PATIENT GUIDE

Patient Care Line

904.407.7700

communitypalliative.com

Important Names and Numbers

To contact your Community Palliative Consultants℠ team,
please call 904.407.7700

Please notify your Palliative Care Team:

- If patient condition changes, patient becomes restless or agitated
- About patient and family questions or concerns
- Before transfer to hospital or nursing home

Your Palliative Care Team

APRN: ____

Patient ID: ____

Provider Relations Coordinator: ____________________________

Community
Palliative Consultants℠

Table of Contents

Welcome

Letter from Community Palliative Consultants℠ Team 3
Palliative Care Services Overview 4
Eligibility Considerations 5
What to Expect from Your Care Team 5
Team Roles & Functions 6

Patient Care

Recognizing and Managing Pain 6
- Treatment of Pain 7
- Taking Your Pain Medications 8
- Non-Drug Treatment of Pain 9
- Medications 9
- Taking Your Medications Safely 9

Advance Care Planning

About Advance Care Planning 10
- The Patient's Right to Decide 10
- Statement of Advance Directives or Living Wills 10
- Community Palliative Consultants℠ Team Practices for Advance Care Planning 11

Types of Advance Care Planning Documents 11
- Deciding About Advance Care Planning 13
- If You Complete an Advance Care Plan 14
- If You Already Have an Advance Care Plan 14
- If You Want to Consider Having a DNRO 14
- Organ, Tissue and Full Body Donations 14

Notice of Privacy Practices and Patient Rights

Community Palliative Consultants℠ Notice of Privacy Practices 15
- Our Commitment to Protecting Your Privacy 15
- How Your Protected Health Information (PHI) may be Disclosed 17
- Your Rights Regarding your PHI 20

Patient and Family Rights and Responsibilities Guidelines 23
How to Get Help with other Languages 26

Appendix: Forms

Authorization to Release Patient Medical Information 28
Medication Use Agreement 30
Consent for Treatment and Universal Patient Authorization 32

Dear Patient and Family,

Thank you for choosing Community Palliative Consultants℠ for your supportive care needs.
We are honored by the trust you have shown in allowing us the privilege of providing care to you and your family.

Community Palliative Consultants℠ believes the home based palliative program will be beneficial in achieving the goal of providing high-quality services that are helpful to you and those who are caring for you.

Community Palliative Consultants℠ offers a specialized, person-centered model of care that coordinates treatment and palliation and moves the focus of care for serious life-limiting illness out of the hospital and into the home and community.

Please review the following information about our services. We are here to help you live better, as well as to provide education to you and your family about your disease process. After reviewing your medical record and speaking with your primary care physician and/or specialist, our goal is to provide you with a better understanding of your current health status. We will assist you in identifying and clarifying your goals of care and helping you understand your future health care needs.

If you have any questions or concerns during the course of your care with us, please contact our Community Palliative Consultants℠ Team at **904.407.7700.**

Sincerely,

Your Community Palliative Consultants℠ Team

Palliative Services Overview

Community Palliative Consultants℠ (CPC) offers this model of care designed for people facing a serious life-limiting illness who wish to benefit from comfort-oriented therapies yet retain the ability to pursue treatment options through their primary and/or specialist care provider(s). It is about maximizing comfort and quality of life through supportive care and coordination of care services.

You have been referred to Community Palliative Consultants℠ by your healthcare and/or insurance provider. CPC is a specialized, person-centered care approach that coordinates treatment and symptom management, and moves the focus of care for a late-stage, serious life-limiting illness to the home and community.

Care is provided by an Advanced Practice Registered Nurse (APRN) that focuses on delivering pain and symptom management, and emotional and spiritual support through collaboration with your primary and/or specialist care provider(s). The care is tailored to your needs and wishes, and supports your family and/or caregivers.

Our dedicated Palliative Care Team gives you the tools to manage your illness and improve your quality of life. We do this through regular visits from our dedicated APRN, who will coordinate with your physicians. This team will help with managing difficult symptoms, and coordinate access to community-based services and other types of care that may help you. Our team also works with you to create a personalized care plan unique to your life, your values and your goals for care.

Patients and families will benefit from:

- Relief from pain and challenging symptoms
- Greater peace of mind in navigating the complex health care system
- Practical and emotional support for family caregivers every step of the way
- Guidance in planning and making decisions about future health care needs

Our professionals support you and your loved ones in person or by phone. Our team will follow you over time for as long as needed. While we help guide you through your options and support your decisions, **we never make them for you**. You and your family's needs always come first, and you are always in control.

Eligibility Considerations

You might be eligible to receive services provided by Community Palliative Consultants℠, if you meet one or more of the following:

- You are a high risk for hospital re-admission
- You have a serious life-limiting illness with a possible life expectancy of less than 2 years
- You are still receiving life-prolonging treatment
- You have recently been discharged from a skilled nursing facility/hospital and your condition is declining
- You have uncontrolled symptoms
- You desire Advance Care Planning

A co-pay may apply for services provided by Community Palliative Consultants℠.

What to Expect from Your Palliative Care Team

Your care team will work with you and/or your caregiver(s) to develop your personalized plan of care. The plan of care is essential to ensure that you, your family and your care team are working together to meet your specific care goals. This plan of care will guide everyone to ensure the entire team supports your unique needs and gives you and your family an excellent experience. After your personalized plan of care is developed, your care team will:

- Collaborate with your primary and/or specialist care provider(s);
- Assist with the coordination of services and/or community resources; and
- Provide you with education, as needed.

Your care team will routinely contact you to make certain your needs are addressed and the plan of care remains appropriate. The members of your care team will discuss all aspects of the care plan, address any questions or concerns you may have and confirm that everyone is in agreement.

Sometimes a patient or family member may wish to seek additional medical care or hospital services. If you and/or your family are interested in these services, we recommend discussing them with your care team or calling our Community Palliative Consultants℠ before seeking care.

If you experience worsening symptoms, pain or change in condition, it is critical that you contact your care team immediately at 904.407.7700.

Team Roles & Functions

Your Palliative Care Team includes you, your family and caregiver, your primary and/or specialist care provider(s), an APRN and other professionals as part of the interdisciplinary team. Each member brings special skills and expertise to the team to provide care that meets your needs.

You and your **Primary and/or Specialist care provider(s)** will work together along with your APRN to create orders for your care, treatment and medications. The team will communicate with your provider(s) regularly and provide updates on your condition.

Your **Palliative Care Physician and/or Advanced Practice Registered Nurse (APRN) consultants** specialize in Palliative Medicine. They tailor your care to address pain and symptom management and provide support to you and your loved ones as you face the challenges of living with a life-limiting illness. Your APRN teaches the "hands-on" caregiving skills needed for your care and comfort so your caregivers feel confident in their abilities to support you. He or she will continually evaluate your pain and any other symptoms, monitoring any changes in your condition and letting you know what to expect as your illness progresses.

Recognizing and Managing Pain

There may be times during the illness when pain is present. This pain may be related to the disease, anxiety or fear. Only the patient knows how it feels and can adequately describe the pain. Whatever the cause may be for the pain, there is no need to suffer.

