BROADVIEW
CHRISTIAN SCIENCE CARE
COMFORT • PROGRESS • HEALING

4570 Griffin Ave.
Los Angeles, CA 90031
Ph: (323) 221-9174
www.csbroadview.org

Patient Statement of Understanding

Progress Review Acknowledgement

By signing below, I understand that the Director of Christian Science Nursing will talk with me periodically about my commitment to healing and my goal of returning home. I understand that Broadview and its staff share the desire to witness healing. I further understand that Broadview is not a place for long-term care.

Patient's Affirmation of Desire for Christian Science Nursing Care

I hereby represent that I have freely and voluntarily elected to use Christian Science treatment for health care in expectancy of healing.
By signing below, I affirm, or reaffirm, that:

- I am receiving daily prayerful Christian Science treatment from a Christian Science Journal- listed practitioner.
- As part of such treatment, I am dedicated to my own metaphysical study and prayer as taught by the religion of Christian Science.
- I am relying exclusively on Christian Science treatment for healing.
- I do not use drugs, liquor, or tobacco of any kind.
- I do not currently use any medical equipment or devices.
- I do not currently use any additional medical remedy drugs, herbal remedies, vitamins or nutritional supplements.

Statement of Understanding for Christian Science Nursing Care

By signing below:

I acknowledge that Broadview, Inc. ("Broadview") provides Christian Science nursing care and that such care is intended to be entirely consistent with Christian Science prayerful treatment exclusively. Broadview's care is provided by or under the supervision of a Christian Science Nurse listed in the Christian Science Journal.

I understand and acknowledge the following:

Christian Science Nursing Care Provided at Broadview Does Not Include:

- Making a medical diagnosis or prognosis;
- Recording of either symptoms or conditions;
- Emergency medical procedures;

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- Medical treatment or recording of the effect of medical treatment;
- Administering medication, drugs or using medicated, herbal, or vitamin-based products and remedies;
- Intravenous or force-feeding;
- Using or administering medically-oriented techniques, equipment or technology;
- Physical therapy, massage or manipulation.

Broadview Will Not:

- Offer advice, assume responsibility or take any other role in my health-care decisions;
- Assume responsibility for my financial or household business transactions;
- Intrude on my private relationship with my Christian Science practitioner or my health-care agent.

I Represent That:

- I understand the special nature of Christian Science treatment for health care and the importance of my continuous cooperation and voluntary support thereof;
- I understand that I may terminate the services of Broadview at any time without penalty or prior notice;
- I will notify Broadview immediately if I elect to use any other type of health-care;
- I will notify Broadview immediately if I elect to change Christian Science practitioners.

I Further Acknowledge That Broadview Will:

- Rely on these acknowledgements and representations; and
- Terminate their service if I select any other type of health care or treatment that Broadview's representatives believe to be inconsistent with Christian Science treatment.

I understand that Broadview (and its Christian Science nurses, employees, trustees, and agents) have a duty to provide care that is consistent with this Statement, with Christian Science Nursing Care and Christian Science Treatment.

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I promise to hold Broadview, its Christian Science nurses, employees, trustees and agents harmless from any claims that may arise regarding methods of patient care, that are inconsistent with the foregoing paragraph.

Patient Name _____

Patient Signature _____ Date _____

For minors and Persons Unable to Sign this Statement:

The undersigned represent(s) that: 1) he/she/they are all persons with authority to make health-care decisions for the above-listed patient; and 2) the undersigned make(s) the same acknowledgements, representations and promise as set forth above. Parents of a minor child additionally acknowledge that Broadview will not attend to their child until both parents sign this statement.

_____ Signature

_____ Print Name

_____ Signature

_____ Print Name

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APPLICATION FOR ADMISSION

Please answer every question. Write "unknown" if the answer is unknown.

Please check: Date of Inquiry: _____

Date of Admission: _____

Name of Patient *(Mr., Mrs., Miss, Ms.)* _____
(Print in full. Please use own first name)

Address _____
(Including apartment number)

City _____ **State** _____ **Zip** _____

Phone _____ **E-mail Address** _____

Birthdate _____ **Birthplace** _____

Social Security # _____ **Medicare Card #** _____

Father _____ **Birthplace** _____
(*Patient's Father's Name)* *(Father's Birthplace)*

Mother _____ **Birthplace** _____
(*Patient's Mother's Maiden Name)* *(Mother's Birthplace)*

Practitioner Name _____ **Phone** _____

E-mail Address _____

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For Payment, Please Send Bills To:

Name _____

Address _____

City _____ **State** _____ **Zip** _____

Home Phone _____ **Business Phone** _____

Cell Phone _____ **Fax #** _____

E-mail Address _____

While I am here at Broadview, please bring my bills to my room: ☐ Yes ☐ No

Payment and Financial Information:

