



PATIENT'S RIGHTS AND RESPONSIBILITIES

To comply with the federal regulations (HIPAA), this office has established procedures to make your identity and medical records more secure. Our only use of your personal information is for billing purposes and for proper medical treatment. We must have on record a signed acknowledgement that you have read your rights and responsibilities as patients and that you understand them. Please contact the offices staff if you have any question.

PATIENT'S RIGHTS

- To receive service within a reasonable period of time.
- To receive medically necessary service.
- To be treated with respect and courtesy.
- To receive all available information about your care and treatment, including risk and options.
- To have your medical coverage explained to you.
- To have all medical and personal records treated as confidential.
- To participate in treatment decisions.
- To refuse treatment.
- To receive a second opinion regarding any treatment plan.
- To review or to receive a copy of your medical records subject to legal restrictions and reasonable copying charges.
- To request review of your medical records by the physician, and to request corrections if necessary.
- To be given information on how to file a complaint/grievance.
- To formulate an advance directive if you have a life threatening illness or injury.
- To provide, or have provided for you, an interpreter in your primary language.

PATIENT'S RESPONSIBILITIES

- Having appropriate identification, insurance membership cards, coverage stickers, etc. at the time of the appointment.
- Fulfilling financial obligations at the time of the service such as deductible or co-pay fees.
- Providing complete and accurate information.
- Following the health plan you and the physician agree on.
- Being considerate of others.
- Providing legal documentation of guardianship of minor being treated.
- Providing a list of persons who may receive medical information about you, on your behalf, in an emergency.

Please sign and return this form to the front desk.

*If you prefer a longer version, you may request one.

Patient's Signature _____ Date _____

Print Name _____ Account Number _____