conditions to assist in making treatment decisions.*

Right to Immediate Advocacy: *As a Medicare beneficiary, you have the right to contact the Medicare Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) to request for Immediate Advocacy if you (or your representative) disagree with the decision of the hospice agency on items not covered because the hospice has determined they are unrelated to your terminal illness and related conditions.*
BFCC-QIO Name: LIVANTA / https://livantaqio.com/en and BFCC-QIO Phone Number: 1-877-588-1123; 1-855-887-6668 (TTY).

The purpose of this addendum is to notify the beneficiary (or representative), in writing, of those conditions, items, services, and drugs the hospice will not be covering because the hospice has determined they are unrelated to the individual's terminal illness and related conditions. I acknowledge that I have been given a full explanation and have an understanding of the list of items, services and drugs not related to my terminal illness and related conditions not being covered by hospice. Signing this addendum (or its's updates) is only acknowledgment of receipt of the addendum (or its updates) and not necessarily agreement with the hospice's determinations.

CONSENT TO PHOTOGRAPH

A patient, while under the care of Avery Care Hospice, Inc., depending on the overall condition of the patient, could develop some skin conditions like rashes, wounds (whether stage 1 or higher) etc. As a matter of Avery Care Hospice, Inc's policy, patients at the onset of these underlying condition, needs to be addressed immediately. Initially, our field nurses and/or other staff must report the situation as soon as possible, and at the same time, there might be a need to take photo/s of the skin condition for further consultation with Avery Care Hospice, Inc., Medical Director or a third party wound specialists. The photo could also be used during the discussion of patient's condition, status of the wounds and its progression, with the Inter Disciplinary Team (IDT) members. In such a case, as a matter of policy, Avery Care Hospice, Inc., will see to it that the photo/s taken shall be done strictly with the following condition/s:

1. The focus of the photo shall be on the skin condition only.
2. That there will not be, at any point in time, in any frame of the photo, will it show the face of the patient, nor any private part of the patient that is not relevant and/or necessary in addressing the said skin condition.
3. That the said photo shall be used entirely for the purpose of developing a plan of care for the patient, specifically, in addressing the skin condition, and will not be sold, published, or used in any other way, other than patient care.

Given the conditions discussed, I hereby:

☐ Give my consent to***Avery Care Hospice, Inc.*** to take photograph/s if applicable.

☐ Refuse to give my consent to***Avery Care Hospice, Inc.*** to take any photograph/s.

I acknowledge and understand the above, and authorize Medicare hospice coverage to be provided by

Avery Care Hospice Inc. to begin on _____
(Hospice Agency) **(Effective Date of Election)**

Note: The effective date of the election, which 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.

_____ _____
Signature of Patient / Patient Representative **(Date Signed)**

☐ Beneficiary is unable to sign - Reason:_____

_____ _____
Signature of Hospice Representative **(Date Signed)**

_____ _____
Witness signature **(Date Signed)**

AVERY CARE HOSPICE, INC.

11030 Arrow Route, Ste 209, Rancho Cucamonga, CA 91730
Tel # 909-727-3200 E-Fax # 909-727-3082

PATIENT CONSENT FOR PRIMARY CARE PHYSICIAN

Patient Name: _____ MR #: _____

Physician's Name: _____ Date: _____

☐ I wish to continue my Primary Care with my current Physician.

Primary Care Physician: _____

NPI: _____

☐ I would prefer **Avery Care Hospice, Inc.,** Medical Director to attend to my care needs.

☐ I would prefer **Avery Care Hospice, Inc.,** Medical Director to intercede for only my terminal illness treatment needs and pain management.

Comments:

_____
_____
_____
_____
_____

_____ _____
Patient/Legal Guardian Signature Date:/Time

_____ _____
Hospice Representative Signature Date:/Time

AVERY CARE HOSPICE, INC.

11030 Arrow Route, Ste 209, Rancho Cucamonga, CA 91730
Tel # 909-727-3200 Fax # 909-727-3082

PATIENT ACKNOWLEDGEMENT

Patient's Name: _____
MR # _____ Date: _____

I have received the following information and have been given the opportunity to ask questions.