Do you wish information about financial assistance? ☐ Yes ☐ No

I Understand That Broadview's Current Charges Are:

- *CSNC = $800/day*
- *CSC = $500/day*

I Intend To Pay For Care At Broadview: *(Check all that apply)*

☐ Medicare ☐ Insurance* ☐ Self Pay ☐ Other *(please specify below)*

**If insurance is checked, a copy of the health care policy must be provided.*

If The Medicare option Is Checked Above, Please Answer The Following:

1. Have you voluntarily received medical care not required under Federal, State or local laws? ☐ Yes ☐ No
2. Have you voluntarily revoked a RNHCI election and notified CMS in writing? ☐ Yes ☐ No
3. Has an election been made and revoked in the past? ☐ Yes ☐ No
4. If an election has been revoked, how many times and when was the last revocation?_____
5. Dates of most recent hospital/nursing home stay *(if applicable)* _____

I Understand that A "Minimum Care Deposit" Is Due, amount indicated and payment method to be selected On the Payment Options Form Enclosed In This Packet.

Please confirm *Patient's Objective:*

☐ *I desire to be healed and return to my home.*

Signature _____ Date _____

By _____ Relationship _____

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HIPAA PRIVACY NOTICE

At Broadview, the confidentiality of all information concerning patients is of the utmost importance. The ethical standards upheld by Christian Science nurses and other staff come from the teachings of Christian Science with its emphasis on the confidential relationship between the Christian Science nurse and patient, and the Christian Science practitioner and patient. Maintaining this confidentiality for your protection is now a federal law known as HIPAA (Health Insurance Portability and Accountability Act of 1996, effective April 14, 2006). This law requires that all organizations such as ours protect the privacy of patients in a variety of ways. Broadview, Inc. adheres to the letter and spirit of this law.

1. I understand that the use or disclosure of my protected health information (PHI) by Broadview will be only for the purpose of providing Christian Science nursing care to me, obtaining payment for my care bills, and running the organization. (PHI) refers to any information about me and my care needs that are deemed necessary to care for me properly, including discharge planning.

2. I understand that, for my protection, Broadview may sign agreements with any business associates (for example, our auditor or individuals or organizations assisting a patient), that would have a valid reason to disclose my PHI. These agreements will include a promise that the business will not disclose any PHI in any way not essential to the normal activities of their business.

3. For my further protection, I understand that I may be asked to sign a specific authorization any time Broadview decides to disclose any of my PHI to anyone for purposes other than the needs described above. The only exceptions to this would be for contact with legal authorities, my family and close friends and others deemed to be within the normal scope of providing care, including when a patient may be discharged to another facility.

4. I understand Broadview expects me to bring any concerns about this policy, or Broadview's compliance with it, to the attention of the Broadview HIPAA Compliance Officer in our Business Office. I also have the right to file a formal complaint with the Broadview HIPAA Compliance Officer and/or with the federal Health and Human Services (HHS) agency if I feel that there has been a violation of these privacy rights. Broadview will not retaliate against me if I feel the need to file a complaint.

5. I understand that I have the right to review the complete Broadview HIPAA Privacy Policy which is always available upon request. This policy describes the types of uses and disclosures of PHI that may occur in the course of my stay at Broadview. I may also inspect, copy, or amend my PHI.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

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DISCHARGE TO HOME GUARANTEE AGREEMENT

If a patient needs to be relocated because of specific circumstances listed below, Broadview requires two individuals other than the individual being admitted who will arrange for a different location.

***We understand that she/he cannot stay at Broadview if*:**

- She/he becomes noisy or seems confused and this becomes a disturbance to others
- Broadview Inc. is unable to oversee the safety of the patient beyond reasonable measures due to the legal denial to non-medical care facilities the use of any form of restraint.
- Refusal of Christian Science nursing care or proper Christian Science nursing care cannot be rendered.
- Payment is not received by the due date

I also understand that if I do not provide a home for the patient in the event any of the above circumstances arise, I will still be responsible for providing for the patient's relocation. I understand that in an emergency, or if the above locations are unavailable, the patient may be relocated to a local medical facility.

I, _____ _____as the primary Home Guarantor
Name of patient's Home Guarantor ***Relationship***

residing at _____
Home Guarantor's Address

_____ _____ _____
Email ***Cell Phone*** ***Work or Other Phone***

in consideration of Broadview's acceptance of _____
Patient's Name

as a patient, do hereby guarantee to make arrangements for a home and such care as may be needed at the termination of her/his stay at Broadview Inc.