When pain is present, your life can be affected in many ways. You may notice the following symptoms: loss of appetite, inability to sleep, restlessness, anger, withdrawal and/or exhaustion. There also may be other reasons for these behaviors, as well as other causes for the discomfort that may not be related to the illness, such as arthritis or headache pain.

Remember pain is whatever you say it is, and occurs whenever and wherever you say it does. Your care team is concerned about your comfort, so keep us informed of your level of pain and if it is not being controlled.

People have different coping patterns and may not always look like you think a patient with pain should look. You are encouraged to share these with your caregiver, as you may display any of the following, either at rest or while being moved:

- Sleeping a lot or having difficulty sleeping
- Using terms such as "hurting," "aching" or "hurts all-over"
- Verbal expressions such as moaning, groaning or crying out
- Facial expressions such as grimacing, frowning, looking sad and wrinkling of the brow, especially in patients who are less alert
- Movements such as restlessness, fidgeting, moving slowly, protecting a body part, pacing, rocking back and forth
- Difficulty concentrating
- Rubbing or protecting the place that hurts
- Changes in eating patterns
- Changes in usual behaviors (for example, a vocal patient becomes quiet or a quiet patient becomes vocal)
- Changes in activity levels, or resisting activity or movement
- Withdrawal from friends and family

Treatment of Pain

For mild to moderate pain, over-the-counter medications or prescription medicine can be ordered by your primary and/or specialist care provider(s).

For moderate to severe pain, your APRN will discuss a treatment plan with your primary and/or specialist care provider(s). Most pain medications are taken by mouth. If you have difficulty swallowing and cannot take a tablet or liquid, your physician may order other options including:

- Oral medication
- Patch on the skin
- IV pump
- Suppositories

Some medications are long-acting, which means they are taken on a regular schedule (e.g., once a day) and work around the clock. There may be times when your pain returns before it is time to take your next dose; your doctor may prescribe a short-term ("break-through") pain medication for these situations.

All medications have side effects, pain medications are no different. Some medications can cause:

- Constipation
- Nausea and vomiting
- Drowsiness
- Dry mouth

Taking Your Pain Medications

Many people are concerned about taking pain medications and may think it is better not to take them as directed by your primary and/or specialist care provider(s).The goal of pain treatment is to prevent your pain from getting out of control. Please consider the following:

- Take your medicine regularly, as ordered. Taking medicine regularly will keep pain under control. Never wait for the pain to get worse before taking your medication.
- If your pain gets worse at certain times of the day or during an activity, you may need to take an extra dose prior to doing that activity. However, if you feel your pain is uncontrolled, please notify your APRN before taking any medications.
- Remember that once you feel pain, it is harder to get it under control.
- Keep a record of medications you have taken, especially if your pain is not well controlled, so your APRN can discuss it with your primary and/or specialist care provider(s) and make changes.

Non-Drug Treatment of Pain

Several techniques may be effective to control pain without medications, including:

- Breathing and relaxation
- Massage
- Hot/cold packs
- Aromatherapy
- Music
- Imagery
- Distraction
- Rest

For additional information about these methods, please speak with a member of your care team. Our specially trained staff work with you and your primary and/or specialist care provider(s) to achieve pain relief.

Discuss any concerns or questions you have regarding pain and your medications with your APRN OR call Community Palliative Consultants℠ at 904.407.7700 with questions.

Medications

Our staff are experts in pain and symptom management. Your APRN will consult with your specialty and/or primary care provider(s) to determine the best medicines for your comfort while honoring your wishes.

Your APRN will offer instructions on the safe administration of medications and will review your medications with you at each visit and if/when changes occur.

Taking Your Medications Safely

Your physician orders your medications to help treat your condition. It is important to take them safely:

- Read the labels and information that come with your prescriptions and take them as directed.
- Check the label on the bottle to be sure you are taking the right medicine and dosage.
- Keep your medicine in the original bottle, safely away from children, pets and confused household members.
- Medicines that look alike should be stored apart to prevent mistakes and confusion.
- Keep your medicine in a cool, dry place. Refrigerate medicine if required.
- Keep medications in set locations so it is easier for you to remember to take them.
- Keep each family member's medications in separate locations.
- Keep tubes of ointments and creams away from toothpaste.
- Do not chew, crush or break any capsules or tablets unless instructed.
- Discard all medications that are no longer used or are expired.
- If your medications are running low, call your pharmacist to request a refill. If you no longer have refills, your APRN can assist by writing a prescription and/or contacting your primary and/or specialist care provider(s).
- Do not share your medicines with family members or friends.
- Don't take over-the-counter (non-prescription) medications without checking with your primary care provider first.
- Keep track of your medications with the medication list provided by your care team.
- If you have any questions about the medications you are taking, ask your APRN or call the Patient Care Line.

About Advance Care Planning

The Patient's Right to Decide

Adults with capacity have the right to make decisions concerning their own health, including the right to choose or refuse medical treatment. A federal government law called the Omnibus Budget Reconciliation Act of 1990 allows you to make your health care wishes known to everyone who provides health care to you.

When a person becomes unable to make decisions due to a physical or mental change, such as being in a coma or developing dementia, like Alzheimer's disease, he/she is considered incapacitated. To make sure that an incapacitated person's wishes about health care will still be honored, the Florida legislature also enacted laws pertaining to health care advance directives.

The law recognizes your right to make an advance care plan. Your advance care plan identifies your wishes about continuing, withholding or withdrawing life-prolonging procedures; designates someone to express your wishes and make treatment decisions if you become incapacitated; and/or indicates your desire to make an anatomical donation after death.

Individuals often do not think about or document health care wishes in advance, and therefore they and their family are forced to make difficult decisions under stressful circumstances. The Community Palliative Consultants℠ Team encourages you and your family to discuss the care you would want and make plans that can be easily implemented at the appropriate time. We also provide trained facilitators who can guide you through the conversation and help you complete an advance care plan if you choose.

Whether or not you have an advance care plan, it is important that you inform your nurse of your wishes and any changes you might make while in our care. Please make sure your Palliative Care Team is aware of your wishes so they can honor them.

By law, hospitals, nursing homes, home health agencies, hospices and health maintenance organizations (HMOs) are required to provide their patients with written information concerning health care advance directives.

Statement of Advance Directives or Living Wills

The following is provided to inform you about Florida law regarding "advance directives" and/or "living wills."

Under Florida law, every adult has the right to make certain decisions concerning his or her medical treatment. The law also allows for your rights and personal wishes to be honored even if you are too sick to make decisions for yourself.

You have the right, under certain conditions, to decide whether to accept or reject medical treatments, including whether to continue medical treatments and other procedures that would prolong your life artificially.

Your wishes may be spelled out by you in an advance care plan, sometimes called a "living will." It contains your personal directions about life-prolonging treatments in the case of a serious illness that could cause death.

You also may designate another person, or surrogate, to make decisions for you if you become mentally or physically unable to do so. This surrogate may speak on your behalf and can make health care decisions based on your expressed wishes when your doctor has said you lack capacity. You can identify and document any limits to the power of the surrogate in making decisions for you.

