1780 Town & Country Dr. Unit 106, Norco, CA 92860 www.Arborvitaehospice.com Tel: 951.735.3485 Fax: 951.735.0900

A: ELECTION OF HOSPICE BENEFIT INFORMED CONSENT

I request admission to **ARBOR VITAE HOSPICE CARE, INC.** ("Hospice") for the provision of hospice services. I understand and agree to the following:

1. I understand that the care provided by the Hospice program is palliative, not curative, in nature and is aimed at management of my symptoms and to help me attain a level of maximum comfort during my terminal illness. My right to management of pain and symptom control will be respected, supported and addressed appropriately.
2. I understand that my care will be provided by and/or under the direction of a hospice team composed of a physician, nurse, social worker, chaplain and other disciplines that may be deemed necessary. I may also request a volunteer.
3. I understand that my attending physician may collaborate with the hospice team to provide my care. He/she may also consult with the Hospice medical director, as necessary, for management of the symptoms associated with my terminal illness, such as discomfort, nutrition, etc.
4. I understand that Hospice services are designed to be delivered primarily in my residence and are available 24 hours a day, 7 days a week. However, if inpatient care is required for pain control, symptom management or respite purposes, Hospice will provide continuity of care through admission to a contracted inpatient facility.
5. I understand that room and board is the responsibility of the patient/family. Should I apply for Medi-Cal for nursing facility room and board I accept responsibility for participating fully in the application process.
6. I understand that Medicare/Medi-Cal/Champus Hospice program consists of two 90-day periods and unlimited 60 day periods if no revocations or discharges occur. I will use the benefit periods in the above order. However, I understand that if I have commercial insurance, my benefit periods may not be exactly the same as described above.
7. I understand that I can revoke this benefit at any time in writing and resume those insurance benefits which are waived during the period I am an **ARBOR VITAE HOSPICE CARE, INC.** patient. I understand that with revocation I will lose days remaining in the benefit period in which I revoke. I understand that I may at any time file a re-election of the hospice benefit, for any other election period that is still available to me.
8. I understand that I may change hospice providers only once in each benefit period. A change in hospice providers is not a revocation and I will not lose any benefit days. I understand that to change hospice programs, I must file this change in writing with **ARBOR VITAE HOSPICE CARE, INC.** and specify a date to discontinue care and the name of the hospice I wish to receive care and the date care will start.
9. I understand that if during the continued evaluation of the appropriateness of care, I no longer meet the criteria for hospice care, I will be discharged. I will be notified as soon as possible of the planned discharge from **ARBOR VITAE HOSPICE CARE, INC.**
10. I waive all rights to regular Medicare benefits for the duration of the election of hospice care for the following services.
    a. Hospice care provided by a hospice other than the ARBOR VITAE HOSPICE CARE, INC. (***unless provided under arrangements made by ARBOR VITAE HOSPICE CARE, INC.***);

b. Any Medicare services related to the terminal condition or that are equivalent to hospice care except:
   1. Services provided (either directly or under arrangement) by ARBOR VITAE HOSPICE, INC.;
   2. Services provided by another hospice under arrangements made by ARBOR VITAE HOSPICE, INC., or
   3. Services provided by the beneficiary's independent attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.

11. Hospice provides four levels of care: I understand that it is the professional hospice team which makes the determination when a level of care change is needed and which level of care is most appropriate. Hospice provides routine home care, general inpatient care, continuous care, and respite care.
    a. Routine home care is provided wherever the patient resides at home or in a nursing facility.
    b. Acute inpatient care is provided during periods of crisis in a hospice inpatient unit, or skilled nursing facility.
    c. Continuous care is provided during periods of crisis when a patient remains at home while acute symptoms are being resolved.
    d. Respite care is provided, in a skilled nursing facility for a period of 5 days when needed.
12. I understand that I may be responsible to **ARBOR VITAE HOSPICE CARE, INC.** for any balance of service charges over and above this insurance payment. I understand that I am fully responsible for all services rendered by **ARBOR VITAE HOSPICE CARE, INC.**, subject to the following:
    a. If I am eligible for Medicare or Medi-Cal hospice benefits, all costs will be paid under these programs and I will have no financial obligation.
    b. If I am not eligible for Medicare or Medi-Cal hospice benefits, but I have hospice benefits under a commercial medical insurance policy, I will be responsible for all or a portion of those costs not paid under the policy, i.e., deductibles, co-payments, and costs that exceed policy limits. The actual amount of these costs for which I am responsible will be determined based on a personal assessment of my finances and/or my family's finances.
    c. If I am not eligible for Medicare or Medi-Cal hospice benefits and I have no commercial insurance coverage, I will be responsible for all or a portion of the cost for hospice services based on a financial assessment to be performed on me and/or my family.
    d. I understand that admission to Hospice is not based upon my ability to pay, and Hospice will not discontinue or diminish care because of lack of insurance coverage for medically necessary hospice care.
    e. I understand that I may be financially responsible for any hospital care, emergency services or medical treatment related to the terminal illness, which is not arranged by **ARBOR VITAE HOSPICE CARE, INC.** and not included in the hospice Plan of Care.
    f. I understand that **ARBOR VITAE HOSPICE CARE, INC.** will pay for consultant physician bills that are related to the terminal illness, home health aide, and medically necessary durable medical equipment approved by the Hospice and medications related to terminal illness.
    g. I understand I may use Medicare/Medi-Cal/Champus in the usual manner to pay for:
       i. Attending physician charges if he/she is not a Hospice employee and/or
       ii. Treatment of condition(s) unrelated to the terminal illness for which I am receiving hospice care.