IMPORTANT INFORMATION EXPLAINED TO PATIENT/ FAMILY/ CAREGIVER	Explained	Left in Home
1. Patient's freedom of choice in selecting a hospice agency.		
2. Patient's condition/plan of care/goals and how related to his / her condition.		
3. Patient's right to participate in the plan of Care, treatment, and informed of Change.		
4. Patient/Caregiver is expected to learn and participate in care consistent with capabilities.		
5. Disease process, medication regime and diet.		
6. Written notice of Patient's Rights & Responsibilities, Consent, Assignment of Benefits, Patient grievance Procedure. Guidelines for Patient care and Emergency Care.		
7. Advance Directive. Has Patient executed an Advance Directive? YES, NO • Given written materials about right to accept or refuse medical treatment • Been informed of rights to formulate Advance Directives. • That patient is not required to execute an Advance Directives to receive medical treatment from this health care facility. • That the terms of any Advance Directives executed will be followed by the agency and caregivers to the extent permitted by laws.		
8. Visit Plan to include disciplines and frequencies.		
9. Confidentiality and Disclosure of Clinical Records.		
10. Basic Home Safety, Infection Control, Disaster Plan		
11. Patient liability for payment and right to be informed of any changes.		
12. Toll-free State Hospice Hot Line number and purpose.		
13. How to register a complaint with the agency and their right to voice grievance without fear of reprisal.		
14. Discharge Planning.		
15. Emergency Disaster Plan Priority Code: Good support system, efficient caregivers in place (Lowest Priority) Support system in place requiring frequent agency interventions (High Priority) Support systems unreliable and inconsistent and/or on 0_2, Infusion, or ventilator Therapy (Highest Priority)	Circle One Category 3 Category 2 Category 1	

Patient/Caregiver Signature: _____ Date: _____

Staff Signature/Title: _____ Date: _____

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Tel # 909-727-3200 Fax # 909-727-3082

Individual Patient Emergency Preparedness Plan

Identifying Information

Patient Name:_____ SOC Date:_____
Phone Number:_____ Physician:_____
Address:_____
City:_____ State:_____ Zip:_____

Relevant Healthcare Information

Primary Dx:_____Secondary Dx:_____
Daily or more frequently Agency Services: No____ Yes____
If Yes, describe:_____
Oxygen dependent: Flow Rate_____ Hours of Use:_____ Delivery Device:_____
Life-Sustaining Infusion: No____ Yes____
If Yes, describe:_____
Other IV Therapy: No____ Yes____
If Yes, describe:_____
Patient/Caregiver Independent: No____ Yes____
Ventilator Dependent: No____ Yes____
Dialysis: No____ Yes____
If Yes, describe:_____
Tube Feeding:No____ Yes____
If Yes, describe:_____
Patient/Caregiver Independent with Self-Administered Medications: No____ Yes____
Functional Disabilities (check all that apply): ____Walker/cane ____Wheelchair ____Bedbound
____Hearing Impairment ____Visual Impairment ____Mental/Cognitive Impairment

Emergency Plan

Emergency Contact Name: _____ Phone Number: _____
If necessary, patient will evacuate to: Relative/Friend
(Name/PhoneNumber):_____
Hotel (Name / Phone Number): _____
Shelter (Location):_____
Is patient registered for special need shelter? No____ Yes____
Other (Describe):_____

Priority/Acuity Level: _____

_____
Clinician/Date

*Copy to patient and original on medical record.

AVERY CARE HOSPICE,INC..RIGHTS AND RESPONSIBILITIES

Patient Rights

Written administrative policies shall be developed and shall be reviewed as necessary and, if indicated, revised. These policies shall be made available to patients/families or their agents upon request.

Written policies regarding rights and responsibilities of patients shall be established and made available to the patient, guardian, next-of-kin, sponsoring agency or representative payee and the public. Such policies shall ensure that each patient receiving care shall have the following rights and responsibilities:

* To be fully informed, as evidenced by the patient's or his/her appointed representatives written acknowledgement prior to or at the time of admission of these rights and of all rules and regulations governing patient conduct.

*To be fully informed prior to or at the time of admission, of service available in the hospice and of related changes, including any change for service not covered under Titles XVIII or XIX of the Social Security Act.

