empath health

Informed Consent for Hospice Care

Name _____ **MR#** _____

INFORMED CONSENT AND AGREEMENT TO THE FOLLOWING:

- I request admission to □ Suncoast Hospice □ Suncoast Hospice of Hillsborough.
- I have a life-threatening illness and understand the focus of the program is comfort rather than cure.
- A representative has explained the type of care and services that hospice may provide during the course of my illness.
- I understand and was given the opportunity to ask questions.
- I consent to care and treatment that may be performed as part of my care plan and that I along with my family, attending physician, and the hospice interdisciplinary team will develop my plan of care.
- I will ask family members or significant others to respect the choice of hospice and to fulfill the role ofprimary caregiver.

RELATIONSHIP BETWEEN SUNCOAST HOSPICE/SUNCOAST HOSPICE OF HILLSBOROUGH AND PATIENT/FAMILY:

- Hospice promotes the comfort and dignity of patients and addresses the physical, emotional, social and spiritual needs of the patient and family through an interdisciplinary team approach.
- Patient care is provided by professionals and volunteers both on a scheduled basis and as needed 24-hours a day, seven-days a week.
- The hospice team does not take the place of the family in caring for the patient.
- The Hospice Medical Director does not take the place of the attending physician but will provide consultation in symptom control as a member of the interdisciplinary team.
- Notations will be made on hospice medical records including care plans concerning the medical, nursing, psychosocial, spiritual and personal information.

ACKNOWLEDGEMENT OF RECEIPT AND/OR UNDERSTANDING OF THE FOLLOWING:

- Notice of Privacy Practice
- Statement of Advance Directive Law
- Patient and Family Rights and Responsibilities
- Scope of Care and Services provided
- The above information can be found in Patient and Family Guide and at SuncoastHospice.org

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

- I authorize the hopice to release medical information, including the results of any HIV tests or related diagnosis to my Insurance company or any authority or organization, private or governmental, whose purpose is for reimbursement or payment of the care and services provided, licensure, quality review or accreditation, including but not limited to the Social Security Administration, the intermediary and Medicare. I authorize the release of medical records/information to/from other healthcare providers, including hospitals, physicians, and business associates necessary for continuity of care and as permitted by law. This includes no limitations on dates, history of illness or diagnostic and therapeutic information.
- I authorize the release of information pertaining to psychiatric and/or psychological care; alcohol and/or substance abuse, AIDS, ARC or HIV diagnoses, testing and/or treatment when needed for purposes noted in the above.

CONSENT TO TELEHEALTH: □ I Agree □ I Do Not Agree

To accept the use of a video conferencing program for virtual visits with an Empath Health care team member. Bychoosing this option, I understand that I will use an online communication tool enabling face-to-face video. I also understand the following limitations of virtual visits and agree that Empath Health is not responsible for ensuring the securityfrom a potential breach of the video conferencing software's security protections.

Patient Signature_____ **Date of Consent**_____

Unable to obtain signature but verbal consent was received by the: ❑ Patient ❑ Patient's Authorized Representative Patient unable to sign consent because (Print) _____

I attest I am the legal Patient's Authorized Representative: HCS ❑ HC Proxy ❑ POA ❑ DPOA ❑ Guardian ❑

Patient's Authorized Representative (Print) _____ **Relationship**_____

Signature of Patient's Authorized Representative_____

Name of SH/SHH Representative (Print)_____

Signature of SH/SHH Representative_____ **Date**_____