Your health care provider will furnish you with written information about its policy regarding advance directives.

Community Palliative Consultants℠ Team practice for Advance Care Planning

It is the practice of the Community Palliative Consultants℠ Team to involve the patient and family in all health care decisions while admitted to any of our care programs.

The Community Palliative Consultants℠ Team will not attempt to influence your decisions, nor promote a specific action; nor will the Community Palliative Consultants℠ Team take measures to either hasten or postpone death. You may receive care from us, regardless of whether or not you have executed an advance care plan.

Types of Advanced Care Planning Documents

Honoring Choices® Florida Advance Care Plan

Included in the back pocket of this booklet is an advance care plan used in the Northeast Florida community. It was reviewed and approved by the legal departments at the local hospitals and it adheres to Florida statutes. Honoring Choices® Florida is a comprehensive advance care planning program available at no charge to area residents. Facilitators have been trained to guide a conversation about wishes when facing a serious or life-limiting illness. The facilitator can also assist in the completion of the advance care plan. If you choose to complete the document without the guidance of a facilitator, make sure to follow the directions carefully, sign and date it, have it witnessed as directed, and distribute copies as noted on the last page. Advance care planning is about the conversation, not just the document, so make sure to talk to your family, significant others

and your health providers, making everyone aware of your wishes to ensure you get the care you want. If you would like a facilitator to meet with you, tell a member of your care team, or contact us at HonoringChoicesFL.com or 904.407.7024.

Living Will

A living will is a form that documents a person's wishes regarding life-prolonging medical care when he or she is no longer able to make decisions.

Health Care Surrogate

A health care surrogate designates another person to make health care decisions and carry out your wishes when you are no longer able to make them for yourself. This would include decisions concerning life-prolonging treatments such as ventilator or respirator, CPR, feeding tube and IVs.

Power of Attorney

A power of attorney is a written document that is immediately effective that allows you to name someone as your agent. The agent steps into your shoes, legally speaking, for the financial powers you have authorized in the power of attorney directive. You can authorize your agent to do such things as sign checks and tax returns, enter into contracts, buy or sell real estate, deposit or withdraw funds, run a business, apply for government benefits, enter into certain trusts, or anything else you do financially for yourself. Your agent's rights end at any time you lack capacity and you can revoke the power of attorney at any time.

Durable Power of Attorney

A durable power of attorney serves the same function as a power of attorney, but also gives your agent the authority to carry out your health care wishes. The agent's authority remains effective even if you become incapacitated, so long as it contains legal language that states something similar to "this durable power of attorney survives incapacity except as otherwise provided under Florida law."

This makes the durable power of attorney an important estate planning tool. If incapacity should strike you, your agent can maintain your financial affairs and carry out your health care wishes until you are again able to do so. That way, your family's needs continue to be provided for, and the risk of financial loss is reduced.

The authority of a durable power of attorney ends at death and you can revoke your durable power of attorney at any time.

About Do Not Resuscitate Orders (DNRO)

A Do Not Resuscitate Order (DNRO) order is an instruction that you want to decline lifesaving measures, such as cardiopulmonary resuscitation (CPR), if you have a medical emergency. The DNRO is a specific yellow form available from the Florida Department of Health (FDOH).

A member of your care team, another health care provider or your attorney has copies available for your use. You, or your legal representative, and your physician must sign the DNRO form. More information is available on the FDOH website, **FloridaHealth.gov** or **MyFlorida.com** (type DNRO in these website search engines) or call **850.245.4440**.

When you are admitted to a hospital, the pre-hospital DNRO may be used during your hospital stay, or the hospital may have its own form and procedure for documenting a DNRO.

Community Palliative Consultants℠ patients are not required to have a DNRO in place to receive supportive care services.

If you have not signed a DNRO and you or your caregiver call 911, you should know what to expect. Once 911 is called, emergency personnel are required to begin CPR upon arrival if you do not have a yellow State of Florida DNRO form present and completed. To be valid, the form requires a signature from you or your health care surrogate and your physician.

If the DNRO form is not completed and available, emergency personnel are required by law to begin CPR even if you have chosen not to receive it. This may result in unwanted medical treatment, including placing you on life support.

If you choose to complete a DNRO, your physician and family members should each keep copies on yellow paper. Please keep your copy of your DNRO form in a location where it is easy for you, your caregiver and other health care professionals to find. Be prepared to provide the original yellow DNRO form to emergency medical personnel upon request.

The DNRO form always should be with you when you transfer to a different care setting. For example, if you leave your home to go to the hospital, a long-term care or assisted living facility, or your family member's home, you should bring the DNRO form with you.

Deciding About Advance Care Planning

When Making a Decision about an Advance Care Plan

Various organizations, including Community Palliative Consultants℠, make advance care planning documents available. One such document is the Honoring Choices® Florida advance care plan developed in collaboration with area hospitals. This document gives you the opportunity to specify the care and treatment you would or would not want when faced with a serious or life-limiting illness. The Honoring Choices® Florida advance care plan is in the back folder of this notebook. You can ask a member of your Palliative Care Team, or you can find out more at:

HonoringChoicesFL.com or 904.407.7024

If You Complete an Advance Care Plan

Talk with the person you designate as your surrogate to make sure they accept the responsibility to carry out your wishes. Discuss your wishes with your surrogate and other family members to make sure everyone knows what you want. Give them copies of your advance care plan and make sure to give a member of your Care Team a copy for your medical records.

Set up a file where you keep a copy of your advance care plan. If you keep original documents in a bank safe deposit box, make sure to also keep copies of your advance care plan at home. Keep a card or note in your wallet that states that you have an advance care plan and where it is located. See the cut-out card in the Honoring Choices® Florida document. If you change your advance care plan, make sure your surrogate, other family, health care providers, and a member of your care team have the latest copy.

If You Already Have an Advance Care Plan

Provide a member of your care team a copy so that your wishes are known and it can be placed in your medical record. Make sure your family and significant others know you have an advance care plan in place, have copies, know your wishes, and know who you have designated as your surrogate. Ask to speak with a member of your care team if you have questions about your advance care plan or think you may want to update your plan.

If You Want to Consider Having a DNRO

Ask a member of your care team for help with completing this order. See above for more details.

Organ, Tissue and Full Body Donation

If you would like to read more about organ and tissue donation to persons in need, you can find information at:

- U.S. Department of Health and Human Services website at **OrganDonor.gov**
- Agency for Health Care Administration website at **AHCA.MyFlorida.com**

Click on "Licensure & Regulation," "Consumer Resources," and "Organ & Tissue Donation."

Donate Life Florida at **donatelifeflorida.org** where you can also register your intent to donate.

Community Palliative Consultants℠

Notice of Privacy Practices (“Notice”)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED A ND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

If you have any questions regarding this notice please contact our **Privacy Officer**. The contact information for our **Privacy Officer** may be found at the end of this Notice. This Notice describes how our practice and our health care professionals, employees, volunteers and, trainees may use and disclose your medical information to carry out treatment, payment or health care operations and for other purposes that are described in this Notice. We understand that medical information about you and your health is personal and we are committed to protecting medical information about you. This Notice applies to all records of your care generated by this practice.