*To exercise one's rights as a patient of the hospice

*Receive information about the services covered under the Medicare hospice benefit

*Receive information about the scope of services that the hospice will provide and specific limitations on those services

*Be fully informed in advance about care/service to be provided, including the disciplines that furnish care and the frequency of visits, as well as any modifications to the plan of care

*Be informed in advanced, both orally and in writing, of care being provided; of the charges, including payment for care/service expected from third parties, and any charges for which the patient will be responsible

*Participate in the development and periodic revision of the plan of care

*Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property

*Voice grievances/complaints regarding treatment or care that is (or fails to be) furnished and lack of respect of property by anyone who is furnishing care/service on behalf of the hospice

*Have grievances/complaints regarding treatment or care that is (or fails to be) furnished or lack of respect of property investigated

*Confidentiality and privacy of all information contained in the patient record and of Protected Health Information

*Be advised on agency's policies and procedures regarding the disclosure of clinical records

*Refuse care or treatment after the consequences of refusing care or treatment are fully presented

*Be informed of patient rights under state law to formulate Advance Directives

*Receive effective pain management and symptom control for conditions related to terminal illness(es)

*Have one's property and person treated with respect, consideration, and recognition of patient dignity and individuality

*Be able to identify visiting personnel members through agency generated photo identification

*Recommend changes in policies and procedures, personnel or care/service

*Not be subject to discrimination or reprisal for the exercising of one's rights

*Choose a health care provider, including an attending physician

*Receive appropriate care without discrimination in accordance with physician orders

*Be informed of any financial benefits when referred to a hospice

*Be fully informed of one's responsibilities

*Be informed of anticipated outcomes of care and of any barriers in outcome achievement

*To be informed by the licensee of the provisions of the law regarding complaints and procedures for registering complaints confidentiality, including but not limited to the address and telephone number of the local district of the department.

To lodge a complaint please call
State of California, Department of Public Health
at (818) 901-4375
Toll Free (800) 228-1019
Fax Number (562) 409-5096
Or file a complaint at:
www.cdph.ca.gov

*To be informed of the provisions of law pertaining to advanced directives, including withdrawal or withholding of treatment and/or life support.

*To be assured that the personnel who provide care are qualified through education and experience to carry out the service for which they are responsible.

Retaliation or Discrimination
No program or employee of a program shall discriminate or retaliate in any manner against any patient or family or any employee on the basis or for the reason that the patient or family or the employer has presented a grievance or complaint or has initiated or cooperated in any investigation or proceeding of any governmental entity relating to care, services or conditions of the program.

Patient Responsibilities

You have the responsibility to:

A. To remain under a doctor's care while receiving hospice care.
B. To inform the program of any advance directives or any changes in advance directives and provide the program with a copy.
C. To cooperate with primary doctor, program staff and other caregivers.
D. To advise the program of any problems or dissatisfaction with patient care.
E. To notify the program of address or telephone number changes or when unable to keep appointments.
F. To provide a safe home environment in which care can be given, in the event that conduct occurs such that the patient's or staff's welfare or safety is threatened service may be terminated.
G. Obtain medications, supplies, and equipment ordered by the patient's physician if they cannot be obtained or supplied by the program.
H. Treat personnel with respect and consideration
I. Sign the required consents and releases for insurance billing and provide insurance and financial records as requested.
J. Accept the consequences for any refusal of treatment or choice of non-compliance.

The program shall describe in writing patient and family responsibilities and the mechanism to file a grievance and obtain a receipt that this information has been received by the patient/family.

Patient and or responsible party will be responsible for all room and board charges if the patient is in a skilled nursing facility, residential care facility or assisted living.

Should the patient have Medi-Cal and is in skilled nursing facility (SNF), Medi-Cal will pay the room and board up to 390 days.

Should the patient be on respite care, Angel's Pure Hospice Care Inc. will only pay room and board for up to five (5) days each benefit period.

Medical Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **PLEASE REVIEW THIS NOTICE CAREFULLY.**

As a patient receiving health services and care, we understand you may be concerned about how your medical and other health-related information may be handled. That is why we, as an organization, are committed to ensuring patient privacy and confidentiality to you and others we serve. That is also why we have developed this Notice, made it available to you, and why we, as an organization, are dedicated to abiding by the terms of the Notice, as currently in effect. To the extent you may have any questions, or concerns relating to the mattes and issues addressed in this Notice, please do not hesitate to contact our Privacy Officer.

