ADVANCE DIRECTIVE
ACKNOWLEDGEMENT

PATIENT NAME: PARVIN, MARY JEAN

MEDICAL RECORD NO: M053082

ACCOUNT NUMBER: V023912512

DATE OF BIRTH: 03/16/43

PLEASE READ THE FOLLOWING FOUR STATEMENTS.

Place your initials after <u>each</u> statement.

1. I have been given written materials about my right to accept or refuse medical treatments. MP (Initialed)
2. I have been informed of my rights to formulate Advance Directives. MP (Initialed)
3. I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility. MP (initialed)
4. I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my care givers to the extent permitted by law. MP (Initialed)

PLEASE CHECK <u>ONE</u> OF THE FOLLOWING STATEMENTS:

- ☒ **I HAVE** executed an Advance Directive.
- ☐ **I HAVE NOT** executed an Advance Directive.
- ☐ **I REQUEST ADDITIONAL INFORMATION** or a referral for assistance to execute an Advance Directive
- ☐ I have provided a copy of my Healthcare Directive for the medical chart.
- ☐ Scanned: Date: _____

MP Mary Jean Parvin
PATIENT OR REPRESENTATIVE SIGNATURE

9/5/2012
DATE

Suzie Roza
WITNESS

9/5/2012
DATE

FOR OFFICIAL USE ONLY
☐ REFERRAL MADE
TO:

Lodi Memorial Hospital

975 S. Fairmont Ave. * P.O. Box 3004 * Lodi, California 95240 * (209)334-3411

Patient Name: PARVIN, MARY JEAN
Patient ID Number: V023912512 M053082
Physician: Freund, Edmund MD-Mills Freu

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
OMB Approval No. 0938-0692

AN IMPORTANT MESSAGE FROM MEDICARE ABOUT YOUR RIGHTS

AS A HOSPITAL INPATIENT, YOU HAVE THE RIGHT TO:

- Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
- Be involved in any decisions about your hospital stay, and know who will pay for it.
- Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (HSAG) listed here Health Services Advisory Group 1-800-841-1602.

YOUR MEDICARE DISCHARGE RIGHTS

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

If you think you are being discharged too soon:

- You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.
- You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (HSAG). Health Services Advisory Group is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.
    - **If you want to appeal, you must contact the HSAG no later than your planned discharge date and before you leave the hospital.**
    - If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.
- **Step by step instructions for calling HSAG and filing an appeal are on page 2.**

To speak with someone at the hospital about this notice, call the Utilization Management Department 1-800-323-3360 ext 7564.

Please sign and date here to show you received this notice and understand your rights.

Mary Jean Parvin
Signature of Patient or Representative

9/5/2012
Date

Delivery of discharge notice:

Date

CMS-R-193 (approved 05/07)

10. PERSONAL VALUABLES

it is understood and agreed that the hospital maintains a safe for the safekeeping of money and valuables, and the hospital shall not be liable for the loss or damage to any money, jewelry, dentures,. clothes, glasses, hearing aides, etc. unless deposited with in the hospital for safekeeping. The liability of the hospital for loss of any personal property which is deposited with the hospital for safekeeping is limited by California Civil Code Section 1860 to $500, unless a written receipt for a greater amount has been obtained from the hospital by the patient. Initial [MJP]

MEDICARE PATIENT'S CERTIFICATION, Authorization to Release Information, and Payment Request. I certify that the information given by me in applying for payment under Title XVII 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 and/or the Medicare Program or its intermediaries or carriers or to the Professional Standards Review Organization any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

Medicare Patients - If your physician is admitting you to the hospital for "Observation" it will be considered an outpatient service and will be paid by Medicare as an outpatient (Part B) service.

I have received the ***"Smoking Cessation"*** brochure. This facility is ***"Smoke Free, no smoking allowed."***
I have received the ***"Admissions and Payment Guide"*** brochure.
I have received ***"Your Right to Make Decisions about Medical Treatment"*** brochure.
I have received ***"An Important Message from Medicare"*** and understand my rights as outlined in this document.
I have received the ***"Notice of Privacy Practices"*** brochure.
I have received the "***Patient Rights"*** document and have verified my personal information.

I have been actively encouraged on how to report concerns related to care, treatment, services, and patient safety issues by calling the Quality Services Response Line (209 339-7400) as well as directly reporting to the Hospital Administration (209 339-7560), the California Department of Public Health Services (916 558-1784) or the Joint Commission hotline at (800-944-6010).

By signing below the patient and/or responsible party indicate that they have read the agreement, clarified any doubts as to its meaning and consent to be legally bound by all of its terms and implementation and have received a copy.

Mary Jean Parvin — *PATIENT/PARENT/GUARDIAN/CONSERVATOR*

Susie Loza 9/5/2012 12:35 — *WITNESS* *DATE* *TIME*

IF OTHER THAT PATIENT, INDICATE RELATIONSHIP

Financial Responsibility Agreement by Person Other than the Patient, or the Patient's Legal Representative: I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement, and Assignment of Insurance Benefits.

PARENT/GUARDIAN/CONSERVATOR

I, the undersigned am requesting a private room with full knowledge that I am responsible for charges not covered by my medical insurance.

PATIENT/PARENT/GUARDIAN/CONSERVATOR

Mary ER
5-5-12

discharged
5-9-12
home