This Notice also describes your right to access and control your medical information. This information about you includes demographic information that may identify you and that relates to your past, present and future physical or mental health or condition and related health care services. Typically your medical information will include symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment.

We are required by law to protect the privacy of your medical information and to follow the terms of this Notice. We may change the terms of this Notice at any time. The new Notice will then be effective for all medical information that we maintain at that time and thereafter. We will provide you with any revised Notice if you request a revised copy be sent to you in the mail or if you ask for one when you are in the office. You may request a copy of this Notice at any time by contacting the **Privacy Officer**.

I. <u>Uses and Disclosures of Protected Health Information</u>

Your medical information may be used and disclosed for purposes of treatment, payment and health care operations. The following are examples of different ways we use and disclose medical information. **<u>These are examples only</u>**.

(a) <u>Treatment</u>:
We may use and disclose medical information about you to provide, coordinate, or manage your medical treatment or any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your

medical information. For example, we could disclose your medical information to a home health agency that provides care to you. We may also disclose medical information to other physicians who may be treating you, such as a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your medical information to another physician or health care provider, such as a laboratory.

(b) Payment:

We may use and disclose medical information about you to obtain payment for the treatment and services you receive from us. For example, we may need to provide your health insurance plan information about your treatment plan so that they can make a determination of eligibility or to obtain prior approval for planned treatment. For example, obtaining approval for a hospital stay may require that relevant medical information be disclosed to the health plan to obtain approval for the hospital admission.

(c) Healthcare Operations:

We may use or disclose medical information about you in order to support the business activities of our practice. These activities include, but are not limited to, reviewing our treatment of you, employee performance reviews, training of medical students, licensing, marketing and fundraising activities and conducting or arranging for other business activities.

For example, we may use your PHI to develop ways to assist our physicians and staff in deciding how we can improve the medical treatment we provide to others. Another example is that your PHI may be seen by doctors reviewing the services provided to you and by accountants, lawyers and others who assist us in complying with the law and managing our business.

We may share your medical information with third party "business associates" that perform activities on our behalf, such as billing or transcription for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your medical information, we will have a written contract that contains terms that asks the "business associate" to protect the privacy of your medical information.

(d) Health Information Exchange:

We, along with certain other health care providers and practice groups in the area, may participate in a health information exchange ("Exchange"). An Exchange facilitates electronic sharing and exchange of medical and other individually identifiable health information regarding patients among health care providers that participate in the Exchange. Through the Exchange we may electronically disclose demographic, medical, billing and other health-related information about you to other health care providers that participate in the Exchange and request such information for purposes of facilitating or providing treatment, arrangement for payment for health care services or otherwise conducting or administering health care operations.

(e) Fundraising:
We may use or disclose your PHI in order to contact you or a family member as part of a fundraising effort. Your name, address, phone number and the dates you received care may be used as part of a fundraising effort. If you do not wish to be contacted, you may opt-out by sending a notification in writing to our Privacy Officer, indicating that you do not wish to be contacted.

II. Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your medical information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your medical information. If you are not present or able to agree or object to the use or disclosure of the medical information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the medical information that is relevant to your health care will be disclosed.

(a) Others Involved in Your Healthcare:
If you have signed an acknowledgement agreeing to be listed in our patient directory the permits us to let your family, friends and other persons who inquire know your care location, general condition and religious affiliation. You will be assigned a Protected Health Information (PHI) Security Code. When you share your PHI Security Code you will be allowing the person you provide your PHI Security Code with access to your health information and physician location. We may use or disclose medical information to notify or assist in notifying a family member or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your medical information to an entity assisting in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

(b) Emergencies:
We may use or disclose your medical information for emergency treatment. If this happens, we shall try to obtain your consent as soon as reasonable after the delivery of treatment. If the practice is required by law to treat you and has attempted to obtain your consent but is unable to do so, the practice may still use or disclose your medical information to treat you.

(c) Communication Barriers:
We may use and disclose your medical information if the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and, in our professional judgment, you intended to consent to use to use or disclosure under the circumstances.

III. Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your medical information in the following situations without your consent or authorization. These situations include:

(a) Required By Law:
We may use or disclose your medical information when federal, state or local law requires disclosure. You will be notified of any such uses or disclosure.

(b) Public Health:
We may disclose your medical information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. This disclosure will be made for the purpose of controlling disease, injury or disability.

(c) Communicable Diseases:
We may disclose your medical information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

(d) Health Oversight:
We may disclose medical information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure. These activities are necessary for the government agencies to oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

(e) Abuse or Neglect:
We may disclose your medical information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your medical information to the governmental entity authorized to receive such information if we believe that you have been a victim of abuse, neglect or domestic violence as is consistent with the requirements of applicable federal and state laws.

(f) Food and Drug Administration:
We may disclose your medical information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

(g) Legal Proceedings:
We may disclose medical information in the course of any judicial or administrative proceeding, when required by a court order or administrative tribunal, and in certain conditions in response to a subpoena, discovery request or other lawful process.

(h) Law Enforcement:
We may disclose medical information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include: (i) responding to a court order, subpoena, warrant, summons or otherwise required by law; (ii) identifying or locating a suspect, fugitive, material witness or missing person; (iii) pertaining to victims of a crime; (iv) suspecting that death has occurred as a result of criminal conduct; (v) in the event that a crime occurs on the premises of the practice; and (vi) responding to a medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

(i) Coroners, Funeral Directors, and Organ Donors:
We may disclose medical information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose medical information to funeral directors as necessary to carry out their duties.

(j) Research:
We may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Internal Review Board ("IRB") or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate, written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

(k) Criminal Activity:
Consistent with applicable federal and state laws, we may disclose your medical information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose medical information if it is necessary for law enforcement authorities to identify or apprehend an individual.

(l) Organ and Tissue Donation:
If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

(m) Military Activity and National Security:
If you are a member of the armed forces, we may use or disclose medical information, (i) as required by military command authorities; (ii) for the purpose of determining by the Department of Veterans Affairs of your eligibility for benefits; or (iii) for foreign military personnel to the appropriate foreign military authority. We may also disclose your medical information to authorized federal officials for conducting national security and intelligence activities, including for the protective services to the President or others legally authorized.

(n) Worker's Compensation:
We may disclose your medical information as authorized to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illness.

(o) Inmates:
We may use or disclose your medical information if you are an inmate of a correctional facility and our practice created or received your health information in the course of providing care to you.

(p) Required Uses and Disclosures:
Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500, et seq. seq.

IV. The Following Is a Statement of Your Rights with Respect to Your Medical Information and a Brief Description of How You May Exercise These Rights.

(a) You have the right to inspect and copy your medical information.

This means you may inspect and obtain a copy of medical information about you that has originated in our practice. We may charge you a reasonable fee for copying and mailing records. To the extent we maintain any portion of your PHI in electronic format; you have the right to receive such PHI from us in an electronic format. We will charge no more than actual labor cost to provide you electronic versions of your PHI that we maintain in electronic format.

After you have made a written request to our **Privacy Officer**, we will have thirty (30) days to respond to your request and up to sixty (60) days to comply with the request. If we deny your request to inspect or copy your medical information, we will provide you with a written explanation of the denial.

