



PATIENT CHOICE LETTER [for use where post-acute facility is not affiliated with the acute facility]

Dear Patient and Family:

Your physician has ordered/recommended additional or continued services after you leave the hospital or inpatient treatment setting.

You have the right to select any provider to provide the care ordered/recommended by your physician. **This is your choice.** If you need more information before making this decision, please ask our Discharge Planning Staff who will be happy to assist and provide you with alternatives. [When discharging to a home health agency or skilled nursing facility include: A list of home health care providers who have asked the hospital to be so listed and/or skilled nursing facility providers is being provided for your review and decision making.] Because we are unfamiliar with the policies and procedures of any of the other providers, nor whether or not they actually service the area where you live, we cannot make any recommendations concerning them.* Your provider of choice should be verified by you with the managed care organization responsible for your benefit management, as necessary.

Please acknowledge that you received the list of Home Health Agencies or Skilled Nursing Facilities: _____ (Initial)

OR

Please acknowledge that you declined the list of Home Health Agencies or Skilled Nursing Facilities: _____ (Initial)

Patient or Family: Please check one of the following:

- ☐ I hereby choose to use _____
- ☐ Other Preference _____

Signature of Patient

Date

Time

Signature of Family/Guardian/Relationship

Date

Time

***Caution:** We are not aware of whether or not the listed non-HCA providers are Medicare certified and/or an approved provider for your insurance benefit plan.

ALASKA REGIONAL HOSPITAL
Patient Choice Letter [Not Affiliated English]



CM
Form: CM.06 Rev 8/16 dld 11/16

SCANNED

PLACE PATIENT
LABEL HERE



PATIENT CHOICE LETTER INPATIENT REHABILITATION

Dear Patient and Family:

Your doctor has ordered a pre-admission assessment to determine if you would benefit from an Inpatient Rehab Program prior to returning home. Below, are facilities, which are all HCA affiliated hospitals, which can provide the assessment services recommended by your physician. Note, however, there are other inpatient rehabilitation programs in this area that are not HCA affiliated.

In fact, you have the right to select any provider to conduct this pre-admission assessment and to provide the care recommended by your doctor. **This is your choice.** If you need more information before making this decision, please ask our Discharge Planning Staff who will be happy to assist and provide you with alternatives. Please note that with regard to these non-HCA providers, we are not familiar with their policies and procedures, nor whether or not they actually service the area where you live. So, we cannot make any recommendations or endorsements about these providers*. Your provider of choice should be verified by you with the managed care organization responsible for your benefit management, as necessary.

Patient or Family: Please check one of the following:

_____ I hereby choose to use the HCA affiliated hospital:

☐ Alaska Regional Hospital – Anchorage

_____ Other Preference: _____

Signature of Patient

Date

Time

Signature of Family/Guardian/Relationship

Date

Time

***Caution:** We are not aware of whether or not the listed non-HCA providers are Medicare certified and/or an approved provider for your insurance benefit plan.

ALASKA REGIONAL HOSPITAL

Patient Choice Letter



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