Jefferson Healthcare Hospice
Financial Consent

Patient Name (First, Last)_____ Date_____

I, _____, herby authorize payment from my insurance benefit to be paid directly to Hospice of Jefferson County. I understand hospice care is a choice I am making and that my care will be provided by Hospice of Jefferson County staff and their contracted vendors and facilities.

I understand that hospice only pays for services, equipment, medication, and supplies that are related to the terminal prognosis and included in the individualized plan of care. I understand that I am financially responsible for services, equipment, medication, and supplies related to the terminal illness that I might seek beyond what is considered medically necessary, not pre-authorized by hospice and /or outside the plan of care regardless of whether the services are palliative or curative in nature. Hospice of Jefferson County is not responsible for any care not approved by the hospice team.

I understand Medicare/Medicaid will continue to make payment to the independent attending physician for services if the physician is neither a hospice employee nor receiving payment for Hospice of Jefferson County services. I understand that the Medicare Hospice benefit takes the place of Medicare Part A or the Medicare HMO plan for treatment of the terminal illness and I waive my rights to Medicare benefits related to the terminal illness while enrolled in hospice.

I understand that under routine care Hospice of Jefferson County does not pay for room and board in a skilled nursing facility. Ambulance services must be pre-authorized by Hospice of Jefferson County to be covered under the hospice benefit.

I acknowledge that the Medicare/Medicaid hospice benefit and private health insurance reimbursable charges for hospice care have been explained to me and I understand the services offered. I have been given the opportunity to discuss any financial concerns I may have. I understand that consideration for admission to the program will be given regardless of ability to pay.

Patient Signature: _____ Date/Time: _____

If patient is unable to sign:

Legal Decision Maker Signature: _____ Date/Time: _____

Print Name: _____ Relationship: _____

Reason patient is unable to sign: _____

I have explained the hospice program and answered all related questions asked by the patient or the legal decision maker on behalf of the patient.

Hospice of Jefferson County
Representative Signature: _____ Date/Time: _____