SYMPONIA HOSPICE
We Are Compassion

# PATIENT CONSENT AND AUTHORIZATION

**Patient Name** _____ **MR #** _____

I consent to have services provided for me and I understand the nature and philosophy to be as follows:

1) I understand that hospice care is **not intended to be curative**, but the goal is to provide **supportive care** for people who have an incurable illness. I further understand that Hospice provides emotional, social, and spiritual support not only for me, but **also for my family** and others closely involved in my life.
2) I understand services will be **provided in my place of residence**, or a hospice contracted inpatient facility.
3) I understand that the hospice team is **not intended to take the place of family**, assisted living or nursing home staff, but rather support the primary caregiver(s) in the care of the patient.
4) I understand that the hospice Interdisciplinary Team includes **nurses, social workers, home health aides, chaplains and volunteers**. Specialty team members such as dietitians and physical/occupational therapists may also assist when appropriate.
5) I understand **preauthorization** from the hospice team is necessary should I elect to receive or undergo medical tests and services primarily curative in nature and not in accordance with the plan of care designed for me by the hospice team. I further understand that I may be financially responsible for such services should preauthorization not be obtained.
6) I understand that the **Hospice Medical Director** in consultation with other members of the Interdisciplinary Team (including my attending physician) will coordinate my hospice care services.
   I have received a copy of the hospice **Disaster Plan** and understand what my duties are in the event of an emergency.
7) I have received a copy of the **Patient/Family Rights** with explanations and I understand them.
8) I have been given the **opportunity to ask questions** about my care from hospice and all questions have been answered to my satisfaction.

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**AUTHORIZATION FOR BILLING AND MEDICAL RECORD RELEASE:**

( ) **MEDICARE**: I certify that the information given me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the release of all records required to act on this request & that payment of authorized benefits be made on my behalf.

( ) **MEDICAID**: I authorize release of all records from hospice to facilitate collection of payment for services rendered under Title XIX for the Social Security Act.

( ) **INSURANCE**: I authorize release of all records from hospice to _____ Insurance Co. and to Case Management _____ to facilitate collection of payment for services. I authorize the above company to pay directly to Hospice all payments due for services rendered.

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I do not object to an agent of GA Dept. of Human Resources and other certifying and accrediting bodies reviewing my medical record and visiting my place of residence to ensure the state and federal requirements are met.

| _____ | _____ | _____ |
|---|---|---|
| PATIENT / LEGAL REPRESENTATIVE SIGNATURE | RELATIONSHIP | DATE |
| _____ | _____ | _____ |
| HOSPICE REPRESENTATIVE SIGNATURE | TITLE | DATE |

Created:
Updated: