THE JEWISH HOME
CENTER FOR
PALLIATIVE MEDICINE
A program of the
Los Angeles Jewish Home

Consent for Palliative Care Medical Services, Financial Agreement and Advance Directives

Medical Consent: The undersigned hereby consents to and authorizes any medical treatment, examination, laboratory procedure, x-ray examination, taking of medical photographs, or other medical services that may be considered advisable or necessary for the patient in the judgment of the consulting physicians and nurse practitioners.

Financial Agreement: The undersigned agrees, whether signing as a patient or as a legally authorized representative, that in consideration of the services to be rendered to patient, the undersigned shall have the obligation to pay the account of the patient with Jewish Home Center for Palliative Medicine (The Center) of the Los Angeles Jewish home in accordance with the regular rates and terms of The Center in effect from time to time. Such account shall be due and payable at the time of the completion of services unless other arrangements are proved for in writing by The Center, which shall have sole discretion whether to approve other payment arrangements.

Release of Information: The Center may disclose all or any part of the patient's record to any person or corporation which is or may be liable under a contract to The Center or to the patient or to a family member or the employer of the patient for all or part of The Center charges, including, but not limited to, medical service companies, insurance companies, Workmen's Compensation carriers, welfare funds or the patient's employer. All such information would be available after a written request and the approval of the physician or nurse practitioner providing care to the patient.

Release of Medical Records: I understand The Center 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 for services. I authorize the above persons and entities to release to The Center and its representative's medical records and related information necessary for the provision of hospice care. I also authorize The Center 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 extent permitted by law. A photocopy of this authorization shall be as valid as the original.

Medicare: The undersigned certifies that the information given in applying for payment under Title XVIII and Title XIX of the Social Security act is correct. The undersigned authorizes any holder of medical or other information about the patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or any related medical claim. The undersigned requests that payment of authorized benefits be made on the patient's behalf.

Insurance Assignment: the undersigned hereby authorizes payment directly to The Center of any benefits payable to the patient including disability insurance and payment under Title XVIII or Title XIX of the Social Security Act which is applicable to the patient's account, but not to exceed the regular charges of The Center. The undersigned understands that the undersigned individuals are financially responsible to The Center for charges not covered by the patient's medical plan.

Release for Future Contact: The undersigned hereby authorizes The Center staff to contact the patient subsequent to the present visit for information relating to the patient's medical condition or any change in the patient's medical condition.

Consent for Palliative Care Medical Services, Financial Agreement and Advance Directives (continued)

ADVANCE DIRECTIVES

I have been provided the following information regarding advance directives.

- ☐ I have the right to formulate an Advance Directive.
- ☐ I am not required to have an Advance Directive in order to receive medical treatment by any healthcare provider.
- ☐ The terms of any Advance Direcive that I have executed and disclosed to The Center will be followed to the extent permitted by law.

☐ **The patient has an Advance Directive:** **Name and Address of Agent:**

☐ Power of Attorney for Health Care _____

☐ Living Will _____

☐ POLST (Physician Orders for Life Sustaining Treatment)_____

Copy received: ☐ Yes ☐ No

☐ **The patient does not have an Advance Directive.**

ACKNOWLEDGEMENT

I acknowledge I have received a copy of the Palliative Medicine Patient Information handbook which includes a detailed listing of patient rights and responsibilities and notice of privacy practices. The undersigned certify that they have read the foregoing and/or the patient, or duly authorized by the patient as patient's legally authorized representative to execute the above and accepts its terms:

_____ _____

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)

PALLIATIVE CARE
REPRESENTATIVE:_____

PATIENT:_____MR#:_____