

# TIDEWELL CONNECT ELECTION FORM

(PLEASE PRINT)

<b>PATIENT NAME:</b>	<b>PATIENT NUMBER:</b>
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## I, choose to receive care by Tidewell Hospice.

I acknowledge the following:

1. Supportive palliative care, rather than curative care, is provided by Tidewell. Tidewell's goal is to reduce pain and other symptoms and to provide emotional and spiritual support.
2. By choosing to participate in Tidewell Connect you will not forfeit payment for other Medicare coverage.
  - a. Medicare or other designated payor source will pay your attending physician as they always have.
  - b. Your current Medicare benefits will be unaffected by participation in Tidewell Connect.
  - c. Visits made by Tidewell staff are included in the daily fee rate and are the responsibility of the patient/legal representative as established through a sliding fee schedule.
3. You can choose not to continue Tidewell care at any time by completing a Discharge Request Form.
4. To transfer to another hospice Medicare program, you must first confirm availability of service and acceptance. Tidewell Hospice must be notified of your wishes to allow for coordination of the transfer.

I hereby authorize the release of information and appropriate medical records to or from any hospice, skilled nursing facility, hospital, home health agency or private physician. I also authorize release of pertinent medical information to any source of third party reimbursement.

Acknowledging the above, I authorize Tidewell Hospice services to begin on

\_\_\_\_\_  
(MONTH/DAY/YEAR)

\_\_\_\_\_  
Date                      Patient or Legal Representative Signature                      Relationship

\_\_\_\_\_  
Date                      Primary Caregiver Signature                      Relationship

\_\_\_\_\_  
Date                      Witness Signature                      Relationship

If patient is unable to sign, state reason: \_\_\_\_\_