13. I understand that I have the right to formulate Advance Directives, but that I am not required to have an Advance Directive in order to receive services. I further understand that any Advance Directive I have executed will be followed by hospice and my caregivers to the extent permitted by law. I have executed the following:

	Durable Power of Attorney		Designation of Health Care Surrogate
	Living Will		I have not formulated Advance Directives at this time

14. If you have a complaint regarding the services you have received from **ARBOR VITAE HOSPICE CARE, INC.**, please contact the **Administrator or Director of Patient Care Services at 951-735-3485**. Our address is **1780 Town & Country Dr. Ste 106, Norco, CA 92860.** Additionally, you also have the right to file a complaint against **ARBOR VITAE HOSPICE CARE, INC.** by contacting the Department of Health Services office hours are M-F, 9am–5pm, except holidays at 1-909-388-7170. You may write to them at the following address: Department of Health Services (Riverside County) 625 E. Carnegie Drive, Suite 280, San Bernardino, CA 92408, (Orange County) 7575 Metropolitan Drive, Suite 104, San Diego, CA 92108. CHAP (Community Health Accreditation Program) 1-800-656-9656; 1300 19th Street N.W., Suite 150, Washington DC 20036.
15. I understand that **ARBOR VITAE HOSPICE CARE, INC.** may need to obtain medical records and related information from 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 **ARBOR VITAE HOSPICE CARE, INC.** and its representative's medical records and related information necessary to be helpful to the provision of hospice care. I also authorize **ARBOR VITAE HOSPICE CARE, 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 these authorizations specifically include my permission and consent to release any information regarding a diagnosis of AIDS or results of Human Immunodeficiency Virus (HIV) tests to the extend permitted by law. A photocopy of this authorization shall be as valid as the original.
16. My signature on this form acknowledges that I elect to receive hospice services from **ARBOR VITAE HOSPICE CARE, INC.** on the effective date below. The nature of my terminal illness and of hospice care, the palliative, rather than curative nature of the services provided by hospice, and the coverage provided through **ARBOR VITAE HOSPICE CARE, INC.** have been fully explained to me by **ARBOR VITAE HOSPICE CARE, INC.** I have been given the opportunity to discuss the services, requirements, and limitations of the hospice benefit; our questions regarding the hospice care have been answered to our satisfaction and we have been given a full understanding of hospice care. I have been provided a handbook containing the following written materials: Notice of Privacy Practices, Patient's Rights and Responsibilities and information regarding preparation of an Advance Directive.

1780 Town & Country Dr. Unit 106, Norco, CA 92860 www.Arborvitaehospice.com Tel: 951.735.3485 Fax: 951.735.0900

B: PATIENT RIGHTS

As an ARBOR VITAE HOSPICE CARE, INC. patient, you have the right to:

