



Notice of Patient Rights and Responsibilities

You have the right to:

- Be treated in a dignified and respectful manner and to receive reasonable responses to reasonable requests for service.
- To effective communication that provides information in a manner you understand, in your preferred language with provisions of interpreting or translation services, at no cost, and in a manner that meets your needs in the event of vision, speech, hearing or cognitive impairments. Information should be provided in easy to understand terms that will allow you to formulate informed consent.
- Respect for your cultural and personal values, beliefs and preferences.
- Personal privacy, privacy of your health information and to receive a notice of the facility's privacy practices.
- Pain management.
- Accommodation for your religious and other spiritual services.
- To access, request amendment to and obtain information on disclosures of your health information in accordance with law and regulation within a reasonable time frame.
- To have a family member, friend or other support individual to be present with you during the course of your stay, unless that person's presence infringes on others' rights, safety or is medically contraindicated.
- Care or services provided without discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.
- Participate in decisions about your care, including developing your treatment plan, discharge planning and having your family and personal physician promptly notified of your admission.
- Select providers of goods and services to be received after discharge.
- Refuse care, treatment or services in accordance with law and regulation and to leave the facility against advice of the physician.
- Have a surrogate decision-maker participate in care, treatment and services decisions when you are unable to make your own decisions.
- Receive information about the outcomes of your care, treatment and services, including unanticipated outcomes.
- Give or withhold informed consent when making decisions about your care, treatment and services.
- Receive information about benefits, risks, side effects to proposed care, treatment and services; the likelihood of achieving your goals and any potential problems that might occur during recuperation from proposed care, treatment and service and any reasonable alternatives to the care, treatment and services proposed.
- Give or withhold informed consent to recordings, filming or obtaining images of you for any purpose other than your care.
- Participate in or refuse to participate in research, investigation or clinical trials without jeopardizing your access to care and services unrelated to the research.
- Know the names of the practitioner who has primary responsibility for your care, treatment or services and the names of other practitioners providing your care.
- Formulate advance directives concerning care to be received at end-of-life and to have those advance directives honored to the extent of the facility's ability to do so in accordance with law and regulation. You also have the right to review or revise any advance directives.
- Be free from neglect; exploitation; and verbal, mental, physical and sexual abuse.
- An environment that is safe, preserves dignity and contributes to a positive self-image.
- Be free from any forms of restraint or seclusion used as a means of convenience, discipline, coercion or retaliation; and to have the least restrictive method of restraint or seclusion used only when necessary to ensure patient safety.
- Access protective and advocacy services and to receive a list of such groups upon your request.

You have the right to: (continued from page 1)

- Receive the visitors whom you designate, including but not limited to a spouse, a domestic partner (including same-sex domestic partner), another family member, or a friend. You may deny or withdraw your consent to receive any visitor at any time. To the extent this facility places limitations or restrictions on visitation; you have the right to set any preference of order or priority for your visitors to satisfy those limitations or restrictions.
- Examine and receive an explanation of the bill for services, regardless of the source of payment.

You have the responsibility to:

- Provide accurate and complete information concerning your present medical condition, past illnesses or hospitalization and any other matters concerning your health.
- Tell your caregivers if you do not completely understand your plan of care.
- Follow the caregivers' instructions.
- Follow all medical center policies and procedures while being considerate of the rights of other patients, medical center employees and medical center properties.

You also have the right to:

Lodge a concern with the state, whether you have used the hospital's grievance process or not. If you have concerns regarding the quality of your care, coverage decisions or want to appeal a premature discharge, contact the State Quality Improvement Organization (QIO).

- Quality Improvement Organization
 Phone: (813) 280-8256
 Toll Free: (855) 408-8557 • Fax: (844) 834-7130

 Mail: KEPRO
 5201 W. Kennedy Blvd.
 Suite 900
 Tampa, FL 33609

If you have a Medicare complaint you may contact

- Indiana State Department of Health
 Phone: (317) 233-1325

 Mail: Indiana State Department of Health
 2 N Meridian Street
 Indianapolis, IN 46204

Regarding problem resolution, you have the right to:

Express your concerns about patient care and safety to facility personnel and/or management without being subject to coercion, discrimination, reprisal or unreasonable interruption of care; and to be informed of the resolution process for your concerns. If your concerns and questions cannot be resolved at this level, contact the accrediting agency indicated below:

- The Joint Commission
 Phone: (800) 994-6610 Fax: (630) 792-5636
 Email: complaint@jointcommission.org

 Mail: Office of Quality Monitoring/
 the Joint Commission
 One Renaissance Boulevard
 Oakbrook Terrace, IL 60181

The undersigned certifies that s/he has read the foregoing, understands it, accepts its terms, has received a copy of it and is the patient or is duly authorized by the patient as their agent to execute the above.

Patient's Signature or Legal Representative			Date	Time	
Relationship to Patient		Interpreter, if Utilized		Date	Time
Witness Signature	Date	Time	If Telephone Consent, Second Witness Signature	Date	Time

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