



Informed Consent and Authorization Forms

This agreement is entered into and by and between BeLoved Hospice and _____ (hereinafter called Patient). This agreement is entered into pursuant to a desire by Patient to obtain hospice services. I request admission to BeLoved Hospice and understand and agree to the following conditions:

- 1. Hospice Philosophy** – The Hospice program provides care to meet the physical, emotional and spiritual needs of the patient and family facing a life-threatening illness. The focus of care is palliative, not curative.
- 2. Palliative Care** – The focus of palliative care is to provide relief of symptoms such as pain, nausea and/or anxiety. I understand that the BeLoved Hospice program does not provide life-prolonging treatments.
- 3. Home Services** – BeLoved Hospice services are provided primarily in the home by a team of professionals and volunteers. These services are available both on a scheduled basis and emergency on-call twenty-four hours a day, seven days a week. These services may include nursing, physician care, social work, home health aides, chaplain, volunteers, dietary counseling, bereavement counseling, physical therapy, occupational therapy, medical supplies, equipment and medications.
- 4. Primary Caregiver Role** – The hospice team is not intended to take the place of the family, but rather to support the primary caregiver and family in caring for the patient. A caregiver plan must be identified at the time of admission to BeLoved Hospice program.
- 5. Physician Role** – BeLoved Hospice works with the patient's attending physician who becomes a part of the Hospice team. The BeLoved Hospice Medical Director is not intended to take the place of the attending physician, but rather to provide consultation to the Hospice team. You have the right to be informed of your condition and /or changes in condition by your attending physician.
- 6. Routine Home Care** – I understand that hospice services are delivered primarily in the home (which may include a skilled nursing facility, assisted living or group home) and provided by a team of hospice professionals, staff and volunteers. These services are available both on a scheduled basis and as needed. I understand that these services may include, as set forth in the hospice plan of care: nursing, physician care, social work, spiritual, nutrition and bereavement counseling, certified nursing assistants, medical supplies, physical therapy, occupational therapy and medication prescribed for relief of pain or discomfort.
- 7. General Inpatient Care** – I understand that inpatient hospice care is provided in an inpatient facility when it is deemed necessary by the Hospice Interdisciplinary Team. I understand that hospice inpatient care is designed for short-term stays with the goal of stabilizing the patient and family emotionally and physically so that the patient can return home.
- 8. Respite Care** – I understand that inpatient respite care is designed to provide brief periods of respite for the family or primary caregiver for up to five consecutive days while the patient receives hospice care in an inpatient facility.

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- 9. Continuous Care** – I understand that continuous care (a minimum of 8 hours of care in a 24-hour period) may be provided in a patient's home when it is deemed necessary by the Hospice Interdisciplinary Team. I understand that continuous care is designed for short-term periods during periods of crisis requiring skilled professionals to manage acute medical symptoms with the goal of stabilizing the patient.
- 10. Documentation** – I understand and consent is granted for documentation on hospice records and care plans concerning the medical, nursing, psychosocial, and personal information necessary for BeLoved Hospice to fulfill its functions.
- 11. Patient/Family Role with Hospice Team** – I understand that I have the opportunity to join the BeLoved Hospice team in making the decisions about the services and the techniques utilized to provide care, including review of the Plan of Care.
- 12. The Plan of Care** – I understand I have access to the information included in the hospice Plan of Care that details services and goals for me and my family. I understand that I have the option of obtaining services not included in the Plan of Care from other sources and that BeLoved Hospice would not be responsible for any part of these costs.
- 13. Release of information** – I authorize any other health care provider in which the undersigned has been a patient to disclose all or any part of the patient's medical record to BeLoved Hospice. I give my permission to BeLoved Hospice to release all or any part of my medical record accumulated during my course of care under the direction of BeLoved Hospice. I understand that this information may go to the Medicare Claims department and/or my insurer or all others who need it in order to pay for review for licensing or accreditation, or to research the care given to me. Authorization is granted to BeLoved Hospice to release records to other health care providers who are providing care. Permission is granted for the use of facsimile (fax) transmission, e-mail (electronic mail), and/or the United States Postal Service as the mode of conveyance of this information by all parties.
- 14. Permission to Photograph** – I authorize BeLoved Hospice to take photographs to be used for identification, monitoring the progress of decubitus ulcers, wounds or other medical diagnoses as deemed appropriate by BeLoved Hospice. I consent to the use of this photograph, along with my name, to become part of my permanent medical record. Only those who are legally authorized to know, or who have a medical need to know, will see my personal health information.
- 15. Oxygen and Smoking Risk Acknowledgment** – As a patient of BeLoved Hospice, I have been or may be prescribed the use of oxygen by the Hospice Medical Director. I acknowledge that my choice to continue smoking while using oxygen is a hazard and involves serious risks. These risks include decreased lung capacity, the possibility of fires in my place of residence and the risk of bodily harm to myself and others, including the potential for life threatening burns. I acknowledge that the BeLoved Hospice team has explained these risks to me and that for my own safety and the safety of others, including the BeLoved Hospice staff, I further agree to not smoke in the presence of oxygen. I understand that if I should smoke, there is a possibility that BeLoved Hospice may terminate my services immediately for failure to comply with this agreement.
- 16. Infection Control/Universal Precautions** – I acknowledge that I have received a copy of BeLoved Hospice's Infection Control/Universal Precautions information handout. I understand that this information provides an explanation of the ways in which infection control/universal precautions should be handled for both my safety and the safety of others. I have been provided with the opportunity to discuss concerns that I may have in regards to the use of infection control and universal precautions.

