PALLIATIVE CARE
VISITING NURSE HEALTH SYSTEM

PATIENT COPY

Palliative Patient Agreement

Patient Name: _____

ID#: _____

PATIENT RIGHTS AND RESPONSIBILITIES: I acknowledge receipt of my rights and responsibilities as a patient and I understand them. I acknowledge that I have chosen Visiting Nurse Health System to provide palliative care. No employee of Visiting Nurse Health System has solicited or coerced my decision in selecting Visiting Nurse Health System.

CONSENT FOR TREATMENT: I hereby give my permission for authorized personnel of Visiting Nurse Health System to perform all necessary procedures and treatments required for admission and ongoing care under the Visiting Nurse Palliative Program. I understand that Visiting Nurse Health System will supervise services provided. I may refuse treatment or terminate services at any time, and Visiting Nurse Health System may terminate their services to me as explained in my orientation.

RELEASE OF INFORMATION: I acknowledge receipt of the Notice of Privacy Practices and was given an opportunity to ask questions and voice concerns. I understand that Visiting Nurse Health System may use or disclose protected health information about me to carry out treatment, payment or healthcare operations. Visiting Nurse Health System may release information to or receive information from insurance companies, health plans, Medicare, Medicaid or any other person or entity that may be responsible for paying or processing for payment any portion of my bill for services; any person or entity affiliated with or representing for purposes of administration, billing and quality and risk management; any hospital, nursing home or other healthcare facility to which I may

be/have been admitted; any assisted living or personal care facility of which I am a resident; any physician providing my care; family members and other caregivers who are part of my plan of care; licensing and accrediting bodies and other healthcare providers in order to initiate treatment. I further understand and agree that Visiting Nurse Health System may release my information to contractors or consultants working with Visiting Nurse Health System.

CONSENT TO FILM OR RECORD: I hereby consent for Visiting Nurse Health System to record or film my care, treatment and services and allow Visiting Nurse Health System to use the photographs/recordings for their internal use, for documenting my medical condition or for insurance providers to document my condition for payment purposes.

CONSENT TO OBSERVATIONS: I grant my permission for students in healthcare related programs, supervisory staff, members of the Board of Directors, healthcare consultants, State of Georgia and The Joint Commission surveyors and representatives of any other certification/accreditation/professional bodies to observe Visiting Nurse Health System employees perform my prescribed care and/or review my medical record. I am aware that I may revoke permission for observation verbally or in writing at any time.

NONDISCRIMINATION: Visiting Nurse Health System and I agree that services are provided without regard to race, color, religion, handicap, national origin, gender preference or ability to pay.

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PATIENT COPY

I certify that I have received and read a copy of this Patient Agreement, Patient Rights and Responsibilities, written materials on my right to refuse or accept medical treatment and my right to formulate an advance directive.

I certify I have read each of the documents or that they have been explained to me and that I understand the information.

I also certify that I am the patient or the patient's legal representative duly authorized to execute the terms of this Patient Agreement.

By signing this document, I hereby acknowledge that I have reviewed the Patient Agreement, a hard copy of which has been provided to me, and I hereby consent to and agree to be bound by same.

_____ _____

Patient/Legal Representative Signature **Date**

_____

Printed Name and Relationship of Legal Representative

_____ _____

Visiting Nurse Health System Representative Signature **Date**