AdventHealth
Hospice Care
Central Florida

CONSENT, ACKNOWLEDGEMENT AND AUTHORIZATIONS

I / we, the patient and/or authorized representative(s), choose to receive hospice care from AdventHealth Hospice Care, and acknowledge, consent and agree to the following:

Hospice Care and Services

1. It is not the goal of hospice to cure life-limiting illness. The AdventHealth Hospice Care program provides care to meet the physical, emotional and spiritual needs of the patient and family. The focus of care is to provide comfort, relief of pain and other symptoms.
2. Hospice services are provided where the patient lives by a team of professionals and volunteers on a scheduled and as-needed basis. The hospice care team may include physicians, nurses, social workers, counselors, chaplains, hospice aides, volunteers and physical or other therapies. Hospice will provide medications, equipment and supplies necessary for the palliation of the terminal condition that are included in the established Plan of Care. Additional levels of care, including inpatient services, continuous care or respite care may be provided when specific guidelines and criteria are met.
3. The hospice team is not intended to take the place of family or caregivers, but rather to provide support in caring for the patient. Patients, families and caregivers are a part of the hospice team and participate in decisions about care and services provided.
4. Acceptance into the hospice program of care is contingent on physician certification of terminality/eligibility. A patient may be discharged from hospice care if the patient no longer meets eligibility requirements, moves out of the AdventHealth Hospice Care service area, or if care cannot be safely or effectively provided.
5. It is understood that I/we, the patient or authorized representative, may choose to withdraw (revoke) from hospice care at any time. I/we understand that revocation must be in writing.

Coverage of Services and Authorization for Payment

1. I / we authorize payments to be made directly to AdventHealth Hospice Care for health insurance or coverage under Medicare, Medicaid and/or other insurance plans. I understand that I am financially responsible to AdventHealth Hospice Care for all charges not covered by my health insurance plans.
2. The decision to receive AdventHealth Hospice care and services will not be based on my ability to pay. The coverage for hospice care has been explained and I have been given the opportunity to discuss financial needs with a AdventHealth Hospice Care representative to the extent that I desire. I understand that it is my responsibility to provide accurate information and cooperate in completion of documentation for private insurance, Medicare, Medicaid or other third party payer to hospice.

Authorization to Obtain/Use/Disclose Patient Health Information (Confidentiality is maintained in accordance with current laws and regulations.)

1. I authorize the use and disclosure of: Diagnostic radiology and lab reports, History & Physical, surgical and pathology reports, serial physician assessments, physician progress notes, orders and discharge and medication summaries which are pertinent to my admission and continuation of care from AdventHealth Hospice Care. This authorization for records will expire 1 year from the date it is signed, but I have the right to revoke this authorization at any time.
2. Previous Hospital(s)/Facility(ies) at which I received diagnostic testing or care for my hospice diagnosis:

_____ / / _____ _____ / / _____
Name of hospital/facility/physician City/State Date Name of hospital/facility/physician City/State Date

3. I authorize the disclosure of testing/treatment information for ☐ HIV/AIDS ☐ substance abuse _____ (Initials)

Acknowledgement of Receipt

I have received and understand the information indicated below, and have been given the opportunity to discuss the information to the extent that I desire.

- AdventHealth Hospice Care Notice of Privacy Practices. This document provides an explanation of the ways in which my health information may be used or disclosed by AdventHealth Hospice Care and my rights with respect to my health information.
- Patient and Caregiver Rights and Responsibilities.
- Information on my right to formulate advance directives, including my options and the process for formulating advance directives.
- Information on emergency planning and understanding my responsibilities for planning for hurricanes or other emergency events.
- The Medicare Hospice Benefit (CMS Publication).
- Disposal of Controlled Substances.
- Help Resources and Regulatory Telephone Numbers to report complaints or concerns, including possible abuse or neglect.
- Information about Patient Financial Responsibility. I have received and been given the opportunity to ask questions about hospice care and services, including what care and services will or will not be provided by AdventHealth Hospice Care. _____ (Initials)

_____ / / Signature of patient / Date

_____ *(If patient cannot sign, explain reason)*

_____ / / Signature of legal representative / Date

_____ Printed name of legal representative

_____ / / Signature of AdventHealth Hospice Care representative / Date

_____ Printed name/title of AdventHealth Hospice Care representative

Authority of legal representative

☐ HCS ☐ DPOA ☐ Legal Proxy
☐ Court Appointed Guardian
☐ _____

Address of legal representative

_____
_____

Patient Name _____

Patient # _____