I. General

This Notice is drafted to you, consistent with the requirements of the privacy rules ("Privacy Rules") of the Health Insurance Portability and Accountability Act ("HIPAA"). As a health care provider, we are committed to meet the requirements of the law to maintain the privacy of our patient's Protected Health Information, and to provide you with this Notice of your legal duties and our privacy practices relating to your Protected Health Information.

As you may already know, the privacy rules of the Health Insurance Portability and Accountability Act ("HIPAA") have come into effect. The HIPPA Privacy Rules mark this nation's first set of comprehensive standards to ensure patient privacy and confidentiality. We, as a health care provider, are subject to the requirements of the HIPAA Privacy Rules. Equally, or perhaps more important, we are committed as an organization to continually strive to act consistently with the underlying purpose and philosophy of the HIPAA Privacy Rules – to properly safeguard and protect from improper disclosure health information that either identifies you or can be reasonably used to ascertain your identify, and which is transferred or maintained to another party in electronic or other form. This information is what this Notice refers to as "Protected Health Information."

II. Uses/Disclosures Related to Treatment/Payment or Health Care Operations

The law permits us to use and/or disclose Protected Health Information to carry out treatment, payment and other health care operations.

Treatment: An example of when we might use/disclose your Protected Health Information for treatment/care purpose is when your medical/health information is needed by another health care provider, such as a hospital, to better understand your medical/health condition, properly diagnose, care and treat you. Another example is when we might disclose certain information about a patient to facilitate a pharmacy's filling your prescription.

Payment: An example of when we might use/disclose your Protected Health Information for payment purpose is when we disclose your Protected Health Information to you insurance company to facilitate our ability to receive reimbursement from that health insurance company. When we disclose information for payment purposes, we will work to only disclose that Protected Health Information which is minimally necessary to ensure proper and timely payment of claims.

Health Care Operations: Best described, the term Health Care Operations means those other functions and activities that we perform, which allow us to best serve you as a health care provider. Some examples of what might constitute Health Care Operations are when we use and/or disclose your Protected Health Information for quality assessment and improvement activities – to make us a better health care provider to serve you. Another example may be when we use and/or disclose Protected Health Information to better manage our operations, such as when we share information with a Business Associate to ensure proper accounting and record-keeping relating to our services.

III. Uses/Disclosures When An Authorization Is Not Required

In some cases, the law permits us to use and/or disclose Protected Health Information, without requiring you to sign an Authorization. In many cases, these types of uses and/or disclosures are permitted to promote the government's need to ensure a safe and healthy society. In other cases, the law does not require and Authorization because it would be impracticable to require an Authorization.

The law also permits us to use/disclose Protected Health Information for certain specific purposes, where we are not specifically required to obtain your advance written Authorization. Whenever doing so, we are committed to make sure that we meet the necessary prerequisites before using/disclosing your Protected Health Information for those purposes, and to not use/disclose more of your Protected Health Information than is otherwise required/permitted under the law.

There are several types of areas where the law permits us to use/disclose Protected Health Information in good faith, and consistent with the requirements of the HIPAA Privacy Rules and other laws. Sometimes, emergency circumstances may-dictate our need to use and/or disclose Protected Health Information without obtaining an authorization, to properly treat and care for patients.

In other cases, the law emphasizes society's need for disclosing Protected Health Information, without first requiring patients to enter into an Authorization. These types of uses/disclosures of Protected Health Information include those: to avert communicable or spreading diseases; for public health activities; for federal intelligence, counter – intelligence and national security purposes; to properly assist law enforcement to carry out their duties; when a judge or administrative tribunal order the release of such Protected Health Information; for cadaveric organ, eye and tissue donations (where appropriate); to help separation/discharge matters; for coroner/medical examiner purposes; for health oversight purposes (such as when the government requests certain information from us); to assist victims of abuse, neglect or domestic violence; to address work-related illness/workplace injuries and for worker's compensation purposes; to carry out clinical research that involves treatment where the proper body has determined the importance for doing so; for FDA-related purposes; certain health and safety purposes; for funeral/funeral director purposes; to help determine veteran's eligibility status; to protect Presidential and other high-ranking officials; to correctional institutions/law enforcement officials acting in custodian capacity.

