

Patient Name & HPC #: _____
(place sticker here)

HOSPICE & PALLIATIVE CARE OF GREATER WAYNE COUNTY INFORMED CONSENT FORM

We, the patient and caregiver, agree to admission to the Hospice & Palliative Care of Greater Wayne County (HPC) program. We request that HPC assume professional management of patient care and we understand and agree to the following conditions:

Introduction: We understand that the Hospice program is palliative, not curative, in its goals. The program emphasizes the relief of symptoms such as pain and physical discomfort and addresses the spiritual needs and emotional stress which may accompany a life-limiting illness.

Caregiver: We understand that Hospice services are not intended to take the place of care by family members or others who are important to the patient, but rather to support them in the care of the patient. With the help of Hospice, the person designated as “caregiver” will provide around-the-clock care to the patient at home. If 24 hour care is not available, the caregiver will make arrangements for 24 hour care. The “caregiver” will also participate in decisions about the care provided to the patient at home and/or in the inpatient setting.

Home Care: We understand that home care is the main focus of the Hospice program. Services are provided in the patient’s place of residence by a team of Hospice staff and volunteers through scheduled visits. Consultation and visits for urgent matters and pain and symptom control are available twenty-four hours a day, seven days a week. When home is a nursing facility, we understand that care will be provided by the nursing home staff in collaboration with the Hospice & Palliative Care of Greater Wayne County professional staff and volunteers.

Choice of Care: We understand that we will have a choice about the care provided to us. We may review the plan of care that guides Hospice services and, if we desire, may refuse a particular treatment or service offered.

We further understand that some medical services or procedures, such as advanced cardiac life support or respirators, are not provided by Hospice. The subject of resuscitation should be discussed with the patient’s physician. Other services, such as intravenous therapy, are provided only if they are determined by the Hospice Interdisciplinary Team to be necessary for the patient’s comfort.

Follow-Up Care for Families: We understand that the “caregiver” and others who are part of the patient’s family or who are important to the patient may choose to participate in the Hospice bereavement program. Services designed for family members and others include individual counseling, support groups, phone contacts, mailings, and memorial services.

Records: We authorize Hospice & Palliative Care of Greater Wayne County to obtain copies of medical and billing records and to keep records which may include necessary information about the patient’s medical condition, family and finances during the time which we are under the care of the Hospice program.

We permit the release of necessary information and medical records for purposes of providing treatment, obtaining payment for care and conducting health care operations. Hospice has established policies to guard against unnecessary disclosure of your health information.

Definition of Family & Unit of Care: We understand that the Hospice focus is on the care of the patient/family unit as defined by the patient. We will attempt to identify immediate family & the extended family upon admission to Hospice, thus allowing Hospice to offer Bereavement Services to any family member who desires those services.

Financial Responsibility: We have read the explanation regarding the benefits, provisions and scope of services to be offered to us. We understand that efforts will be made to recover cost of care through private insurance, Medicaid, or Medicare. However, we understand that the patient will not be denied admission to the program if we are not able to pay

Withdrawal/Discharge: We accept the conditions of Hospice & Palliative Care of Greater Wayne County as described, understanding that we may choose not to remain in the program and that Hospice may discharge us from the program if Hospice care is no longer appropriate. This means there will be no further liability to us or Hospice & Palliative Care of Greater Wayne County. We understand, however, that we may request to be readmitted at a later date.

Rights/Responsibilities and Privacy Notice: We have received and reviewed the patient/family rights and responsibilities as outlined by Hospice & Palliative Care of Greater Wayne County. We have received a copy of Hospice & Palliative Care of Greater Wayne County's Privacy Notice.

Preferred Drug List: We have been informed that Hospice & Palliative Care of Greater Wayne County uses a Preferred Drug List.

We have been able to discuss the above conditions with a member of the Hospice staff and have had our questions answered to our satisfaction.

Hospice services to begin on _____

Signature of Patient, DPOA for Health Care, or Legal Guardian _____
Date

Signature of Caregiver _____
Date

Signature of Hospice Representative/ Title _____
Date

Type of Hospice Benefit: Medicare _____ Medicaid _____ Per Diem Insurance _____

Date of Benefit Election _____