



Licensed by the State of Florida Since 1984

INFORMED CONSENT/ASSIGNMENT OF BENEFITS

MR#: _____
Patient Name: _____
Team: _____
Date: _____

I/we, the patient and family, choose to receive hospice care from Hope Hospice and acknowledge, consent and agree to the following:

- Hospice and Palliative Care - The Hope Hospice Program provides care to meet the physical, emotional, and spiritual needs of the patient and family. The focus of this care is to provide comfort, relief of pain and other symptoms.
- Hospice Services - Homecare services are provided where the patient lives by a team of professionals and volunteers on a scheduled and as-needed basis, 24-hours a day, 7 days a week. Services may include nursing, physician care, pharmacy, social work, counseling, home health aides, homemakers, volunteers, medical supplies, durable medical equipment, and dietary counseling.
Inpatient services are provided in the hospital or at a Hospice Inpatient Unit when it is deemed necessary by the Hospice Interdisciplinary Team and the attending physician. The hospice physician may be designated as attending physician unless otherwise specified by the patient or patient's legal representative. From time to time, to enhance a patient's care, an Advanced Registered Nurse Practitioner (ARNP) may assist the hospice physician in attending to the medical needs of the patient unless otherwise specified by the patient or the patient's caregiver.
Continuous care over a period of 8-hours or more in a patient's home may be provided when guidelines are met.
Respite care in the hospice inpatient facility or a local nursing home may be provided when guidelines are met.
- Patient and Family Rights and Responsibilities - The hospice team is not intended to take the place of the family or caregivers but rather to provide support in caring for the patient. Patients, caregivers and families are encouraged to join the hospice team in making decisions about the variety, frequency, and intensity of services. Patient and Family Rights and Responsibilities have been explained, understood and a copy received.
- Patient Health Information - Confidentiality is maintained within current guidelines and regulations. Hope Hospice honors all donations and memorials by printing patient and contributors' names in our newsletter.
- Coverage of Services - Services not covered, if any, by insurance will be explained. It is understood I/we, the patient and family, are responsible for charges not covered by health insurance. Florida State Law and the Florida Department of Insurance require all healthcare providers to send a monthly statement reflecting the balance due after the insurance company has considered the submitted expenses. The decision to receive Hope Hospice care and services will not be based on my ability to pay. The coverage for Hope Hospice care has been explained and I have been afforded the opportunity to discuss financial needs with a hospice representative to the extent I desire.
- It is understood I/we, the patient and family, may choose to withdraw from hospice care at any time. I may be discharged from the program if my condition no longer warrants hospice care.
- Payment is hereby authorized to be made on my behalf directly to Hope Hospice for health insurance benefits otherwise payable to me in connection with the provision of Hospice services. Release of all records required to implement this authorization is approved. I am responsible to Hope Hospice for charges (including deductible or coinsurance) not covered by my health insurance.

I have received a brief explanation and copy of The Notice of Privacy. _____ (Initials)

I have received a copy of my Rights and Responsibilities. _____ (Initials)

Patient/Surrogate or Proxy Name (print) Patient/Surrogate or Proxy Signature Date

Address (if different from Patient's) Phone #

Witness (print) Witness Signature Date

ORIGINAL - Medical Record CANARY - Patient/Family