In addition, the law recognizes that there are certain instances where using and/or disclosing Protected Health Information, without first requiring an Authorization, would not unduly intrude upon a patient's rights to privacy and confidentiality, and where it would be too administratively burdensome to require and Authorization. An immediate example is when the use and/or disclosure of the Protected Health Information is made to the patient, him/herself, or to a personal representative of the patient who the law requires to be treated as the patient. Other types of uses/disclosures include those made to prepare and maintain facility directories; to notify family members and close others about a patient's condition and/or location; or for disaster relief purposes. In those cases, although an Authorization is not required, we will attempt to provide you with the opportunity to verbally or otherwise agree/object to the use/disclosure, to the extent required by the HIPAA Privacy Rules.

IV. Disclosures Where An Authorization Is Required

For other types of uses and/or disclosures of Protected Health Information, the law requires us to obtain what is known as an Authorization. An Authorization can be revoked by you at any time, as long as we have not already reasonably relied on it to make a particularly use and/or disclosure.

Some examples of when the Authorization form would be required include when the uses/disclosures are made to a patient's employer for disability, fitness for duty or drug testing purposes. Other examples include certain types of marketing activities.

V. Appointment Reminders And Information On Treatment Alternatives

We may use and/or disclose your Protected Health Information, as appropriate, for appointment reminders and to provide you with information on potential treatment alternatives.

From time to time, we may need to use and/or disclose your Protected Health Information to provide you with appointment reminders or provide you with information about treatment alternatives or other health-related benefits and services.

VI. Your Right To Request Additional Restrictions On The Use/Disclosure Of Protected Health Information

You have the right to request additional restrictions relating to the use and/or disclosure of your Protected Health Information. Although we are not legally required to grant such additional restrictions, it is your right to make such request.

You have the right to request and obtain proper accounting of disclosures we have made of you Protected Health Information, consistent with the requirements of the HIPAA Privacy Rules. Please note that, under this section, we reserve the right to, among other things, limit any such accountings to disclosures made after the compliance date of the HIPAA Privacy Rules, as well as deny accounting requests that are otherwise no required under the HIPAA Privacy Rules.

In providing you with an accounting of you Protected Health Information, we reserve the right to charge you a reasonable, cost-based fee in connection with any second or other subsequent accounting request you may make during a twelve (12) month period. In reserving the right to charge you such fee, you should note that you have the opportunity to withdraw or modify any such second or other such accounting request made during the twelve (12) month period, to permit you to avoid/reduce the fees charged.

VII. Your Right To Obtain A Paper Copy Of This Notice

You have the right to obtain a paper copy of this Notice.

You have the right to obtain a paper copy of this Notice. If you do not already have a paper copy of this Notice, please do not hesitate to contact our Privacy Officer in order to receive one, in addition to providing you the right to obtain a paper copy of the Notice, we may also provide copies of out Notice via email and/or website, to the extent applicable and as permitted by the HIPAA Privacy Rules. This, however, does not alleviate our duty to provide you with a paper copy of the Notice upon request.

VIII. You Right To Complain About How Your Protected Health Information Is Handled

We recognize and respect your right to file a complaint against us, if you believe in good faith that we have violated your privacy rights, including under the HIPAA Privacy Rules. We do not retaliate against persons who file such complaints either with us or with the United States Department Of Health and Human Services Office of Civil Rights.

You have the right to complain to us about how we handle your Protected Health Information, including if you believe in good faith that we may have violated your privacy rights under the law. To register a complaint with us, you may either write, call or request to see our Privacy Officer.

We do not have a rigid set of requirements for you to file a complaint. Rather, we simply ask that you provide us with the necessary information to properly and timely follow-up on your concerns/complaint, so that we may be able to address it in the most proactive and effective manner.

In addition, if you believe that we have not been attentive and have violated your privacy rights, you may also have the right to contact the United States Department of Health and Human Services ("HHS") about us. The office within HHS responsible for processing and reviewing complaints relating to the HIPAA Privacy Rules, and for enforcing the HIPAA Privacy Rules is the HHS Office of Civil Rights ("OCR").

You may contact the HHS OCR about any complaints you have, as follows:

Medical Privacy Complaint Division, Office of Civil Rights
United States Department of Health and Human Services
200 Independence Avenue, S.W., Room 509F, HHH Building
Washington, D.C. 20201

Voice Hotline Number: (800) 368-1019 Internet Address: www.hhs.gov/ocr

We again emphasize that it is against our policies and procedures to retaliate against any patient who has filed a privacy complaint, either with us or the HHS OCR. Should you believe that we might have retaliated against you in any way upon filing a complaint with us or the HHS OCR, please immediately contact our Privacy Officer so that we may properly address that issue for you.