1. Be informed of your rights in a manner, which you understand.
2. Make informed decisions regarding proposed and ongoing care and services.
3. Choose whether or not to participate in research, investigational or experimental studies, or clinical trials.
4. Have your communication needs met.
5. Have complaints heard, reviewed, and if possible, resolved
6. Confidentiality of information, privacy and security
7. Be fully informed, as evidenced by your written acknowledgement or by that of your' appointed representative, of these rights and of all rules and regulations governing patient conduct, prior to or at time of admission.
8. To choose attending physician.
9. Be involved in the care planning process.
10. Be fully informed by a physician of your medical condition, unless medically contraindicated, and to be afforded the opportunity to participate in your medical treatment.
11. Formulate advance directives.
12. Have an appropriate assessment and management of pain.
13. Keep and use personal clothing and possessions.
14. An environment that preserves dignity and contributes to a positive self-image. Unlimited contact with visitors and others.
15. Be fully informed, prior to or at time of admission, of services available through ARBOR VITAE HOSPICE CARE, INC., and of related charges, including any charges for services not covered under Titles XVIII or XIX of the Social Security Act.
16. Refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.
17. Be advised of what hospice services are to be rendered and by what discipline, e.g., registered nurse, counselor, chaplain, etc.
18. Be advised in advance of any change in treatment, care, or services.
19. Be assured confidential treatment of personal and clinical records and to approve or refuse their release to any individual outside the hospice, except in the case of transfer to another health facility, or as required by law or third-party payment contract.
20. Be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs.
21. Not be subjected to exploitation, verbal, sexual or physical abuse of any kind, and to be informed that corporal punishment is prohibited.
22. Be informed by the licensee of the provisions of the law regarding complaints and procedures for registering complaints confidentially, including, but not limited to, the address and telephone number of the local District office of the Dept. of Health Services.
23. Be informed of the provisions of the law pertaining to advanced directives, including but not limited to living wills, power or attorney for health care, withdrawal or withholding of treatment and/or life support.
24. Be assured the personnel who provide care are qualified through education and experience to carry out the services for which they are responsible.
25. Be informed of any beneficial relationship between hospice and referring entities.

1780 Town & Country Dr. Unit 106, Norco, CA 92860 www.Arborvitaehospice.com Tel: 951.735.3485 Fax: 951.735.0900

C: PATIENT RESPONSIBILITIES

As an ARBOR VITAE HOSPICE CARE, INC. patient, you have the responsibility to:

1. Remain under a doctor's care while receiving hospice services.
2. Inform the hospice of advance directives or any changes in advance directives, and provide the hospice with a copy.
3. Cooperate with your primary doctor, hospice staff and other caregivers by providing information, asking questions and following instructions.
4. Advise the hospice of any problems or dissatisfaction you have with the care provided.
5. Notify the hospice of address or telephone number changes or when you are unable to keep appointments.
6. 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.
7. Obtain medications, supplies and equipment ordered by your physician if they cannot be obtained or supplied by the hospice.
8. Treat hospice personnel with respect and consideration.
9. Sign the required consents and releases for insurance billing, and provide insurance and financial records as requested.
10. Accept the consequences for any refusal of treatment or choice of non-compliance.
11. Advise the agency of any problem or dissatisfaction with our care, without being subject to discrimination or reprisal. The Hospice shall investigate all grievances; document the existence of the complaint and findings. Findings will be communicated to the patient/family.

D: HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY!

I. USE AND DISCLOSURE OF HEALTH INFORMATION

ARBOR VITAE HOSPICE CARE, INC. may use your health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996) for purposes of providing you treatment, obtaining payment for your care and conducting health care operations. The Hospice has established policies to guard against unnecessary disclosure of your health information.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH THE LAW PERMITS YOUR HEALTH INFORMATION TO BE USED AND DISCLOSED:

To Provide Treatment. The Hospice may use your health information to coordinate care within the Hospice and with others involved in your care, such as your attending physician, members of the Hospice interdisciplinary team and other health care professionals who have agreed to assist the Hospice in coordinating care. For example, physicians involved in your care will need information about your symptoms in order to prescribe appropriate medications. The Hospice also may disclose your health care information to individuals outside of the Hospice involved in your care including family members, caregivers, clergy who you have designated, pharmacists, suppliers of medical equipment or other health care professionals.

To Obtain Payment. The Hospice may use and disclose your health information to collect payment from third parties for the care you receive from the Hospice. For example, the Hospice may be required by your health insurer to provide information regarding your health care status so that the insurer will reimburse you or the Hospice. For this purpose, your health information may be used and disclosed on invoices, correspondence and other communications with your health insurer. The Hospice also may need to obtain prior approval from your insurer and may need to use and disclose health information to explain to the insurer your need for hospice care and the services that will be provided to you.

