

TIDEWELL CONNECT CONSENT FOR CARE

(PLEASE PRINT)

PATIENT NAME:	PATIENT NUMBER:
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I, _____ hereby consent to admission to and care by Tidewell Hospice. This consent is applicable to any geographic area (AHCA District) in which Tidewell Hospice administers care. I also acknowledge and consent to the following:

1. I understand Tidewell's goal is not to cure my illness, but to provide palliative care related to my advanced illness. The Tidewell team will work to manage pain and control symptoms, as well as provide emotional and spiritual support to me and my family.
2. I understand that Tidewell respects my right to make choices for my health care and services including choices related to foregoing resuscitation and other life-sustaining measures. I further understand that if I have not made my wishes known to Tidewell, and/or in the absence of a DNRO, trained Tidewell staff will initiate basic life support resuscitation should I experience cardio-pulmonary arrest.
3. The Tidewell team concept of treating physical, psychological and spiritual needs has been explained. I am aware the team consists of my attending physician, the Tidewell medical director, nurses, counselors, aides, volunteers, other professionals, and medical and nursing students.
4. I have been informed that the Tidewell team will make regularly scheduled visits and will be available 24 hours a day, seven days a week. I understand the Tidewell team is not intended to take the place of my family, but rather to support, educate and assist in providing my care.
5. I have received a copy and understand the Patient's Rights and Responsibilities. I have been given the opportunity to ask questions.
6. I have received a copy of Tidewell 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 Tidewell 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.
7. I understand that if I am to receive the full benefits of hospice care it is important to make my needs and concerns known to the Tidewell team. I agree to actively participate in my plan of care.
8. I understand that the hospice medical record will contain information about me and my family. The medical records will be kept confidential.
9. Tidewell will provide services regardless of my ability to pay. Tidewell does accept Medicare, Medicaid and private insurance. If I have none of these available to me, I understand an assessment will be done to assist me in accessing available resources or determining my ability to contribute to my care.

I authorize Tidewell Hospice services to begin on _____
(MONTH/DAY/YEAR)

Date Patient or Legal Representative Signature Relationship

Date Primary Caregiver Signature Relationship

Date Witness Signature Relationship

If patient is unable to sign, state reason: _____