_____
Primary Guarantor's Signature ***Date***

I, _____ _____as the secondary Home Guarantor
Name of patient's Home Guarantor ***Relationship***

residing at _____
Home Guarantor's Address

_____ _____ _____
Email ***Cell Phone*** ***Work or Other Phone***

in consideration of Broadview's acceptance of _____-
Patient's Name

_____
Secondary Guarantor's Signature ***Date***

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FINANCIAL RESPONSIBILITY AGREEMENT

Guest Name _____Admission Date_____

The undersigned agrees, whether he/she signs as agent or as guest, that in consideration of the services rendered to the guest, he/she hereby individually obligates himself/herself to pay the account of Broadview, Inc. by the due date on statement, in accordance with the regular terms of Broadview, Inc.

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the guest, the guest's legal representative, or is duly authorized by the guest as the patient's general agent to execute the above, and accepts its terms, and agrees that they are irrevocable.

Signature_____Date_____
Guest/Power of Attorney/Family/Responsible Party

If signed by other than guest, indicate relationship: _____

SECONDARY RESPONSIBLE PARTY

The undersigned agrees, that in consideration of the services rendered to the above named guest, he/she hereby individually obligates himself/herself to pay this patient's account at Broadview, Inc. and hereby authorizes such charge to his/her credit card or checking account through ACH payment for the full balance due if such guest account becomes more than 15 days past due. Credit card or ACH information will be provided for this purpose at the time of admission.

Signature_____Date_____

Relationship to guest_____

Witness Signature_____

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Patient Payment Options

Patient Name: _____

Deposit fees required for admission to Broadview:

- Admission Processing Fee: $ 250.00
- Est. Medicare Deductible **or**
  Deposit toward Daily Rates (below): $ $ 1,750.00
- **TOTAL** **$ 2,000.00**
- Notary Fee per signature. (if applicable): $ 15.00

DAILY RATES:

- **Christian Science Nursing Care (CSNC): $800/day**
- **Christian Science Care (CSC): $500/day**

Invoice for care will be issued monthly. Payment due upon receipt

Please note, if the care level changes, the rate will adjust accordingly.

I authorize Broadview, Inc. to debit my designated bank account or charge my designated credit card for the deposit amount indicated above and all appropriate charges due on my periodic statements. Invoices will be sent before charges are made. A 3% processing fee will be added to credit card payments. Transactions will be processed in accordance with the payment option selected below. I certify that I am authorized to use the payment method provided.

☐ **ACH Direct Payment: Bank Name** _____

Transit Routing Number _____ *(Must be 9 digits)*

Account Number _____ **Checking** ☐ **Saving** ☐

☐ **Credit Card: Name on Card:** _____

Credit Card # _____ **Exp.** _____

CVV # _____ **Billing Address Zip Code** _____

☐ **Personal Check for Admission Deposit: Check #** _____ **Amount:** _____

My signature below indicates that I have verified and confirmed that all of the information on this page is correct and that I agree to the terms stated.

Signature _____ **Date** _____

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INSURANCE QUESTIONNAIRE

Patient Name _____
Admission Date _____ Level of Care _____

Does the patient presently have private health insurance policy?

☐ Yes *(please provide requested information in the box below, and complete the reverse side of this form)*
☐ No *(skip to the signature box, at the bottom, and sign and date this form)*

Name of Insurance Company _____
Address _____
City _____ State _____ Zip _____
Phone _____ FAX _____
Website _____

Policy Number

Group Number

Group Name _____

Type of Policy ☐ HMO ☐ PPO ☐ Medicare Supplement
☐ Other *Please specify* _____

Copy of insurance card provided for Business Office file? ☐ Yes ☐ No

Policy terms/limits *(if known)* _____
Has insurance information been verified within the past 6 months? ☐ Yes ☐ No

I certify that the information stated above is true and correct to the best of my knowledge.

Signature _____ Date _____

Print Name _____ Relation to Patient _____

If patient has insurance, fill out the Assignment of Benefits form on reverse side.

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ASSIGNMENT OF BENEFITS

Broadview, Inc.
4570 Griffin Avenue
Los Angeles, CA 90031
Tax Identifcation Number: 95 168 4091

Date _____

Patient Name _____

Social Security Number _____

Insurance Company or Group Name _____

Policy or Member Number _____

I hereby instruct and direct _____ to send a
Name of Insurance Company or Group
check, made payable and mailed to:

Broadview, Inc.
4570 Griffin Avenue
Los Angeles, CA 90031

OR

If my current policy prohibits direct payment to Broadview, I hereby instruct and direct you to send a check made payable to me, and to mail it as follows:

_____
(Print patient's name above)
c/o Broadview, Inc.
4570 Griffin Avenue
Los Angeles, CA 90031

For the expense allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

I authorize Broadview, Inc. to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at _____ this _____ day of _____, 20____

_____ _____
Signature of Policyholder *Witness*

_____
Signature of Claimant, if other than Policyholder

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BROADVIEW POLICY ON CONTACTING PRACTITIONERS

Broadview respects the confidentiality of the patient-practitioner relationship; however, there are times when Broadview's commitment to the well-being of the patient requires our staff to contact Christian Science practitioners. Sometimes Christian Science practitioners request direct and regular reports from the Broadview Christian Science nursing staff regarding their patients.

