Patient Rights & Responsibilities

As a patient, you have certain rights and responsibilities. Our primary responsibility is to give you the best possible healthcare. We encourage you to understand, cooperate, and participate in your healthcare. Your questions, comments, and suggestions are welcome.

You have the Right…	You have the Responsibility….
• To receive kind and respectful care, regardless of your personal values and beliefs, age, sex, race, color, religion, national origin, or ability to pay for the care; • To get complete, current information about our diagnosis, treatment, and prognosis from your medical team in terms you can understand; • To refuse treatment to the extent permitted by law, and to be informed of the medical consequences if you do refuse treatment; acceptance of any service is not a prerequisite to eligibility for other services, assistance from or participation in any other program that is offered by the Health Department; • To participate in care decisions; • When informed consent is needed, to receive effective communication about the potential risks, alternatives (including non-treatment), and benefits associated with proposed procedures, care, treatment, and services; • To privacy and confidentiality about your care and medical records; • To receive information in a manner you understand including language interpreting and translation. A full range of assistive and communication aids including qualified sign language interpreters and readers is available at no cost to the patient; • To receive considerate and respectful care in a safe setting; • To designate a family spokesperson to work with the staff if ethical issues arise in your care;	• To provide accurate information that facilitates your care, treatment, and services; • To ask questions or acknowledge when you do not understand the treatment course or care decisions; • Accept responsibility for outcomes related to refusing treatment or not following the medical team's instructions; • To treat staff and other families in a considerate, courteous, and cooperative manner; • To respect the cultures, values, beliefs, privacy, and confidentiality of other patients and families receiving care; • To take care of your personal property and valuables and to respect the property of the Health Department; • To follow Health Department site rules affecting patient care and conduct; • To ensure your behavior, as well as the behavior of your visitors, is reasonable and responsible and considerate of the rights of other patients and staff; • To support mutual consideration and respect by maintaining civil language and conduct in your interactions with staff and clinicians; • to pay your bill or make arrangements to pay your bill within 30 days; **Adults are expected to supervise children in their care. Inappropriate behavior can result in removal from the facility and/or discharge from the Health Department.*

Consents & HIPAA Acknowledgement Receipt
For calendar Year: _____

- **General Consent:** I authorize the Unified Government Public Health Department to provide me or my child with healthcare services. *Autorizo el Departamento de Salud Pública de Gobierno Unificado para proporcionarme servicios de atención médica.* Departamento de Salud Publica.
- **Tuberculosis Consent:** I authorize the Unified Government Public Health Department to provide me or my child with Tuberculosis healthcare services. *Autorizo el Departamento de Salud Publica de Gobierno Unificado para proporcionarme servicios de atencion medica de Tuberculosis.*
    - I understand that my health information and visits to the clinic are confidential pursuant to state and federal law, and my case will not be discussed with anyone outside the clinic unless I give my written permission to do so, except as necessary to provide services or required by law. *Entiendo que mi información de salud y visitas a la clínica son confidenciales conforme a leyes estatales y federales, y mi caso no será discutido con nadie fuera de la clínica si no doy mi permiso para hacerlo, excepto según sea necesario para prestar servicios o requerido por la ley.*
    - I understand that if I require care beyond the scope of the clinic, I will be referred to a healthcare provider of my choice. *Comprendo que si yo require cuidado mas alla del alcance de esta clinica, sere referido al proveedor de cuidado de salud de mi eleccion.*
    - AGE 17 AND UNDER/*Menores de 17 anos*: I understand the following additional exceptions to my confidentiality rights may occur: *Comprendo que podrian producirse las siguientes excepciones adicionales a mis derechos de confidencialidad*:
        - If a life-threatening condition is identified and I am unwilling or unable to follow-up on referrals, clinic staff may notify a parent or legal guardian. *Si se identifica una condicion de riesgo a las vida y no deseo o no puedo dar seguimientos a mis referidos, el personal de la clinca pordia notificar a un padre o tutor legal.*
        - Clinic staff is required to comply with Kansas State Laws regarding reporting of child abuse and neglect. *El personal de la clinica debe cumpli con las Leyes Estatales de Kansas en relacion a informar sobre el abuso o negligencia infantile.*

I have read this form, understand the information in it, have had all my questions answered to my satisfaction and I am voluntarily signing this consent to receive the services provided by this Clinic. I am aware of the Financial Policy and fully understand my financial responsibilities. I agree to pay for all services rendered and for services that are not covered by my insurance. If health coverage exists I give permission to bill my health plan, unless otherwise specified in writing. I authorize usage of my WIC financial information.

Signature of Patient or Patient Representative/*Firma de Paciente o el Representante de Paciente:*

_____ Date/*Fecha*: _____

ACKNOWLDGEMENT OF RECEIPT OF REVISED NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered a copy of the UNIFIED GOVERNMENT PUBLIC HEALTH DEPARTMENT's Notice of Privacy Practices. *Reconozco que me han ofrecido una copia del aviso del GOBIERNO del DEPARTAMENTO UNIFICADO de la SALUD PÚBLICA de las* AVISO DE PRÁCTICAS DE PRIVACIDAD.

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Signature of Patient/Patient Representative *Firma de Paciente/Representante de Paciente* Date/*Fecha*

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Relationship to Patient/*Relación al Paciente*