(b) You have the right to request a restriction of your medical information.

You may ask us not to use or disclose part of your medical information for the purposes of treatment, payment or healthcare operations. You may also request that part of your medical

information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. You must state in writing the specific restriction requested and to whom you want the restriction to apply. You have the right to restrict information sent to your health plan or insurer for products or services that you paid for solely out-of-pocket and for which no claim was made to your health plan or insurer.

(c) We are not required to agree to your request.

If we believe it is in your best interest to permit use and disclosure of your medical information, your medical information will not be restricted; provided, however, we must agree to your request to restrict disclosure of your medical information if: (i) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (ii) the information pertains solely to a health care item or service for which you (and not your health plan) have paid us in full. If we do agree to the requested restriction, we may not use or disclose your medical information in violation of that restriction unless it is needed to provide emergency treatment. Your written request must be specific as to what information you want to limit and to whom you want the limits to apply. The request should be sent, in writing, to our Privacy Officer.

(d) You have the right to request to receive confidential communications from us at a location other than your primary address.

We will try to accommodate reasonable requests. Please make this request in writing to our **Privacy Officer**.

(e) You may have the right to have us amend your medical information.

If you feel that medical information we have about you is incorrect or incomplete, you may request we amend the information. If you wish to request an amendment to your medical information, please contact our **Privacy Officer**, in writing to request our form "*Request to Amend Health Information*". In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us.

(f) You have the right to receive an accounting of disclosures we have made, if any, of your medical information.

This applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, family members or friends involved in your care, or for notification purposes. To receive information regarding disclosures made for a specific time period of up to six (6) years prior to the date of the request; please submit your request in writing to our **Privacy Officer**. To the extent we maintain your PHI

in electronic format; you may request an accounting of all electronic disclosures of your PHI for treatment, payment, or healthcare operations for the preceding three (3) years prior to such request.

(g) Other Uses and Disclosures of Protected Health Information.

We will obtain your written authorization for uses and disclosures that are not identified by this Notice or permitted by applicable law. If you have authorized us to use or disclose PHI about you, you may revoke your authorization at any time, except to the extent we have taken action based on the authorization.

(h) Right to be Notified of a Breach

You have the right to be notified in the event that our practice (or a Business Associate of ours) discovers a breach of unsecured protected health information.

(i) Right to Receive a Paper Copy of this Notice

You have a right to receive a paper copy of this Notice at any time. You are entitled to a paper copy of this Notice even if you have previously agreed to receive this Notice electronically. To obtain a paper copy of this Notice, please contact our **Privacy Officer**.

(j) Complaints

If you believe your privacy rights have been violated, you may file a written complaint with our **Privacy Officer** or the U.S. Department of Health and Human Services. **We will not retaliate against you for filing a complaint.**

Privacy Officer
Community Palliative Consultants
4266 Sunbeam Road
Jacksonville, Florida 32257
Phone: 904.407.7087

Effective Date: June 15, 2017
Last Revision: June 9, 2017

Community
Palliative Consultants℠

Patient and Family Rights and Responsibilities Guidelines

As a Community Palliative Services patient, family member or caregiver, you have certain rights and responsibilities.

The patient/family has the right to:

- Exercise his/her rights as a patient without discrimination on the basis of race, religion, age, gender, national origin, sexual orientation, marital status, disability, veteran status, diagnosis, cost of therapy, ability to pay or life circumstances.
- Be involved in developing his/her plan of care.
- Make informed decisions regarding care or services.
- Accept or refuse care or treatment and be informed of potential results and/or risks.
- Formulate advance directives at the individual's option.
- Have complaints heard and reviewed.
- Confidentiality in accordance with state and federal regulations.
- Have his/her property and person treated with respect.
- Receive effective pain management and symptom control for conditions related to Advanced Care Services qualifying diagnosis.
- Choose his/her physician or primary care provider.
- Be free from mistreatment, neglect, or verbal, mental, sexual and physical abuse, including injuries of unknown source.
- Receive information about Community Palliative Consultants℠.
- Receive information about the scope of services provided and specific limitations on those services.

The patient/family assumes the responsibility for:

- Providing daily physical and emotional support.
- Performing all agreed upon procedures of care according to stated guidelines.
- Following the prescribed procedures for contacting Community Palliative Consultants℠ for assistance.
- Contacting Community Palliative Consultants℠ when admission to a hospital is pending.
- Informing Community Palliative Consultants℠ when unavailable for visits.
- Participating in and complying with the plan of care.
- Helping your care team assess your pain and working with them to develop an effective pain management and symptom control plan.
- Informing your care team about any concerns, complaints or questions regarding needs and/or services being provided by Community Palliative Consultants℠.

If you currently have Medicaid or become Medicaid-eligible, you have a responsibility to report suspected Medicaid fraud. Please call toll-free 888.419.3456.

Medicaid fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law as it relates to Medicaid. The Office of the Inspector General at the Agency for Health Care Administration accepts complaints regarding suspected fraud and abuse in the Florida Medicaid system by phone at 888.419.3456 or on the agency website at http://ahca.myflorida.com/executive/inspector_general/medicaid.shtml.

NONDISCRIMINATION AND ACCESSIBILITY NOTICE AS REQUIRED BY ACA § 1557

Community Palliative Consultants℠ complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Community Palliative Community Palliative Consultants℠ does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

- Community Palliative Consultants℠ provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Community Palliative Consultants℠ provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Kenny Stevenson, Civil Rights Coordinator.

If you believe that Community Palliative Consultants℠ has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, Kenny Stevenson, Civil Rights Coordinator is available to help you. You can file a grievance with Kenny Stevenson, Civil Rights Coordinator, in person or in writing at: 4266 Sunbeam Road, Jacksonville, Florida 32257. You may also file a grievance via telephone at 904.407.5033, via facsimile at 904.407.7880, or via electronic mail to CivilRightsCoordinator@CommunityHospice.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Community
Palliative Consultants℠

How to Get Help with Other Languages

ATTENTION: If need help or speak a non-English language call 904.407.5033 to be connected with an interpreter at no cost.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame 904.407.5033.
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 904.407.5033.
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 904.407.5033.
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 904.407.5033.
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 904.407.5033.
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 904.407.5033.
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 904.407.5033.
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 904.407.5033.
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 904.407.5033.
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 904.407.5033.
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 904.407.5033.
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 904.407.5033.
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 904.407.5033.
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 904.407.5033.
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 904.407.5033.

AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION

Provider:

____
Hospital/Nursing Home/Other Healthcare Provider

____
Street Address

____
City State Zip Code

I authorize the named healthcare provider to release my medical information, including records related to the diagnosis or suspected diagnosis of AIDS or HIV infection, to Community Palliative Consultants℠.