IX. Changes To The Terms Of Our Notice Of Privacy Practices

We reserve the right to change the terms of our Notice of Privacy Practices at any time and to make the new Notice provisions effective for all Protected Health Information that we maintain. If there is a change, we will notify you as soon as practicable by mail or hand delivery.

X. Documentation Requirements

The agency is required to retain copies of the notices it has issued for a minimum of six years. In addition, the agency must retain the patient's acknowledgment of receipt (or documentation of good faith attempts and reason for not receiving acknowledgment) for at least six years.

XI. Contact Information

Should you have any questions, concerns or issues relating to the topics covered in this Notice, we have established a specific contact person for you to contact. In addition, we have also designated a person to receive and properly handle any privacy coin plaints you have, including where you have in good faith believe that we have violated your privacy rights under the HIPAA Privacy Rules.

We have designated the following person for you to contact in the event you may have any questions, concerns or issues relating to the matters addressed in this Notice. The person we have designated to assist you is as follows:

Name/Title: JEMAIMA CASTRO Tel.: (909) 727-3200

In addition, we have designated the following person for you to contact to file complaints you may have on how we handle your Protected Health Information, including if you believe in good faith that we might have violated your privacy rights under the HIPAA Privacy Rules:

Name/Title: JEMAIMA CASTRO Tel.: (909) 727-3200

The person we have designated to receive, process and properly follow-up on you complaints is:

Name/Title: JEMAIMA CASTRO Tel.: (909) 727-3200

Advance Directives

What is an Advance Health Care Directive (AHCD)? An AHCD is a way to make your health care wishes known if you are unable to speak for yourself or prefer someone else to speak for you. An AHCD can serve one or both of these functions.

- Power of Attorney for Health Care (to appoint an agent)
- Instructions for Health Care (to indicate your wishes)

Is the AHCD different from a Durable Power of Attorney for Health Care?
The AHCD was enacted by July 2000 legislation and replaced the DPAHC and the Natural Death Act Declaration. However, if you had already completed one of these forms that were valid before July 1, 2000, it is still valid now. The only advance directive form that didn't change was the Pre-Hospital Do-Not-Resuscitate form.

"Pre-Hospital Do-Not-Resuscitate form?" Never heard of it! This special form allows persons to indicate that they do not way CPR started if something happens to them outside a hospital. Normally, emergency medical personnel are required to start CPR for all persons; having this form protects people from CPR if they choose to forego it. This is the only form that must be signed in advance by your doctor.

I've never completed an "advance health care directive" before. Why should I? Persons of all ages may unexpectedly be in a position where they cannot speak for themselves, such as an accident or severe illness. In these situations, having an "advance health care directive" assures that your doctor knows your wishes about the kind of care you want and/or who the person is that you want to make decisions on your behalf.

Does this mean only one person can decide for me? What if I want others involved, too? Often many family members are involved in decision-making. And most of the time, that works well. But occasionally, people will disagree about the best course of action, so it is usually best to name just one person as the agent (with a backup, if you want). And you can also indicate if there is someone who you do NOT want to make your decisions for you.

But I thought the doctors make all those life-and-death decisions anyway? Actually, doctors tell you about your medical condition, the different treatment options that are available to you and what may happen with each type of treatment. Though doctors provide guidance, the decision to have a treatment, refuse a treatment or stop a treatment is yours.

What if something happens to me and no form has been completed? If you are not able to speak for yourself, the doctor and health care team will turn to one or more family members or friends. The most appropriate decision-maker is the one with a close, caring relationship with you, is aware of your values and beliefs and is willing and able to make the needed decisions.

My "values and beliefs?" But I haven't talked with anyone about these! That's why it is a good idea to talk with family or close friends about the things that are important to you regarding quality of life and how you would want to spend your last days and weeks.

Knowing the things that are most important to you will help your loved ones make the best decisions possible on your behalf. If your agent doesn't know your wishes, then he or she will decide based on what is in your best interest.

