

Informed Consent for Suncoast Hospice Care

Name _____

MR# _____

INFORMED CONSENT AND AGREEMENT TO THE FOLLOWING:

- I request admission to Suncoast Hospice.
- 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 Suncoast 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 Suncoast Hospice interdisciplinary team will develop my plan of care.
- I will ask family members or significant others to respect the choice of Suncoast Hospice and to fulfill the role of primary caregiver.

RELATIONSHIP BETWEEN SUNCOAST HOSPICE AND PATIENT/FAMILY:

- Suncoast 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 Suncoast Hospice team does not take the place of the family in caring for the patient.
- Suncoast 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 Suncoast 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 EmpathHealth.org

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

- I authorize Suncoast Hospice 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 and physicians 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.

Patient Signature _____ Date of Consent _____

Unable to obtain signature but verbal consent was received: by the Patient by the 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 Suncoast Hospice Representative (Print) _____

Signature of Suncoast Hospice Representative _____ Date _____