Information to be Released:

Dates of service for records requested: Beginning ______________________ Through______________________

______ History & Physical
______ Physician Consult
______ Discharge Summary
______ Physician Progress Notes
______ Emergency Department Records
______ Lab / Pathology Reports
______ Radiology Reports
______ HIV-Related Records
______ Nurse / Therapy Notes ______________________
______ Other:______________________

I understand that:

- I am not required to sign this authorization and that my healthcare or payment for care will not be affected by my refusal.
- Federal privacy regulations will no longer apply to information disclosed, and Community Hospice of Northeast Florida, Inc., may re-disclose the information for the purpose of care coordination.
- A copy of this authorization may be utilized with the same effectiveness as an original.
- I can cancel this authorization at any time by writing to the Community Palliative Consultants℠, Privacy Officer at 4266 Sunbeam Road, Jacksonville, FL 32257.
- This authorization is valid from the date of signature below and remains valid until it expires or is canceled, but canceling this authorization will not affect disclosures made or actions taken before the cancellation was received.

____
Patient Printed Name

____
Patient DOB

____
Patient Signature

____
Date

____
Print Legal Representative Name

____
Relationship to Patient

____
Legal Representative Signature

____
Date

Patient Name: ______________________

Patient Number: ______________________

ROI – Effective 3/30/2018

© 2019 Community Palliative Consultants℠, All Rights Reserved.

Community Palliative Consultants℠ is a program of Community Hospice & Palliative Care

Medication Use Agreement

I, ________________________________, understand that I have pain that has not been adequately controlled with other medications and that my function is limited by my pain. I understand that the intent of the medication is to increase my ability to do more, though the medication is unlikely to eliminate the pain.

I will take the medication only as prescribed. I will not take any sedatives, alcohol or other pain medications without the prior approval of my doctor or nurse practitioner.

I understand that the medication will be prescribed by a **Community Palliative Consultants**℠ doctor or nurse practitioner according to an agreed-upon schedule. Prescriptions will be provided only during regularly scheduled appointments. Refills will never be provided by telephone.

I will report pain medications prescribed by other doctors to Community Palliative Consultants℠.
I will not borrow or accept “medications for pain” from family or friends, or illegal sources i.e. illicit or street drugs.

Medication refills will be provided as written prescriptions only. No refills will be given prior to the next scheduled appointment date. If I do not keep my appointment, I will not receive a refill. Two (2) appointment cancellations with less than one working days’ notice or two (2) no-show appointments may constitute grounds for immediate termination of this agreement.

I understand that my doctor is under no obligation to provide these medications to me, and that she or he reserves the right to discontinue these medications at any time. At my doctor’s discretion, I agree to cooperate with random drug testing, which may be requested at any time. If I refuse, I understand the medication will be stopped.

I understand that lost or stolen medications will not be refilled under any circumstances. It is my responsibility to protect and secure any medications. This includes keeping the medication out of reach of children. A copy of a police report will be required for any lost or stolen narcotics or narcotic prescriptions.

I understand that my doctor may require specialist evaluation of my treatment, and I agree to keep appointments when my physician refers me. My doctor will send a report of my care and a copy of this agreement when a referral is made.

CPC MUA – Revised 03/30/2018
© 2019 Community Palliative Consultants℠, All Rights Reserved.
Community Palliative Consultants℠ is a program of Community Hospice & Palliative Care

In addition to the above agreements:

1. I accept the right of my doctor or nurse practitioner to terminate this agreement for any of the following reasons:

   a. I seek or obtain any pain medication from a source other than a licensed doctor or nurse practitioner.

   b. I fail to report prescriptions obtained from another licensed doctor or nurse practitioner.

   c. I give, sell or in any way distribute prescribed medications to any other person(s).

   d. I, in any way, attempt to forge or alter a prescription.

   e. My medical condition declines to the point at which, in the judgment of my doctor, continued therapy with this medication presents a danger to my well-being or safety.

   f. There is evidence that I am no longer receiving a reasonable therapeutic benefit from the medication, or my doctor determines that I am no longer a good candidate to continue the medication.

I understand that by signing this agreement, I must abide by the rules outlined above and that failure to abide by this agreement will result in the termination of medication prescriptions and possibly the termination of services by Community Palliative Consultants℠.

Patient Name ______________________________ Date ____________

Patient Signature ______________________________

❑ Patient's Legal Representative, i.e., Healthcare Surrogate, or Nearest Relative **if patient is unable to sign**

Legal Representative Name ______________________________

Legal Representative Signature ______________________________ Date ____________

Relationship to Patient ______________________________

Address ______________________________

Phone Number ______________________________

© 2019 Community Palliative Consultants℠, All Rights Reserved.
Community Palliative Consultants℠ is a program of Community Hospice & Palliative Care

Consent for Treatment

Consent for Treatment

I request and authorize medical care as my physician, his assistant or designees (collectively called "the physicians") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, and routine medical and nursing care. I authorize my physician(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient) care is directed by my physician(s) and that other personnel render care and services to me (the patient) according to the physician(s) instructions.

- A drug screen by blood or urine sample may be obtained with verbal consent for purposes of verifying compliance with medication regimens or when abuse or misuse is suspected or when signs or symptoms of toxicity exist.
- I have been informed and understand that an HIV (human immunodeficiency virus – AIDS) test may be performed on me without my consent if a health professional or Community Palliative Consultants℠ employee or First Responder sustains an exposure to my blood or other body fluid.

Insurance Certification / Assignment of Insurance Benefits / Financial Responsibility

I certify that the information provided for Medicare, Medicaid or other insurance plan(s) is true and correct.

I authorize direct payment to Community Palliative Consultants℠ from Medicare, Medicaid or any insurance plan is providing insurance benefits on my behalf. This assignment of insurance benefits is provided so that Community Palliative Consultants℠ may obtain my payout history from the insurance carrier and attempt to collect any unpaid and over-due insurance benefits directly from the insurance carrier.

I authorize the release of all medical records as may be required by my insurance plan to reimburse claims submitted on my behalf.

I agree to personally pay for any charges not paid by my health insurance or any other insurance plan or policy, including but not limited to, any deductibles, copays, and coinsurance amounts provided under any coverage source, and charges for which there is no coverage source.

Cancellation / No Show Policy: A $40.00 fee will be charged for any appointment cancelled without a 48 hour notice. This fee is not covered by your insurance carrier and you will personally responsible for the payment of this fee.

Check Returns: It is our office policy to charge all patients a $35.00 fee for checks that are returned for insufficient funds.

CPC Revised 05/2019
© 2019 Community Palliative Consultants℠, All Rights Reserved.
Community Palliative Consultants℠ is a program of Community Hospice of Northeast Florida

Patient Name: ______________________

Patient Number: ______________________

If you currently have Medicaid or become Medicaid eligible, you have a responsibility to report suspected Medicaid fraud. Please call toll free 1-888-419-3456.

Medicaid fraud means intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law as it relates to Medicaid. The Office of the Inspector General at the Agency for Health Care Administration accepts complaints regarding suspected fraud and abuse in the Florida Medicaid system by phone at 1-888-419-3456 or on the agency website at http://ahca.myflorida.com/Executive/Inspector_General/medicaid.shtml

Notice of Privacy Practices

The Community Palliative Consultants℠ Notice of Privacy Practices (Notice) provides information about how protected health information about me (the patient) is used or disclosed. I acknowledge that a copy of the Notice was provided to me and I have been offered the opportunity to review the Notice before signing this consent

Nondiscrimination and Accessibility Notice

I have received a copy of the Nondiscrimination and Accessibility Notice as required by Section 1557 of the Patient Protection and Affordable Care Act.