What if I don't want to appoint an agent? Or don't have one to appoint? You do not have to appoint an agent. You can still complete the Instructions for Health Care and this will provide your doctors with information to guide your care.

What kinds of things can I write in my Instructions for Health Care? You can, if you wish, write your preferences about accepting or refusing life-sustaining treatment (like CPR, feeding tubes, breathing machine), receiving pain medication, making organ donations, indicating your main doctor for providing your care, or other things that express your wishes and values.

If I appoint an agent, what can that person do? Your agent will make all decisions for you, just like you would if you could. Your agent can choose your doctor and where you will receive your care, speak with your health care team, review your medical record and authorize its release, accept or refuse all medical treatments and make arrangements for you when you die. You should instruct your agent on these matters so he/she knows how to decide for you. The more you tell them the better they will be able to make those decisions on your behalf.

When does my agent make decisions for me? Usually the agent makes decisions only if you are unable to make them yourself – such as, if you've lost the ability to understand things or communicate clearly. However, if you want, your agent can speak on your behalf at any time, even when you are still capable of making your own decisions. You can also appoint a "temporary" agent – for example, if you suddenly become ill, you can tell your doctor if there is someone else you want to make decisions for you. This oral instruction is just as legal as a written one!

Are there other oral instructions that don't involve a written form? Yes. You can make an individual health care instruction orally to any person at any time and it is considered valid. All health care providers must document your wishes in your medical record. But it is often easier to follow your instructions if they are written down.

Can I make up my own form or use on from another state? Yes. That's why this law is so flexible. Any type of form is legal as long as it has at least three things: (1) your signature and date, (2) the signature of two qualified witnesses, and (3) if you reside in a skilled nursing facility, the signature of the patient advocate or ombudsman. These signatures, however, must include special wording.

Sounds difficult. Do I need an attorney to help with this? No. Completing an advance health care directive isn't difficult and an attorney is not necessary. But actually the most important part of this is talking to your loved ones. Without that conversation, the best form in the world may not be helpful!

OK, I'll talk to them! But what should I do with the form after I complete it? Make copies for all those who are close to you. Take one to your doctor to discuss and ask that it be included in your medical record. Photocopied forms are just as valid as the original. And be sure to keep a copy for yourself in a visible, easy-to-find location – not locked up in a drawer.

What if I change my mind? You can revoke your form (or your oral instructions) at any time. Also, it's a good idea to try and retrieve old forms and replace them with new ones.

Do doctors or hospitals require a patient to have an Advance Health Care Directive form? No, they cannot require you to complete one. But doctors and hospitals should have information available to you and your family about the form and your right to make health care decisions.

Resources: Check the California Coalition for **AVERY CARE HOSPICE,INC.** website for updates on advance heath care directive materials and community education programs at www.finalchoices.org.

Advance Health Care Directive Forms:

- Forms are often available at no charge from your local hospital – call the Social Services or Patient Education Department. Or ask your doctor.
- The California Medical Association has an Advance Health Care Directive Kit available in English or Spanish for $5 that includes a form, wallet card and answers to commonly asked questions about advance directives. To order single copies, call 1-800-882-1262 or visit www.cmanet.org.
- Five Wishes is user-friendly advance directive that addresses the medical, personal, emotional and spiritual wishes of seriously ill persons. To order single copies in English or Spanish at $5 each, send a check a money order to Aging With Dignity, PO Box 1661, Tallahassee, FL 32302-1661. A companion 30-minute video is available for $19.95. For more information call 1-888-5-WISHES.
- Caring Connections has state-specific forms that can be downloaded from its website at www.caringinfo.org.

Our hospice complies with the Patient Self-Determination Act of 1990 which requires us to:

- Provide you with written information describing your rights to make decisions about your medical care;
- Document advance directives prominently in your medical record and inform all staff;
- Comply with requirements of State law and court decisions with respect to advance directives; and
- Provide care to you regardless of whether or not you have executed an advance directive.

Unless the physician has written the specific order **"DO NOT RESUSCITATE,"** it is our policy that every patient will receive cardiopulmonary resuscitation (CPR). If you do not wish to be resuscitated, you, your family or your agent must request "Do Not Resuscitation" (DNR) orders from your physician. These orders are documented in your medical record and routinely reviewed; however, **you may revoke your consent to such an order at any time.**