Hospice *of* New York

INFORMED CONSENT / ELECTION OF HOSPICE BENEFIT

PATIENT NAME: ____________________

HOSPICE RECORD #: ____________ **DATE OF BIRTH:** ___/___/___

I elect to receive hospice care from Hospice of New York. I understand that the treatment I am choosing is palliative not curative, with the goal of enhancing my quality of life. I understand that every effort will be made to control symptoms so that I may be able to focus my energies on living. I understand that resuscitation will NOT be performed by hospice staff. I also understand that my private physician may continue to care for me on the program.

I have someone in my family or among my friends who is available to me (at least by telephone), who is informed of my election of hospice care, and who will keep in contact with the hospice. I understand that any questions I have about my condition will be answered honestly and directly by the hospice team to the best of their ability.

The hospice services I am electing include:

- medical and nursing management of the physical symptoms of my illness.
- emotional and spiritual support/counseling for myself and primary care person(s).
- a coordinated program of care provided in my own home; regular intermittent visits by any or all of the hospice team: physician, nurse, social worker, home health aide, pastoral or other counselor and volunteer. The frequency and length of home visits and services will be determined by the hospice team.
- provision of pharmaceuticals, supplies, equipment and transportation according to need and reimbursement guidelines. Only prescription drugs which are primarily for the relief of pain and symptom control are covered.
- admission to a hospice inpatient unit 1) for short-term acute care medical/nursing symptom control, and 2) for respite for my caregiver (up to 5 days).

I am aware that by electing hospice care I waive certain other Medicare/Medicaid benefits:

- Hospice care provided by another hospice program (other than under arrangements made by Hospice of New York).
- Any Medicare/Medicaid services that are related to the treatment of the condition for which I am electing hospice care or that are equivalent to hospice care, except the services of my attending physician. All physician consultants must be approved by hospice.

I understand I may revoke my hospice care benefit at any time and my regular Medicare/Medicaid benefits will resume. I may also, after revocation, elect hospice benefits again if I continue to meet admission criteria.

I hereby consent to release information about my medical condition and care to physicians, other consultants and/or other agencies to which I may be referred, and to federal, state and local review agencies and accrediting bodies. In the event of an emergency such as a fire, hurricane, severe snowstorm or other natural disaster, I give my consent to release information about my medical condition and nursing care to any governmental agency, supplemental provider agency, community volunteer service or other providers of service except where otherwise prohibited by law.

I hereby assign to Hospice of New York for hospice sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers, union welfare funds or any other parties that are financially liable to pay the charges for the care, treatment and supplies that were rendered or furnished to me or that were rendered or furnished to this patient for whom I have personally guaranteed payment to Hospice of New York for hospice care.

I am aware that no Medicare or Medicaid co-payments will be billed to me by Hospice of New York.

Hospice services have been explained to me. I have received and understand the following:

- **HOSPICE OF NEW YORK ADMISSION HANDBOOK**
  - **Patient and Family Information**
  - **Advance Directives**
  - **Notice of Privacy Practices**
  - **Patient Care and Safety**
  - **Hospice of New York Ownership and Affiliation Information**

I have the following advance directives:

- ❑ **A LIVING WILL**
- ❑ **HEALTH CARE PROXY** (Power of Attorney for Health Care)
- ❑ **DO NOT RESUSCITATE ORDER**

I hereby designate ____________________, ❑ **MD** ❑ **DO** ❑ **NP** as my attending physician. **NPI#:** ____________

Patient Signature	Date	Legal Representative Signature	Date
Witness Signature	Date	Print Name of Representative	
Print Name of Witness		*If patient is unable to sign, please state reason why*	
Effective Date (if different from date signed)			