To Conduct Health Care Operations. The Hospice may use and disclose health information for its own operations in order to facilitate the function of the Hospice and as necessary to provide quality care to all of the Hospice's patients. Health care operations includes such activities as:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Protocol development, case management and care coordination.
- Contacting health care providers and patients with information about treatment alternatives and other related functions that do not include treatment.
- Professional review and performance evaluation.
- Training programs including those in which students, trainees or practitioners in health care learn under supervision.
- Training of non-health care professionals.
- Accreditation, certification, licensing or credentialing activities.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning related analyses and formulary development.
- Business management and general administrative activities of the Hospice.
- Fundraising for the benefit of the Hospice.

For example the Hospice may use your health information to evaluate its staff performance, combine your health information with other Hospice patients in evaluating how to more effectively serve all Hospice patients, disclose your health information to Hospice staff and contracted personnel for training purposes, use your health information to contact you as a reminder regarding a visit to you, or contact you as part of general fundraising and community information mailings (unless you tell us you do not want to be contacted).

For Appointment Reminders. The Hospice may use and disclose your health information to contact you as a reminder that you have an appointment for a visit.

For Treatment Alternatives. The Hospice may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY ALSO BE USED AND DISCLOSED WITHOUT YOUR PRIOR AUTHORIZATION OR CONSENT, UNLESS SUCH DISCLOSURE IS FURTHER RESTRICTED OR LIMITED BY CALIFORNIA LAW:

When Legally Required. The Hospice will disclose your health information when it is required to do so by any Federal, State or local law.

When There Are Risks to Public Health. The Hospice may disclose your health information for public activities and purposes in order to:

- Prevent or control disease, injury or disability, report disease, injury, vital events such as birth or death and the conduct of public health surveillance, investigations and interventions.
- Report adverse events, product defects, to track products or enable product recalls, repairs and replacements and to conduct post-marketing surveillance and compliance with requirements of the Food and Drug Administration.

- Notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease.
- Notify an employer about an individual who is a member of the workforce as legally required.

To Report Abuse, Neglect Or Domestic Violence. The Hospice is allowed to notify government authorities if the Hospice believes a patient is the victim of abuse, neglect or domestic violence. The Hospice will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

To Conduct Health Oversight Activities. The Hospice may disclose your health information to a health oversight hospice for activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The Hospice, however, may not disclose your health information if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

In Connection With Judicial And Administrative Proceedings. The Hospice may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Hospice makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purposes. As permitted or required by State law, the Hospice may disclose your health information to a law enforcement official for certain law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries pursuant to the court order, warrant, subpoena or summons or similar process.
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
- Under certain limited circumstances, when you are the victim of a crime.
- To a law enforcement official if the Hospice has a suspicion that your death was the result of criminal conduct including criminal conduct at the Hospice.
- In an emergency in order to report a crime.

To Coroners And Medical Examiners. The Hospice may disclose your health information to coroners and medical examiners for purposes of determining your cause of death or for other duties, as authorized by law.

To Funeral Directors. The Hospice may disclose your health information to funeral directors consistent with applicable law and if necessary, to carry out their duties with respect to your funeral arrangements. If necessary to carry out their duties, the Hospice may disclose your health information prior to and in reasonable anticipation of your death.

For Organ, Eye Or Tissue Donation. The Hospice may use or disclose your health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs, eyes or tissue for the purpose of facilitating the donation and transplantation.

For Research Purposes. The Hospice may, under very select circumstances, use your health information for research. Before the Hospice discloses any of your health information for such research purposes, the project will be subject to an extensive approval process.

In the Event of A Serious Threat To Health Or Safety. The Hospice may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Hospice, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Specified Government Functions. In certain circumstances, the Federal regulations authorize the Hospice to use or disclose your health information to facilitate specified government functions relating to military and veterans, national security and intelligence activities, protective services for the President and others, medical suitability determinations and inmates and law enforcement custody.

For Worker's Compensation. The Hospice may release your health information for worker's compensation or similar programs.

THE FOLLOWING IS A SUMMARY STATEMENT OF THE CIRCUMSTANCES UNDER WHICH YOUR AUTHORIZATION IS NEEDED TO USE OR DISCLOSE HEALTH INFORMATION:

Except as described and stated above, the Hospice will not disclose your health information other than with your written authorization. If you or your representative authorizes the Hospice to use or disclose your health information, you may revoke that authorization in writing at any time.

II. YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that the Hospice maintains:

Right to request restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Hospice's disclosure of your health information to someone who is involved in your care or the payment of your care. However, the Hospice is not required to agree to your request. If you wish to make a request for restrictions, please contact Hospice Privacy Officer.