Authorization for Full Disclosure of Health Information for Treatment and Quality of Care

I voluntarily authorize, give my permission and allow use and disclosure (release) of all my heath information, including all records and other information regarding my health history, treatment, hospitalization(s), test, and outpatient care. This information may relate to sensitive health conditions (if any), including but not limited to: drug, alcohol, or substance abuse; psychological, psychiatric or other mental health impairment(s) or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA 45 CFR 164.501); sickle cell anemia; records that may indicate the presence of a communicable disease or noncommunicable disease; test for or records of HIV/AIDS; sexually transmitted diseases; genetic (inherited) diseases; copies of education assessments, test or evaluations, individualized educational programs; psychological and speech evaluations, immunizations recorded health information (such as height, weight), and information about injuries or treatment.

I choose not to authorize the release of my health information to Community Palliative Care. ______________________
Initials

I authorize the (release) of my information to Community Palliative Care for the purpose of providing me with medical treatment and related services, products, and to evaluate and improve patient safety and the quality of medical care provided to all patients. I understand and agree that information created before or after the date of my signature below may be released upon request.

I authorize the use of a copy (including electronic copy) of this authorization for the release of the information described above.

I understand that health information received by Community Palliative Care may be subject to lawful re-disclosure (rerelease), in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

© 2019 Community Palliative Consultants℠, All Rights Reserved.
Community Palliative Consultants℠ is a program of Community Hospice of Northeast Florida

Patient Name: ______________________

Patient Number: ______________________

The authorization to release all of my health information will remain in effect until my discharge, death, or the day I withdraw my permission.

I can revoke (withdraw) my permission at any time by giving written notice to the Community Palliative Care Privacy Officer at the following address: Community Palliative Care Privacy Officer, 4266 Sunbeam Road, Jacksonville, FL 32257.

Health Care Status Authorization

I give permission for Community Palliative Consultants℠ to release information concerning the status of my health, including making and cancelling appointments, refilling medications, and discussing my medical condition(s) with any staff member regarding any and all medical issues which may arise while under the care of Community Palliative Consultants℠.

Below is a list of individuals who are authorized.

Name	**Relationship**	**Telephone#**

I confirm that I have read, or have had read to me, and fully understand this consent document. I acknowledge that I have been given the opportunity to ask questions, and all of my questions have been answered to my satisfaction.

Printed Patient Name | Patient Signature | Date

Consent of Patient's Legal Representative i.e. Health Care Surrogate, HealthCare Proxy or Nearest Relative,if patient is unable to sign.

Legal Representative Name | Legal Representative Signature | Date

Relationship to Patient | Address | Telephone Number

CPC Revised 05/2019

© 2019 Community Palliative Consultants℠, All Rights Reserved.
Community Palliative Consultants℠ is a program of Community Hospice of Northeast Florida

Patient Name: ____________________

Patient Number: ____________________

Authorization to Release Patient Medical Information

Provider: ____
Hospital/Nursing Home/Other Healthcare Provider

____
Street Address

____
City State Zip Code

I authorize the named healthcare provider to release my medical information, including records related to the diagnosis or suspected diagnosis of AIDS or HIV infection, to Community Palliative Consultants℠.

Information to be Released:

Dates of service for records requested: Beginning ______________________________ Through______________________________

_____ History & Physical

_____ Physician Consult

_____ Discharge Summary

_____ Physician Progress Notes

_____ Emergency Department Records

_____ Lab / Pathology Reports

_____ Radiology Reports

_____ HIV-Related Records

_____ Nurse / Therapy Notes ______________________________

_____ Other:____

I understand that:

- I am not required to sign this authorization and that my healthcare or payment for care will not be affected by my refusal.
- Federal privacy regulations will no longer apply to information disclosed, and Community Hospice of Northeast Florida, Inc., may re-disclose the information for the purpose of care coordination.
- A copy of this authorization may be utilized with the same effectiveness as an original.
- I can cancel this authorization at any time by writing to the Community Palliative Consultants℠, Privacy Officer at 4266 Sunbeam Road, Jacksonville, FL 32257.
- This authorization is valid from the date of signature below and remains valid until it expires or is canceled, but canceling this authorization will not affect disclosures made or actions taken before the cancellation was received.

____
Patient Printed Name

____
Patient DOB

____
Patient Signature

____
Date

____
Print Legal Representative Name

____
Relationship to Patient

____
Legal Representative Signature

____
Date

ROI – Effective 3/30/2018
© 2019 Community Palliative Consultants℠, All Rights Reserved.
Community Palliative Consultants℠ is a program of Community Hospice & Palliative Care

Patient Name: ______________________________

Patient Number: ______________________________

Medication Use Agreement

I, ________________________________, understand that I have pain that has not been adequately controlled with other medications and that my function is limited by my pain. I understand that the intent of the medication is to increase my ability to do more, though the medication is unlikely to eliminate the pain.

I will take the medication only as prescribed. I will not take any sedatives, alcohol or other pain medications without the prior approval of my doctor or nurse practitioner.

I understand that the medication will be prescribed by a **Community Palliative Consultants**℠ doctor or nurse practitioner according to an agreed-upon schedule. Prescriptions will be provided only during regularly scheduled appointments. Refills will never be provided by telephone.

I will report pain medications prescribed by other doctors to Community Palliative Consultants℠.
I will not borrow or accept "medications for pain" from family or friends, or illegal sources i.e. illicit or street drugs.

Medication refills will be provided as written prescriptions only. No refills will be given prior to the next scheduled appointment date. If I do not keep my appointment, I will not receive a refill. Two (2) appointment cancellations with less than one working days' notice or two (2) no-show appointments may constitute grounds for immediate termination of this agreement.

I understand that my doctor is under no obligation to provide these medications to me, and that she or he reserves the right to discontinue these medications at any time. At my doctor's discretion, I agree to cooperate with random drug testing, which may be requested at any time. If I refuse, I understand the medication will be stopped.

I understand that lost or stolen medications will not be refilled under any circumstances. It is my responsibility to protect and secure any medications. This includes keeping the medication out of reach of children. A copy of a police report will be required for any lost or stolen narcotics or narcotic prescriptions.

I understand that my doctor may require specialist evaluation of my treatment,and I agree to keep appointments when my physician refers me. My doctor will send a report of my care and a copy of this agreement when a referral is made.

CPC MUA – Revised 03/30/2018
© 2019 Community Palliative Consultants℠, All Rights Reserved.
Community Palliative Consultants℠ is a program of Community Hospice & Palliative Care

In addition to the above agreements:

1. I accept the right of my doctor or nurse practitioner to terminate this agreement for any of the following reasons:

    a. I seek or obtain any pain medication from a source other than a licensed doctor or nurse practitioner.

    b. I fail to report prescriptions obtained from another licensed doctor or nurse practitioner.

    c. I give, sell or in any way distribute prescribed medications to any other person(s).

    d. I, in any way, attempt to forge or alter a prescription.

    e. My medical condition declines to the point at which, in the judgment of my doctor, continued therapy with this medication presents a danger to my well-being or safety.

    f. There is evidence that I am no longer receiving a reasonable therapeutic benefit from the medication, or my doctor determines that I am no longer a good candidate to continue the medication.