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- 17. Proper Disposal of Medications and Management of Controlled Substances** – I acknowledge that I have received a copy of BeLoved Hospice’s policy on proper disposal of medication and management of controlled substances. I have been provided with the necessary information to properly dispose of expired and unused medication and understand how medications should be handled.
- 18. Coverage** – The reimbursement for BeLoved Hospice has been explained. The opportunity has been given to discuss any financial needs and situations with a representative of BeLoved Hospice. The decision to accept myself and my family into the Hospice program of care will not be based on ability to pay and the services of BeLoved Hospice will neither be withheld nor curtailed based upon any change in our ability to pay.
- 19. Advance Directives** – BeLoved Hospice has provided me with information about advance healthcare directives. I have been informed of my rights to formulate and Advance Directive. I understand that I am not required to have an Advance Directive in order to receive medical treatment by any healthcare provider. I understand that the terms of any Advance Directive that I have or will have executed will be followed by any healthcare provider and my caregivers to the extent permitted by law. I have received information on state law and BeLoved Hospice written policy, advising me of my right to make decisions concerning my medical care, including the right to accept or refuse medical or surgical treatment and formulate advance directives. Hospice staff will assist me in completing advance directives at my request.
- 20. 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. BeLoved Hospice will actively offer bereavement services to the patient’s family and loved ones for at least one year following the patient’s passing. Services designed for family members and others include individual counseling, group support, and help with practical matters and social events.
- 21. Receipt of Services** – Patients of BeLoved Hospice have been admitted to hospice on the basis of qualifications of admission criteria set forth by the Centers for Medicare Services. Patients can continue to receive hospice services unless a) the patient no longer meets the hospice criteria, b) the patient and/or family requests discontinuation of services, c) the patient and/or family initiates care not authorized by the BeLoved Hospice plan of care, d) the patient transfers out of the BeLoved Hospice service area, e) the patient transfers to a Medicare skilled bed in a nursing facility not contracted by BeLoved Hospice or f) the patient and/or family refuses to comply with the agreed upon plan of care.
- 22. Complaints/Concerns** – I have been informed and encouraged, that should the need arise; I have several resources to contact for concerns or complaints. I may contact the BeLoved Hospice Administrator or the employee’s immediate supervisor at (971) 236-1199, or through their website www.belovedhospices.com. You may also file a confidential complaint via BeLoved Hospice’s reporting partner All Voices at belovedhospice.allvoices.co. All complaints will be handled confidentially and without coercion, discrimination, reprisal or unreasonable interruption of services. I have also been informed and encouraged that should the need arise, I may contact the Community Health Accreditation Partner (CHAP) via phone at (202) 862-3413 ext. 7000 with my concerns. In addition to these sources, I may also contact the Oregon Health Authority Health License Office at (800) 542-5186 or (971) 673-0540 or via email mailbox.hclc@odhsoha.oregon.gov or in writing at 1430 Tandem Avenue, Suite 180, Salem, OR 97301.

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- 23. Patient Grievance Procedure** – It is the policy of BeLoved Hospice not to discriminate on the basis of race, color, religion, sex, marital status, age, national origin or handicapping condition as provided by law. An internal grievance procedure has been adopted to provide prompt and equitable resolutions of complaints alleging such action. I acknowledge that I have been given a copy of BeLoved Hospice “Patient Complaint and Grievance Procedure.”
- 24. Patient Bill of Rights** – I have received a Statement of the Patient’s Rights and Rights of the Elderly and have had the opportunity to read and ask questions about them.
- 25. Notice of Privacy Practices** – I have received a copy of BeLoved Hospice’s Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by BeLoved Hospice and of my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.
- 26. Communication Assistance** – I acknowledge that I have received a copy of the Communication Assistance Program. I understand that should a translator be needed, I can request one, free of charge. I have been provided with the opportunity to discuss any concerns that I may have regarding my rights to receive communication assistance.
- 27. Freedom of Choice:** I understand that there are multiple hospice care providers available in my area. After careful consideration and discussion of hospice options available to me, I hereby freely choose BELOVED HOSPICE to provide such hospice services.
- 28. Hospice Program** – I understand that the Hospice program is voluntary and that I may choose to withdraw from the program at any time.

I ACKNOWLEDGE THAT I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK ANY AND ALL QUESTIONS I HAVE CONCERNING THE HOSPICE PROGRAM OF CARE.

Treatment Authorization:

The undersigned Patient or Patient’s legally authorized representative hereby consents to any and all examinations and treatments prescribed by the Patient’s physician (or hospice physician) rendered by the Agency’s licensed nurses, physical therapists, occupational therapists, speech therapists, registered dieticians, social workers, spiritual counselors, certified nurses assistants, volunteers and hospice physicians.

Patient or Representative Signature: _____

Date: ____/____/_____

Indicate relationship if signed by other than patient: _____

Reason patient unable to sign: _____

Print Patient Name: _____

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