VNA & HOSPICE
of the Southwest Region
Serving Bennington and Rutland Counties

CONSENT FOR CARE/NOTICE OF INFORMATION PRACTICES

Patient Name ______________________________________**Episode #** __________________________________

CONSENT FOR CARE

The services to be provided to me by the Visiting Nurse Association & Hospice of the Southwest Region (VNAHSR) staff have been explained to me. I hereby consent to periodic visits by staff of said program to render care to me as ordered by my Physician in a documented and mutually agreed upon plan of care. I understand that the treatment plan may change and that such changes will be discussed with me. Instructions for my care will be explained to me and will become my responsibility in the absence of a home care staff member.

The kind of services and their duration will be provided based on medical necessity and the availability of personnel and resources. It is essential that you understand that it is the responsibility of the family/responsible party to provide all needed services in the absence of VNAHSR staff.

NOTICE OF INFORMATION PRACTICE

I acknowledge receipt of a copy of VNAHSR's Notice of Information Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by VNAHSR and of my rights with respect to my health information.

Signature____ Date __________________________