Patient Name: _____ **DOB:** _____

Patient Rights and Responsibilities Acknowledgment

Every Santo Domingo Health Center (SDHC) patient has rights as well as responsibilities. The staff is committed to the protection of these rights and to providing treatment in an atmosphere that is characterized by dignity, respect and responsive to the unique needs, abilities, and characteristics of each person served by the organization.

Patient Rights

As a SDHC patient, you have the right to:

1) The right to be treated with respect and courtesy, with appreciation for your individual dignity and with consideration for your emotional, cultural, and spiritual values.
2) The right to know who will perform a procedure or an operation. Upon request, you will be given the names of all physicians directly participating in your care, along with the names and functions of other healthcare personnel having direct contact with you.
3) The right to access any individual of agency authorized to act on your behalf to protect your rights under this policy.
4) When required, the right to access a qualified interpreter.
5) The right to formulate an advance directive or to appoint a surrogate to make healthcare decisions on your behalf. This facility and its healthcare professionals will hone these decisions within the limits of the law and this organization's mission, values, and philosophy.
6) The right to full information relating to diagnosis, treatment and alternatives, prognosis and any risk of complications provided in layman's terms. When it is not medically advisable to provide the information directly to you, the information will be given to the person designated by you as the patient.
7) The right to appropriate assessment and management of pain, in accordance with policies and law.
8) The right to refuse any procedure, operation, treatment, or drug offered by the physician or facility, to the extent permitted by law, and to have a physician inform you of the medical consequences of such a refusal.
9) The right to assistance in obtaining consultation with another physician, at your own request and expense.
10) Entitled to know the services available at the facility and the charges relating to those services, including charges for services not covered by government funding or other third-party payment.
11) The right to examine and receive an explanation of any charges related to your care.
12) Facility records are private and will be treated as confidential. They will not be released to individuals outside the facility without the patient's consent, except in the case of transfer to another healthcare facility, or as otherwise provided by law or third-party contractual arrangements.
13) The right to every consideration of privacy concerning your medical care. Case discussion, consultation, examination, and treatment are considered confidential and will be conducted discreetly. This includes the right to have a person of one's own sex present during a physical examination, treatment or procedure performed by a member of the opposite sex; to wear appropriate personal clothing and religious or other symbolic items, as long as they do not interfere with diagnostic procedures or treatments; and to request a room transfer if another patient is unreasonably disturbing to you.
14) Patients are encouraged to share any grievances or suggestions about SDHC policies and services with a member of the staff or administration, with an agency or regulatory body with jurisdiction over the facility or through a representative of their choice, without restraint, interference, or reprisal.
15) The right to receive medical transportation services to and from SDHC. During your transport, you have the right to be treated with respect and dignity while being transported in a safe manner; and
16) The right to request your medication refills to be dispensed by one of our pharmacists at the SDHC Pharmacy, but you are not obligated to use the SDHC Pharmacy as your primary Pharmacy.

Patient Responsibilities

As a SDHC patient, and in respect of other patients and staff members, you have a responsibility to:

1) Follow the rules of the facility, including the demonstration of respect and consideration for our staff and/or other patients, and refrain from disruptive, threatening, or dangerous behaviors.
2) Keep appointments and provide accurate information to the Registration Staff (including insurance information, current phone, and address, etc.), and to the Healthcare Provider, which includes medications and allergies at every visit.
3) Communicate with the Healthcare Provider on any questions about medications, treatments, or procedures, or to report any unexpected changes in any condition.
4) Follow the treatment plan agreed upon with our Healthcare Provider, including behavioral and/or preventative healthcare instruction, and taking medications as prescribed and in a responsible manner.
5) Patients are to assume full accountability for their health outcomes when they voluntarily refuse treatment or fail to follow the instruction of the Healthcare Provider.
6) Patients are to understand their financial obligations when they are referred to another facility or if they choose to receive care elsewhere. Our Purchased and Referred Care (PRC) staff is available to answer questions at **(505) 465-3075**.
7) Patients are to provide us with feedback regarding our service, including the submission of SDHC Patient Complaint/Grievance Resolution (PCGR) forms, letters, emails, phone calls, and/or survey responses to report concerns or satisfactory experiences.
8) Patients are to provider a copy of their Certification of Indian Blood (CIB) to prove eligibility for services rendered at SDHC; and
9) Verification of patient demographics such as date of birth, mailing and physical address, phone number(s) and insurance information will be verified at every visit. A valid photo ID and current insurance cards must be presented every visit.

Patient Acceptance and Authorization

By reading and signing this form, I accept my rights and responsibilities as a patient and consent to the treatment and services provided by SDHC. I accept full responsibility for all charges whether or not they are covered by insurance. I authorize SDHC to release any information requested by my insurance company in order to make payments. I acknowledge receipt of above-mentioned educational materials. I have read and understand the above information and hereby give lifetime authorization for payment of insurance benefits to be made directly to SDHC for services rendered.

_____ _____

Patients Name **(Printed)** Date of Birth

_____ _____ _____

Patient or Parent/Guardian **(Signature)** Parent/Guardian (**Printed Name**) Date

_____ _____

KPHC Witness Signature *(Patient Registration **PRINTED NAME**)* Date