Gulfside Regional Hospice Inc.
Caring for Pasco County
Proud since 1986

STATEMENT OF CONSENT AND ELECTION

Patient Name_____ MR#_____ Admission Date_____
Insurance (1)_____ (2)_____
Name of Hospice Provider (required)_____ **Gulfside Regional Hospice**

Informed Consent

My signature on this form certifies that I have been provided with a thorough explanation of the services provided by the above-named Hospice and that I consent to receive care from the hospice program. I have received, reviewed and had explained to me detailed information about:

- ☐ Advance Directives
- ☐ Eligibility for Hospice Care
- ☐ Bill of Rights for Hospice Care Patients
- ☐ The Medicare Hospice Benefit
- ☐ Notice of Privacy Practices

I acknowledge that hospice services are limited to palliative care and that I am not being offered a "cure" for my illness. I understand that should I choose to pursue aggressive treatment for my illness, I may be eligible to receive care from another provider of services. The hospice team will work closely with me and my Attending Physician, Dr._____ _____, to design and implement a palliative plan of care. I understand that the Hospice is financially responsible only for those services included in its plan of care and/or approved by its Medical Director, my attending physician and the Hospice team. If I do not agree with the recommended plan of care, as determined by the Hospice team and my attending physician, I may choose to revoke the Medicare Hospice Benefit.

Consent to Visits: I consent to receive visits from health care professionals, clinical interns and hospice accrediting or regulatory surveyors who are authorized by Hospice to observe my care or interview me.

Medicare Hospice Benefit Election: *I hereby elect to receive the Medicare Hospice Benefit from the above-named Hospice.* Hospice will provide, and is responsible for, services described above and certain prescriptions and durable medical equipment related to my hospice illness. I understand that by electing to receive hospice benefits I am waiving Medicare coverage for:

- Hospice care provided by a hospice other than the above-named Hospice (unless such care is provided by another hospice under arrangements made by the above-named Hospice); and
- Any Medicare services that are related to the treatment of the condition for which I have elected hospice care, or a related condition, or that are the equivalent of hospice care.

Medicare will pay for hospice services provided by the Hospice, services provided by another hospice under arrangements made by the above-named Hospice, services provided by my Attending Physician (if that physician is not an employee of, nor receiving compensation for those services from, the Hospice), and services unrelated to the illness for which I am receiving hospice benefits. I understand that by electing the Medicare Hospice Benefit, I am entitled to hospice care for two (2) election periods of ninety (90) days each, and unlimited sixty (60) day periods thereafter, based on Medicare criteria for eligibility.

Revocation

I understand that I may revoke this Consent/Election and withdraw from the hospice program at any time by signing a Revocation Statement, which will be given to me upon my request. If I revoke this election, I understand that I will forfeit any remaining days in the election period but will be eligible for Medicare benefits previously waived by my electing the Hospice Benefit. I may opt to re-elect my Hospice Benefit at a later date, if eligible.

Receipt of Notice of Privacy Practices: My signature on this form acknowledges receipt of the above-named Hospice's "Notice of Privacy Practices."

Private Insurance Authorization: I hereby authorize any insurer or other organization from whom I am entitled to receive payment for hospice services to make payment for such services directly to the Hospice.

I certify that I have read and understand this Statement of Consent and Election in its entirety. I have also read and understand the additional information provided by the Hospice. I hereby authorize services to be provided by the above-named Hospice to begin on _____/_____/_____ (start of care date).

_____	_____	_____	_____
Patient or Authorized Representative	Date	Witness	Date

If Patient not signing, state reason:

ORIGINAL – HIM COPY - Patient