I understand that by signing this agreement, I must abide by the rules outlined above and that failure to abide by this agreement will result in the termination of medication prescriptions and possibly the termination of services by Community Palliative Consultants℠.

Patient Name ____ Date ____________

Patient Signature ____

❑ Patient's Legal Representative, i.e., Healthcare Surrogate, or Nearest Relative **if patient is unable to sign**

Legal Representative Name ____

Legal Representative Signature ____________________________________ Date ____________

Relationship to Patient ____

Address ____

Phone Number ____

CPC MUA – Revised 03/30/2018

© 2019 Community Palliative Consultants℠, All Rights Reserved.

Community Palliative Consultants℠ is a program of Community Hospice & Palliative Care

Consent for Treatment

Consent for Treatment

I request and authorize medical care as my physician, his assistant or designees (collectively called "the physicians") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, and routine medical and nursing care. I authorize my physician(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient) care is directed by my physician(s) and that other personnel render care and services to me (the patient) according to the physician(s) instructions.

- A drug screen by blood or urine sample may be obtained with verbal consent for purposes of verifying compliance with medication regimens or when abuse or misuse is suspected or when signs or symptoms of toxicity exist.
- I have been informed and understand that an HIV (human immunodeficiency virus – AIDS) test may be performed on me without my consent if a health professional or Community Palliative Consultants℠ employee or First Responder sustains an exposure to my blood or other body fluid.

Insurance Certification / Assignment of Insurance Benefits / Financial Responsibility

I certify that the information provided for Medicare, Medicaid or other insurance plan(s) is true and correct.

I authorize direct payment to Community Palliative Consultants℠ from Medicare, Medicaid or any insurance plan is providing insurance benefits on my behalf. This assignment of insurance benefits is provided so that Community Palliative Consultants℠ may obtain my payout history from the insurance carrier and attempt to collect any unpaid and over-due insurance benefits directly from the insurance carrier.

I authorize the release of all medical records as may be required by my insurance plan to reimburse claims submitted on my behalf.

I agree to personally pay for any charges not paid by my health insurance or any other insurance plan or policy, including but not limited to, any deductibles, copays, and coinsurance amounts provided under any coverage source, and charges for which there is no coverage source.

Cancellation / No Show Policy: A $40.00 fee will be charged for any appointment cancelled without a 48 hour notice. This fee is not covered by your insurance carrier and you will personally responsible for the payment of this fee.

Check Returns: It is our office policy to charge all patients a $35.00 fee for checks that are returned for insufficient funds.

CPC Revised 05/2019
© 2019 Community Palliative Consultants℠, All Rights Reserved.
Community Palliative Consultants℠ is a program of Community Hospice of Northeast Florida

Patient Name: ______________________________

Patient Number: ______________________________

If you currently have Medicaid or become Medicaid eligible, you have a responsibility to report suspected Medicaid fraud. Please call toll free 1-888-419-3456.

Medicaid fraud means intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law as it relates to Medicaid. The Office of the Inspector General at the Agency for Health Care Administration accepts complaints regarding suspected fraud and abuse in the Florida Medicaid system by phone at 1-888-419-3456 or on the agency website at http://ahca.myflorida.com/Executive/Inspector_General/medicaid.shtml

Notice of Privacy Practices

The Community Palliative Consultants℠ Notice of Privacy Practices (Notice) provides information about how protected health information about me (the patient) is used or disclosed. I acknowledge that a copy of the Notice was provided to me and I have been offered the opportunity to review the Notice before signing this consent

Nondiscrimination and Accessibility Notice

I have received a copy of the Nondiscrimination and Accessibility Notice as required by Section 1557 of the Patient Protection and Affordable Care Act.

Authorization for Full Disclosure of Health Information for Treatment and Quality of Care

I voluntarily authorize, give my permission and allow use and disclosure (release) of all my heath information, including all records and other information regarding my health history, treatment, hospitalization(s), test, and outpatient care. This information may relate to sensitive health conditions (if any), including but not limited to: drug, alcohol, or substance abuse; psychological, psychiatric or other mental health impairment(s) or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA 45 CFR 164.501); sickle cell anemia; records that may indicate the presence of a communicable disease or noncommunicable disease; test for or records of HIV/AIDS; sexually transmitted diseases; genetic (inherited) diseases; copies of education assessments, test or evaluations, individualized educational programs; psychological and speech evaluations, immunizations recorded health information (such as height, weight), and information about injuries or treatment.

I choose not authorize the release of my health information to Community Palliative Care. ____________________
Initials

I authorize the (release) of my information to Community Palliative Care for the purpose of providing me with medical treatment and related services, products, and to evaluate and improve patient safety and the quality of medical care provided to all patients. I understand and agree that information created before or after the date of my signature below may be released upon request.

I authorize the use of a copy (including electronic copy) of this authorization for the release of the information described above.

I understand that health information received by Community Palliative Care may be subject to lawful re-disclosure (rerelease), in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

© 2019 Community Palliative Consultants℠, All Rights Reserved.
Community Palliative Consultants℠ is a program of Community Hospice of Northeast Florida

Patient Name: ____________________

Patient Number: ____________________

The authorization to release all of my health information will remain in effect until my discharge, death, or the day I withdraw my permission.

I can revoke (withdraw) my permission at any time by giving written notice to the Community Palliative Care Privacy Officer at the following address: Community Palliative Care Privacy Officer, 4266 Sunbeam Road, Jacksonville, FL 32257.

Health Care Status Authorization

I give permission for Community Palliative Consultants℠ to release information concerning the status of my health, including making and cancelling appointments, refilling medications, and discussing my medical condition(s) with any staff member regarding any and all medical issues which may arise while under the care of Community Palliative Consultants℠.

Below is a list of individuals who are authorized.

Name	**Relationship**	**Telephone#**

I confirm that I have read, or have had read to me, and fully understand this consent document. I acknowledge that I have been given the opportunity to ask questions, and all of my questions have been answered to my satisfaction.

Printed Patient Name ______ Patient Signature ______ Date ______

Consent of Patient's Legal Representative i.e. Health Care Surrogate, HealthCare Proxy or Nearest Relative,if patient is unable to sign.

Legal Representative Name ______ Legal Representative Signature ______ Date ______

Relationship to Patient ______ Address ______ Telephone Number ______

CPC Revised 05/2019

© 2019 Community Palliative Consultants℠, All Rights Reserved.
Community Palliative Consultants℠ is a program of Community Hospice of Northeast Florida

Patient Name: ______

Patient Number: ______

Community
Palliative Consultants℠

NOTES

NOTES

Patient Care Line 904.407.7700
4266 Sunbeam Road • Jacksonville, FL 32257
communitypalliative.com

©2019 Community Hospice & Palliative Care 8/19 CPC 001