CONSENT FOR TREATMENT AND CONDITIONS OF ADMISSION

I ____request admission to Hand In Hand Hospice and understand and agree to the following conditions:

Training nursing professionals is essential to the health care education mission of our agency and for improving the quality of care. If you do not wish students to be involved at any time, then you have every right to say so. Just let the doctor or nurse know. Only hospital authorized students participate in this program. Your care will not be affected in any way by your decision.

PROGRAM PURPOSE: The Hand In Hand program is palliative (comfort-oriented), 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-threatening illness.

CAREGIVER: Hand In Hand services are not intended to take the place of care by my family members, my physician, or others who are important to me, but rather to complement them in my care. I ask that my family member(s) / legal agent or representative (hereinafter responsible party), or significant other(s); respect my choice of Hospice care and that they, insofar as they are able, fulfill the role of primary caregiver for me. **Hand In Hand Hospice is not a 24 hour care provider.**

As the role of family member(s) / or responsible party, I/we understand the role of primary caregiver and pledge to undertake that role with the training and support of the Hospice team.

HOMECARE: Hand In Hand program is primarily services delivered in my place of residence (home or residential facility) by the Hand in Hand team consisting of nursing, social work, pastoral care and volunteer staff. These services are available both on a scheduled basis and as needed 24 hours a day, seven days a week.

INPATIENT CARE: Short-term acute (hospital) care may be arranged if deemed necessary for symptom control by the Hospice team and my physician.

FOLLOW-UP CARE: The caregiver, companions and others who are important to me may choose to participate in the bereavement program. Services include individual and group counseling, seminars and workshops, help with practical matters and social activities.

CARE PLAN: I have the opportunity to join the Hand In Hand Hospice team in making decisions about the variety, frequency, intensity of services and techniques the Hospice team will use to help me. I have access to my Hand In Hand Hospice Care Plan and I am invited to attend the Hospice team meetings to hear and participate in discussions about the services and techniques being used to assist me.

RELEASE OF INFORMATION: I authorize Hand In Hand to obtain copies of medical and billing records which include necessary personal information about my medical condition, family and finances during the time I am under care.

I give consent and approval for notations to be made on Hand In Hand Hospice records concerning the medical, nursing, psychosocial, spiritual and personal information necessary for Hospice to fulfill its functions.

I give consent and approve the release of information and appropriate medical records to or from any skilled facility, hospital, home health agency, health organizations, Department for Children and Families (DCF), regulating bodies, accrediting organizations, and/or private physician, to include any source for third party reimbursement.
In the event the patient is transferred or referred to another physician or to any other hospital or provider to which the patient may be referred. I authorize the release of information and transfer of pertinent medical records by Newman Regional Health personnel to persons, agencies, insurance companies, etc. to assist in obtaining services that may be needed during or after my treatment.

FINANCIAL RESPONSIBILITY: The estimated cost and expected reimbursement of hospice care has been explained to me. I have read Election/Assignment of Benefits form, and understand the benefits and scope of services offered to us. I understand that I am responsible for payment of those services not covered by insurance (i.e. deductibles, co-payments and shift work) unless other arrangements have been made. I have been given the opportunity to discuss my financial obligations. I understand all information is treated in a confidential manner.

WITHDRAWAL/DISCHARGE: I accept the conditions of Hand In Hand Hospice as described. I may choose to remain in the program and/or have Hand In Hand Hospice discharge me from the program if hospice care is no longer appropriate. This means there will be no further liability to me or Hand In Hand Hospice. I may request to be readmitted at a later date. I have been able to discuss the above conditions with a member of the Hand In Hand Hospice staff and have had my questions answered to my satisfaction. I have received and reviewed a copy of the Bill of Rights for Hand In Hand Hospice.

THE PATIENT SELF-DETERMINATION ACT: Individuals have the right to make decisions concerning their care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives as permitted under state statutory and case law. I have been informed of my right to formulate advance directives and that Hand In Hand Hospice will provide further information or help in completing them at my request.

PATIENT/PERSONAL REPRESENTATIVE MUST COMPLETE BY SIGNING OR INITIALING

Acknowledgment Of Receipt Of Notice Of Privacy Practices: I hereby acknowledge that I have received a copy of the Newman Regional Health's Notice of Privacy Practices. (X)__________ (Initials)

I specify the named relative and/or significant other and/or friend to be contacted in an emergency and/or on an as needed basis to discuss my plan of care.

Name	Relationship	Name	Relationship
Address	Phone #	Address	Phone #
Name	Relationship	Name	Relationship
Address	Phone #	Address	Phone #

Power Company

(X)
Funeral Home of Patient's Choice

(X)
Church or Place of Worship

______________________________ ______________
Patient Signature Date

(X) ______________________________ ______________
Power of Attorney/Authorized Representative Signature Date
(Person identified by patient as being Spouse, DPOA, Guardian/Conservator)

____
Reason if patient is unable to sign

______________________________ ______________
Hand In Hand Hospice Representative DATE