Hospice of Warren County
1 Main Avenue, Warren PA 16365 Phone: (814) 723-2455 Fax: (814) 723-6259

INFORMED CONSENT FOR HOSPICE CARE

I, _____, request admission to Hospice of Warren County ("Hospice"). I have read the patient/family rights and responsibilities statement, and voluntarily acknowledge, consent and agree to the following:

I understand that I am suffering from (disease description) _____

_____

and that further attempts to achieve a cure or attain a significant remission are not likely to be successful.

I understand that the care provided by Hospice is palliative, not curative in its goals and techniques, and that the financial benefits of the Hospice program extend only to medications, treatments, hospitalizations and equipment that are **pre-certified** by Hospice. Unauthorized services are not covered.

I understand that the Hospice staff will also provide emotional support and spiritual support (when requested) to me and my family and/or my primary care person ("PCP") and that every attempt will be made to preserve my personal dignity.

I understand that Hospice program policies related to the use of resuscitation or extraordinary heartbeat and breathing measures such as cardio-pulmonary resuscitation and mechanical breathing assistance with the help of a respirator will be made explicit to me and my family.

I understand that my family and/or PCP (when applicable) will also be cared for by the Hospice program and will receive training and support when it is needed to carry out the management of my care.

I agree to identify a PCP who will be available around the clock. This PCP may be a family member, friend, or other person of my choosing.

I understand that (name) _____ will be my PCP. This means that he/she will be the person mainly responsible for meeting my needs at home.

I understand that as long as I am enrolled in the Hospice program my care will take place mainly at home.

If Nursing Home Placement becomes necessary for skilled care, I understand that Hospice of Warren County will continue to provide supportive services to me and my family.

I understand that Hospice care will be provided by a Hospice team of caregivers, which includes physicians, nurses, social worker, spiritual counselor, nutritionist and volunteers. Volunteer services may be of a professional or non-professional nature, but volunteers will all be trained in the basic principles and practices of Hospice care and have adequate supervision.

I understand that the Hospice services are primarily provided on a prearranged schedule, but they are also available as needed twenty-four hours a day, seven days a week. The Hospice program's phone number is 814-723-2455.

I understand that the Hospice program will assist with arranging inpatient services in an appropriate facility if it is deemed necessary by the physician. The Hospice team will continue to follow my care in whatever setting (within the geographic confines of the program) I may temporarily be.

I understand the explanation of the costs and reimbursement methods of payment for Hospice care that have been presented to me.

I understand that I am free to change my mind about this method of care and withdraw from the Hospice program at any time.

I understand the Hospice medical record will contain information about me, my family and my PCP. I give permission for my family, PCP, Hospice staff and/or my physician to exchange information about me. I understand that the Hospice staff will follow a policy of confidentiality and my signature on this form acknowledges that I have received a copy of Hospice's Notice of Privacy Practices. I understand that the Notice of Privacy Practices provides an explanation of the ways in which my health information may be used or disclosed by Hospice and of my rights with respect to my health information. Concerns I may have regarding the privacy of my information may be discussed with any Hospice staff member.

I authorize Hospice to release any information acquired by my participation in the program to my medical insurers.

I have reviewed and understand the information in Exhibit A, which is part of this Informed Consent. Exhibit A describes the possible uses of unsecured texting and unsecured email by and among Hospice staff and me, my family, my PCP, and/or my physician, for communicating confidential clinical information and confidential personal information.

I understand that I am not required to consent to the use of unsecured texting and unsecured email and if I do not, there will be no negative repercussions. I also understand that I may withdraw this consent at any time by informing a Hospice team member, who will document the termination of consent in my medical record. I have been advised of the risks of transmitting information by unsecured means and have made an informed decision regarding consent.

CIRCLE ONE: I DO/I DO NOT consent to allow the use of unsecured texting and unsecured email by me, my designated family and friends, my PCP, Hospice staff and/or my physician to exchange confidential clinical information and confidential personal information about me. It is my responsibility to (a) ensure that this contact information is accurate and up to date and (b) inform my Palliative Care Team of any changes to this contact information.

My Email address: _____ My Mobile number: _____

Designated family and friends and their electronic contact information:

_____

_____

_____

I understand that if I am to receive the full benefits of Hospice care it is important for me and my PCP to make my needs and concerns known to the Hospice staff. I (we) will actively participate in plans for my care.

At this time, I understand both the nature of my disease and Hospice care. My questions about this program have been answered to my satisfaction by

_____

(name of person responsible for obtaining the consent)

_____ _____
SIGNATURE OF PATIENT/ LEGAL REPRESENTATIVE DATE

_____ _____
WITNESS DATE

_____ _____
WITNESS DATE

EXHIBIT A

Email and Texting Informed Consent Information

Email and text message communications are not a secure and confidential means of communication. If you consent to the use of these methods of communication with your Hospice Care team, there is a chance that a third party may be able to intercept or eavesdrop on those messages. These might include people in your home who access your phone, computer or other electronic device, or third parties on the Internet who monitor Internet traffic.

In addition, email and texts may

- be circulated and forwarded to unintended recipients
- be accidentally misaddressed
- be intercepted, altered, forwarded or used without authorization or detection
- exist as a backup copy even after the sender or recipient deletes his/her copy

The Hospice Care team cannot guaranty the security and confidentiality of email and text information sent or received and is not responsible or liable for disclosure of confidential information.

You are responsible for discovering whether your cellular service provider charges a fee for transmitting text messages and, if so, for paying these fees should you choose to consent to communication via email or text message.

You should discuss the use of email and text messaging with your Hospice Care team to understand how and when these types of communications may be used. With your express consent, email and text messaging may be used by your Hospice Care team for communicating appointment reminders to you, acknowledging emails and texts received from you, and informing your family and friends of clinical information regarding your medical condition and treatment. <u>You are not required to consent</u> to the use of email and text messaging to receive Hospice Care. If you consent to the use of email and text messaging, you may withdraw your consent at any time by informing a Hospice Care team member.

The purpose of this information is to briefly outline the purpose of email and text messaging and the risks of email and text messaging so that you may decide whether to consent to these forms of communication.