Right to receive confidential communications. You have the right to request that the Hospice communicate with you in a certain way. For example, you may ask that the Hospice only conduct communications pertaining to your health information with you privately with no other family members present. If you wish to receive confidential communications, please contact Hospice Privacy Officer. The Hospice will not request that you provide any reasons for your request and will attempt to honor your reasonable requests for confidential communications.

Right to inspect and copy your health information. You have the right to inspect and copy your health information, including billing records. A request to inspect and copy records containing your health information may be made to Hospice Privacy Officer. If you request a copy of your health information, the Hospice may charge a reasonable fee for copying and assembling costs associated with your request.

Right to amend health care information. You or your representative have the right to request that the Hospice amend your records, if you believe that your health information is incorrect or incomplete. That request may be made as long as the information is maintained by the Hospice. A request for an amendment of records must be made in writing to Hospice Privacy Officer. The Hospice may deny the request if it is not in writing or does not include a reason for the amendment. The request also may be denied if your health information records were not created by the Hospice, if the records you are requesting are not part of the Hospice's records, if the health information you wish to amend is not part of the health information you or your representative are permitted to inspect and copy, or if, in the opinion of the Hospice, the records containing your health information are accurate and complete.

- **Right to an accounting**. You or your representative have the right to request an accounting of disclosures of your health information made by the Hospice for certain reasons, including reasons related to public purposes authorized by law and certain research. The request for an accounting must be made in writing to Hospice Privacy Officer. The request should specify the time period for the accounting starting on or after April 14, 2003. Accounting requests may not be made for periods of time in excess of six (6) years. The Hospice would provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

Right to a paper copy of this notice. You or your representative have a right to a separate paper copy of this Notice at any time even if you or your representative have received this Notice previously. To obtain a separate paper copy, please contact Hospice Privacy Officer (951) 735-3485.

III. DUTIES OF THE HOSPICE

The Hospice is required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of its duties and privacy practices. The Hospice is required to abide by the terms of this Notice as may be amended from time to time. The Hospice reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all health information that it maintains. If the Hospice changes its Notice, the Hospice will provide a copy of the revised Notice to you or your appointed representative. You or your personal representative have the right to express complaints to the Hospice and to the Secretary of DHHS if you or your representative believe that your privacy rights have been violated. Any complaints to the Hospice should be made in writing to Hospice. The Hospice encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

1780 Town & Country Dr. Unit 106, Norco, CA 92860 www.Arborvitaehospice.com Tel: 951.735.3485 Fax: 951.735.0900

IV. CONTACT PERSON

The Hospice has designated a Privacy Officer as its contact person for all issues regarding patient privacy and your rights under the Federal privacy standards. You may contact the Privacy Officer at Hospice.

IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE, PLEASE CONTACT:

Privacy Officer: Cesar Coruna, RN

E: ACKNOWLEDGEMENT AND CONSENT FOR USE OF COMFORT PACK

1. The "comfort pack" contains emergency medications that may be necessary to manage a patient's pain or other uncomfortable symptoms that may be experienced at the end of one's life.

2. Appropriate use of Morphine, Levsin, Lorazepam, Bisacodyl, Haloperidol, and Acetaminophen generally yields significant symptom improvement without causing dangerous adverse effects and certainly without hastening death.

3. Having immediate access to these medications allows for prompt relief of symptoms, improved quality of life, reduced hospitalizations, and greater control for patient and family.

4. This medication Instruction form is provided to each family member and/or Facility Staff member to ensure optimal safety in the handling, storage and/or destruction of all unused Hospice patient medications.

I understand that the "comfort pack" contains medications used only when needed to relieve symptoms. I hereby authorize the Hospice Nurse, my family members, and Licensed Staff to administer the Comfort Pack as directed by Attending Physician or by a Hospice Physician.

F: ACKNOWLEDGEMENT RECEIPT OF PATIENT HANDBOOK

I acknowledge that I and my family / caregiver received from Arbor Vitae Hospice Care, Inc. staff an education about hospice care, to obtain comfort and palliation of the disease and to preserve the dignity of a person who has terminal illness. This also consists of, but not limited to, the following: Statement of Patient Privacy Rights, Non-Discrimination Policy, Confidentiality of Client Information, Patient's Rights, Complaint Grievance Process, Preparing for Events, Basic Home Instructions, Infection Control at Home, Preparing for Events and Approaching Death, Home Use and Disposal of Controlled Substances, Advance Directives, and Safe/Effective Use of Medications.