In order to fulfill these responsibilities, we require that each patient at Broadview consent to staff contacting their practitioner when we deem it is appropriate or as it is requested.

By signing below, you agree that Broadview may contact your practitioner without your prior knowledge or specific consent.

Patient Name _____

Patient's Signature _____ Date _____

If you are the legal representative, health care agent, conservator, guardian or parent, please sign below, granting Broadview consent to contact the practitioner, for the above-named patient, without your prior knowledge or specific consent.

Signature _____ Date _____

Signature _____ Date _____

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PERSONAL ITEM RESPONSIBILITY RELEASE

Broadview strongly recommends that guests not bring valuable possessions to Broadview. If valuables are brought to Broadview, guests are strongly urged to turn them over to Broadview for secure keeping in Broadview's safe. Broadview can only assume responsibility for valuables placed in its care.

I,_____, understand that Broadview is not responsible for any of my personal items or valuables that are not held in Broadview's safe. Any loss of valuables kept in my possession is solely my responsibility.

Please note that items stored in Broadview's safe are available or may be picked up during business hours.

Guest Signature _____

By_____ Date_____

Relationship to guest _____

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BILL OF RIGHTS FOR GUESTS

General Statement of Rights and Responsibilities

- Your desire to rely radically on Christian Science for healing will receive full support from the Christian Science nursing department and the administration.

- You can expect courteous, compassionate, and impartial treatment. Your dignity and individuality will be respected. You may also expect prompt, high-quality Christian Science nursing service, regardless of race, color, national origin, or payment source for your care.

- You have the right to know which services and supplies are excluded from the per diem rate and for which there will be an additional charge. You have the right to manage your personal financial affairs. Information provided to Broadview regarding your finances will remain confidential except when it needs to be shared to facilitate your care and discharge planning.

- You must cooperate with the facility's staff and be considerate of the rights of other guests. You are also required to uphold the conditions of admission as outlined in Broadview's admission application materials.

Exercise of Rights: You have the right to:

1. Be informed of your rights and participate in developing and implementing your care plan. You have the right to know the names of the Christian Science nurses responsible for your care.
2. Make decisions regarding your care, including transfer and discharge from Broadview.
3. Formulate advanced directives and expect Broadview staff, who provide care, to adhere to those directives. If you do not already have one, you must complete an Advance Health Care Directive with two designated individuals upon admission.

Privacy and safety: You have the right to

1. Personal privacy - including accommodations, written and telephone communications, personal care, visits, and meetings of family and guest groups. Broadview respects your right to confer privately with your Christian Science practitioner, Christian Science nurse, or the Executive Director. You have a right to privacy while receiving Christian Science nursing care. No one from outside the facility may visit without your permission.
2. Care in a safe setting and access properly maintained assistive devices.
3. Freedom from verbal, psychological, and physical abuse, and misappropriation of property.
4. Freedom from the use of restraints.

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5. Freedom from involuntary seclusion. **Confidentiality of guest records:** You have the right to

1. Have your care records maintained confidentially. Information from, or copies of, records may be released only to authorized individuals, and Broadview will ensure that unauthorized individuals cannot gain access to or alter guest records. Original guest care records must be released only per Federal or State laws, court orders, or subpoenas.
2. Have your records and information maintained accurately and promptly.
3. Timely access to your records and other information that pertains to you.
4. Broadview will abide by all Federal and State laws regarding confidentiality and disclosure for guest care records and election information.

Grievance: You have the right to
Have a grievance resolved promptly. For a prompt resolution of any grievance, please get in touch with these individuals in this order if possible:

1) Director of Christian Science Nursing, 323-221-9174, ext. 306
2) Director of Finance and Administration, 323-221-9174, ext. 322
3) Executive Director, 323-221-9174, ext. 300
4) If Medicare coverage has been denied and you disagree:
    i) Centers for Medicare & Medicaid Services: Boston Regional Office, JFK Federal Building, Room 2275 Boston, MA 02203 Phone: (617) 565–1335
    ii) Medicare Beneficiary Ombudsman: 1-800-Medicare or www.cms.hhs.gov/center/ombudsman.asp
5) Department of Health and Human Services
    a) Office of Inspector General 1-800-447-8477
    b) Office for Civil Rights 1-800-368-1019
6) Los Angeles County Social Services: 213-639-5455

Guest Name	Signature
Representative Name	Signature
Date	Broadview Staff name