TRI CITY HOSPICE INC.

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Release of Information & Consent for Treatment

1. PATIENT SELF DETERMINATION ACT AND BILL OF RIGHTS

I have received a written statement of my rights as a patient of TRI CITY HOSPICE INC. I understand my rights because they have been explained to me and my questions have been answered. I have received written and verbal information about advance directives. company policies, applicable state law, my rights state law, the state hot line number, and other information necessary to make decisions about advance directives and my care in accordance with the Patient Self Determination Act of 1990.

2. RELEASE OF INFORMATION I consent to the release of information by my Physician, Licensed Health Care Professionals, or Facility, and to allow the disclosure of medical

records kept by the above to TRI CITY HOSPICE INC. I consent to the release of information by TRI CITY HOSPICE INC. or their representative to representatives of other health providers involved in my care and to third party payers in order to secure continuity to treatment; proper communication of information to my physician(s) and referral source; and proper reimbursement of services.

3 CONSENT FOR TREATMENT

I voluntarily consent to receive treatment from TRI CITY HOSPICE INC., consistent with a medical treatment plan authorized by my physician.

I understand that if I am in such condition as to need services not provided by TRI CITY HOSPICE INC. my legal representative, or I, or my Physician must arrange such services. TRI CITY HOSPICE INC. will assist in locating such services, but shall no way be responsible for failure to provide the same and is hereby released from many and all liability arising from the fact that I am not provided with such additional care. In the event a health care worker sustains exposure to my blood or body fluids. I give permission for my blood to be tested for infectious diseases such as HIV and Hepatitis. I understand that I will not be billed for any lab fees incurred should an employee sustain exposure to my blood.

4. PAYMENT AUTHORIZED AND ASSIGNMENT OF BENEFITS

I hereby authorize my insurance company to make payment directly TM CITY HOSPICE INC. for authorized services provided. in consideration TRI CITY HOSPICE INC. agreement to forego collection of my account for a reasonable period of time. I hereby assign to TRI CITY HOSPICE INC. or its legal representative, all of my rights, including the right to use on my behalf or name, under policy # , issued by to recover charges for services rendered TRI CITY HOSPICE INC. This assignment shall not extinguish or diminish my obligation to pay the full fee to TRI CITY HOSPICE INC. for services rendered, but I shall receive credit for all sums collected pursuant to this agreement. If I enroll in another insurance plan it is my responsibility to notify

TRI CITY HOSPICE INC. otherwise I will be responsible for payment. I understand that my insurance has agreed to pay _______________ of allowable charges and that my secondary insurance (if applicable) will be billed for _______________ % I understand that I am responsible for __________% of allowable charges after my deductible has been met

5. MEDICARE (PART A & B)

I certify that the information given by me in applying for payment under Title XVIII (Medicare) of the Social Security Act is correct. I authorize any holder of medical, or other information about me, to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or related Medicare claim. I request that payment of authorized benefits be made to TRI CITY HOSPICE INC. on my behalf. Services under Medicare part A and Medicaid Medical Assistance are covered at 100%, therefore no co-payment is necessary. I will be notified of any changes in the amount of charges for items and services as soon as possible, but no later than thirty (30) days from the date TRI CITY HOSPICE INC. is aware of the change.

6. PROGRAM GOALS

We understand that hospice care is palliative, not curative, in its goals and techniques, that the program emphasizes controlling physical symptoms, including pain. and meeting emotional and spiritual needs of patient and family in dealing with the illness for which patient is admitted.

7. HOSPICE SERVICES, INCLUDING IN PATIENT SERVICES We understand that following services are available both on scheduled basis and as needed. We understand that these services may include, as set forth

in the hospice plan of care; nursing, physician care, social work, chaplaincy, counseling, home health aides/.homemaker, medical supplies. dietary counseling, physical therapy, occupational and speech language therapy, and medications prescribed for relief of pain and discomfort.

In Patient Care will be provided by TRI CITY HOSPICE INC. for pain control, symptom management, and management of psycho-social problems related to my terminal illness. I understand that this care will be provided at a facility contracted with TRI CITY HOSPICE INC.

Respite Care will be prey TM CITY HOSPICE INC. in a Skilled Nursing Facility, for up to five (5) days at a time, per certification period.

Continuous Care will be provided for crises situations that may occur, and which would require private duty care that some hospice services may require procedures performed in a hospital outpatient setting, and that TRI CITY HOSPICE INC. will arrange for these services as needed.

Hospitalization may be required *for* certain procedures or care. and these will be arranged through a contracted facility of the hospice.

(Return to Office)

PATIENT NAME:____ **DATE:**________________

SIGNATURE: __

HOSPICE REPRESENTATIVE: ______________________________________