Gulfside Hospice
Lic. 1989

INFORMED CONSENT FOR HOSPICE SERVICES

PATIENT NAME: (please print) **MR #**

PROGRAM GOALS
I, the patient or patient's legal representative, request admission to the **Gulfside Hospice & Pasco Palliative Care** program of care and consent and agree to the following:

Hospice Philosophy and Care _____
(Initials)

- I understand Hospice care is not intended to be curative or to alleviate the illness, but to manage symptoms to the extent possible.
- I understand there will be a biweekly conference by the Hospice team to coordinate and review my plan of care.
- I accept the palliative nature of Hospice care as described. I understand I may withdraw my consent at any time.

I acknowledge that I, the patient or patient's representative, have been given a full understanding of the palliative, rather than curative, nature of hospice care, as it relates to the terminal illness.

HOSPICE PROGRAM OF CARE AND COVERED SERVICES
Hospice provides four levels of care: Routine home care, General inpatient care, Continuous (Crisis) care, and Respite care. The **respite level of care** is available for a period of up to five (5) days and is provided in a skilled nursing facility or hospice inpatient unit. I understand the professional hospice team makes the determination when a level of care change is needed.

RIGHTS AND RESPONSIBILITIES
I have been given written materials about my rights and responsibilities as a patient of Gulfside Hospice & Pasco Palliative Care. I understand I have the right to formulate Advance Directives, but I am not required to have an Advance Directive in order to receive services. I further understand any Advance Directive I have executed will be followed by Hospice to the extent permitted by law.

I have executed the following:
☐Living Will
☐Durable Power of Attorney
☐Designation of Health Care Surrogate
☐I have not formulated Advance Directives at this time

RELEASE OF RECORDS
I understand Gulfside Hospice & Pasco Palliative Care may need to obtain or release my medical records and related information to/from hospitals, skilled nursing facilities, physicians, pharmacies, home health agencies, insurance companies, health care benefit plans, or others in order to assure continuity of care and proper reimbursement. I authorize the above persons and entities to release to the Hospice organization all medical records and related information for purposes of my health care or to obtain payment for services and supplies rendered to me. I authorize the Hospice to release all portions of my medical record in order to assure continuity of care and proper reimbursement.

Notice of Privacy Practices _____
(Initials)

- I acknowledge I have received a copy of Gulfside Hospice & Pasco Palliative Care Notice of Privacy Practices. I understand this document provides an explanation of the ways in which my health information may be used or disclosed by the Hospice and of my rights with respect to my health information.
- I have been provided the opportunity to discuss concerns I may have regarding the privacy of my health information.

Patient signed consents: ☐Yes ☐**No** **If No, specify why**_____

_____

Date Patient or Representative Print Signature Relationship

_____

Address State Zip Code

_____

Date Hospice Representative Print Signature Title