Hospice Informed Consent for Care

Due to the extent of my illness, I _____ (beneficiary name), accept and understand and consent to the services of Wellstar Community Hospice, as explained below:

1. I understand that the hospice program is supportive in its goals and techniques; that it emphasizes the alleviation of physical symptoms including pain. Hospice also identifies and addresses emotional and spiritual needs which my family and I may experience related to end-stage disease. I understand that the nature of hospice care is palliative, for comfort, rather than curative.
2. I understand that I will receive medical care from my attending physician and/or Hospice Medical Director and Medical care team, as well as nursing care from Wellstar Community Hospice nurses and staff. I understand that my caregiver(s) and I will be interviewed regarding my care, and that our wishes and needs will guide the Hospice team in the development of my plan of care. I will participate in the development and revision of this plan at any time during the course of hospice care. I understand that I/we will be informed of any responsibilities I/we have in the care process.
3. I understand that care by physicians, nurses, and other Hospice staff will be provided to control pain, discomfort, anxiety and other symptoms of my illness to the greatest extent possible. I understand if arrangements for inpatient care are necessary I will be informed and will participate in the decision.
4. I understand that there are four levels of hospice care available:
   (1) **Routine home care day.** A day on which an individual who has elected to receive hospice care is at home, which is defined as wherever the patient lives, including a nursing facility or assisted living facility.
   (2) **Continuous care.** A day in which an individual who has elected to receive hospice care is not in an inpatient facility and receives hospice care consisting predominantly of nursing care on a continuous basis at home. Home health aide and/or homemaker services may also be provided on a continuous basis. Continuous care is only furnished during brief periods of crisis and only as necessary to maintain the terminally ill patient at home.
   (3) **Inpatient respite care.** An inpatient respite care day is a day on which the individual who has elected hospice care receives care in an approved facility on a short-term basis for respite. The respite stay may be used for up to five days at one time. Respite is intended to
   (4) **General inpatient care day.** A general inpatient care day is a day on which an individual who has elected hospice care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.
5. I understand that Wellstar Community Hospice will, within the limits of its resources, provide emotional, social and spiritual support to my family and/or others closely involved in my life.
6. I understand that I may voice my concerns regarding the care provided either in writing or verbally to the Director of Hospice and Palliative Care and/or the Inpatient Hospice Manager of Wellstar Community Hospice, by calling (770) 732-6710. I may also contact the Office of Regulatory Services HealthCare Section which regulates hospice care in the state of Georgia and maintains a hotline: (404) 657-5727. The website for the state office is https://ors.dhr.georgia.gov. Additionally, I may contact The Joint Commission at 1 (800) 994-6610, or by email at complaint@jointcommission.org.
7. I understand that I have the right to refuse any care or treatment. I will be informed of the potential outcome of any such refusal.
8. I understand that services provided by an other agency will be coordinated by Wellstar Community Hospice.
9. I have received a copy of the hospice written policies and procedures on the management and disposal of controlled drugs, discussed their content with a member of the hospice staff, and my questions have been answered.
10. I acknowledge that I have read and had explained to me Advance Directives, Safety Education, Disaster Preparedness, and if admitted to one of the inpatient hospice facilities, I will be provided a copy of the facility guidelines.

Assignment of Benefits

1. I understand that benefits paid should go directly to Wellstar Community Hospice and that benefits paid directly to me or my family will be forwarded to Wellstar Community Hospice as soon as possible.
2. I understand that if I request a service that is not covered by my insurance, I will be informed, in advance, that the service is not covered and that I will be financially responsible for that service.
3. I understand that I must obtain pre-approval from hospice for all treatments/services/transportation not included in my Interdisciplinary Team Plan of Care (such as hospitalization, aggressive services, emergency room visits), and that I am responsible for all bills incurred for services not approved, or not included in my Interdisciplinary Team Plan of Care.
4. I understand that I am responsible for the payment of co-pays, coinsurance, deductibles, and the total amount if no reimbursement source is identified, or for any reason they fail to pay. This does not apply to patients with current authorizations for a state or federally funded program.
5. I understand that **BILLING OF INSURANCE IS A SERVICE ONLY AND NOT A GUARANTEE OF PAYMENT**. I know my responsibility to provide correct/current information about my insurance, and I will be responsible for any charges incurred if the information provided is not accurate or updated.

Insurance

I, _____ elect to utilize the hospice benefit as provided by my insurance

Name of Insurer ID# Date of birth Employer

☐ I am responsible for all charges incurred until coverage can be verified and authorization obtained.

☐ I am responsible for all co-pays, out-of-pocket and deductible charges which exceed the maximum provided by my coverage.

I elect hospice effective _____
Date Time

Patient signature Date Time

Patient representative signature Date Time

Hospice representative signature Date Time

Self-Pay

I, _____ acknowledge that I have no insurance, Medicare or Medicaid benefit to pay for hospice services and agree to be financially responsible for all charges incurred while under hospice care.

☐ I request assistance in a complete financial assessment and will cooperate in providing all necessary supporting documentation requested by hospice.

I elect hospice effective _____
Date Time

Patient signature Date Time

Patient representative signature Date Time

Hospice representative signature Date Time

Authorization to Release or Receive Patient Information

I authorize Wellstar Community Hospice to release information either verbally or in writing from my medical record to other health care professionals who are going to be directly involved in my care. I also authorize the release of any necessary medical information to Wellstar Community Hospice, including a history and physical, from other healthcare professionals who have been involved in my care.

I understand that access to information regarding my care may be made available to representatives of regulatory and/or accrediting bodies if requested.

Advanced Directives

I understand that hospice staff will provide information to facilitate the completion of a formal advance directive, I agree to keep hospice informed of my decisions.

☐ I have prepared and signed, a [ ] HCPOA, [ ] Living Will, [ ] Georgia Advance Directive; and I have, or will, provide a copy to Wellstar Community Hospice.

My authorized person/designated agent

Address Telephone number

☐ I have not prepared and signed a HCPOA, Living Will or Advanced Directive.

patient/family initial

I acknowledge that I have received and read materials contained in the admissions manual and had explained to me the following:

Advanced Directives
Medicare/Medicaid Benefit Election
Assignment of Insurance Benefits
Authorization to Release or Receive Patient Information
Informed Consent
Patient Bill of Rights
Safety Education/Emergency Preparedness
Notice of Privacy Practices

For Tranquilty Admissions
Tranquilty Guidelines
Admission Letter for Level of Care Change

Consent Agreement

- I have been given an opportunity to review each of the forms, which were signed at the hospice admission.
- I have been given the opportunity to ask questions about my care with Wellstar Community Hospice, and all questions have been answered to my satisfaction.
- I accept the conditions of Wellstar Community Hospice as described with the understanding that I may withdraw my consent to continue hospice care at any time without prejudice or penalty of any kind.

Patient/Patient Representative Signature Date

Reason patient is unable to sign

Team Member Signature Date Time