I accepted the Patient Handbook with good understanding that the contents could help us get educated of our Rights and Responsibilities in order to work with Arbor Vitae Hospice Care, Inc. to obtain what we are hoping for and will gain benefits in accepting Arbor Vitae Hospice Care, Inc. services.

1780 Town & Country Dr. Unit 106, Norco, CA 92860 www.Arborvitaehospice.com Tel: 951.735.3485 Fax: 951.735.0900

G: PHYSICIAN RIGHTS AND RESPONSIBILITIES

PHYSICIAN RIGHTS

The physician has the right to:

A. Be an active participant in the development of the plan of care in the provision of hospice orders.
B. Be provided with timely information regarding his/her patient. Notification and contact will occur with, but will not be limited to, the following:
   1. *Changes in the patient's condition*
   2. *Changes in the patient's psychosocial status*
   3. *Changes in the patient's home environment*
   4. *Lack of achievement of goals within the defined time frame*
   5. *Changes and/or lack of patient response to hospice care*
   6. *Changes needed regarding diagnoses, treatments, medications, precautions, and limitations*
C. Have hospice personnel available to respond to questions regarding patients. When the Case Manager is not available, another clinician familiar with the patient will answer questions.
D. Information to assist in continuity of care, including ongoing updates, written summaries at a minimum every month, and phone consultation.
E. Refer patients to specialty physicians for exacerbation of the patient's terminal illness after consultation with hospice Medical Director, and make appropriate referrals to other organizations for supportive services.
F. Confidentiality of information and communication to the physician by hospice personnel.
G. Legible, complete, and accurate information regarding the patient.
H. Participate in the consideration and resolution of ethical issues related to hospice patients.

PHYSICIAN RESPONSIBILITIES

The physician has a responsibility to:

A. Be an active participant in the development of the plan of care and the comprehensive interdisciplinary group plan of care in the provision of hospice orders.
B. Provide hospice with timely information regarding his/her patient. Notification and contact will occur when there are changes that the hospice may not be aware of, including, but not limited to:
   1. *Changes in the patient's condition*
   2. *Changes in the patient's psychosocial status*
   3. *Changes in the patient's home environment*
   4. *Lack of achievement of goals within the defined time frame*
   5. *Changes and/or lack of patient response to hospice care*
   6. *Changes needed regarding diagnoses, treatments, medications, precautions, and limitations*
C. Be available to respond to questions regarding patients. When the attending physician is not available, another physician who is familiar with the patient will be designated as the alternate coverage.
D. Provide legible, complete, and accurate information, including treatment orders for his/her patient.
E. For non-benefit patients, designate the hospital the patient should be sent to; agree to admit patient to designated hospice-contracted facilities for Medicare/Medicaid/Private Hospice Program beneficiaries, for alternate medical coverage, and for consultative referrals that relate to the patient's terminal illness.
F. Sign and return hospice orders and other required documentation within the time frame specified in organization policy and in accordance with applicable law and regulation.
G. Participate in the consideration and resolution of ethical issues related to hospice patients.

1780 Town & Country Dr. Unit 106, Norco, CA 92860 www.Arborvitaehospice.com Tel: 951.735.3485 Fax: 951.735.0900

As a Medicare Part A or Medi-Cal beneficiary, I hereby elect ARBOR VITAE HOSPICE CARE, INC. as my sole provider of hospice care effective:	Date (mm/dd/yy)
(Note: These are also found on Patient Handbook)	**Patient or Legal Guardian Initials**
A: Election of Hospice Benefit Informed Consent – *page 1*	
B: Patient Rights – *page 4*	
C: Patient Responsibilities – *page 5*	
D: HIPAA Notice of Privacy Practices – *page 5*	
E: Acknowledgement and Consent for Use of Comfort Pack – *page 9*	
F: Acknowledgment Receipt of Patient Handbook – *page 9*	
G: Physician Rights and Responsibilities – *page 10*	

The physician I have chosen to serve as my attending physician is:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

If patient is unable to sign, please state reason:

_____

_____

_____ _____

Patient Name MR #

_____ _____

Signature of Patient or Legal Guardian/Health Care Surrogate Date

_____ _____

Name and Address of Legal Guardian/Health Care Surrogate Date

_____ _____

ARBOR VITAE HOSPICE CARE, INC. Representative Date