

## A Patient's Bill of Rights

It is recognized that a personal relationship between the physician and the patient is essential for the provision of proper medical care. The traditional physician-patient relationship takes a new dimension when care is rendered within an organizations structure. Legal precedent has established that the facility itself also has a responsibility to the patient. It is in recognition of these factors that these rights are affirmed.

1. **The patient** has the right to be treated with dignity, respect and consideration. Our patients will not be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, diagnosis or source of payment.
2. **The patient** has the right to obtain from his/her physician complete current information concerning his/her diagnosis, treatment and prognosis in terms and in a language or manner the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient the information should be made available to an appropriate person on his/her behalf. He/she has the right to know by name the physician responsible for coordinating his/her care.
3. **The patient** has the right to participate in decisions involved in his/her care and to receive from his/her physician information to give informed consent prior to the start of any procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. The patient will be informed of alternatives to the proposed procedure and the associated risks and possible complications of the proposed procedure. The patient has the right to know the name of the person responsible for the procedure and/or treatment.
4. **The patient** will receive treatment that supports and respects their individuality, choices, strengths and abilities.
5. **The patient** has the right to refuse treatment to the extent permitted by law and to be informed of the medial consequences of his/her action. The patient has the right to withdraw consent to treatment before treatment is initiated.
6. **The patient** has the right to every consideration of his/her privacy concerning his/her medical care program. Case discussion, consultation, examination, treatment and attention to personal needs are confidential and should be conducted discretely. Those not directly involved in his/her care must have permission of the patient to be present.
7. **The patient** has the right to expect that all communications and records pertaining to his/her care, including financial records, should be treated as confidential and not released without written authorization by the patient. The patient has the right to review, upon written request, their own medical record.
8. **The patient** has the right to expect that within its capacity, this ambulatory surgery facility must provide evaluation, and/or referral as indicated by the urgency of the case. When medically permissible, a patient may be transferred to another facility only after he/she has received complete information and explanation concerning the needs for and alternatives to such a transfer. The institution to which the patient is to be transferred must first have accepted the patient for transfer.
9. **The patient** has the right to be informed of facility policy on health care directives.
10. **The patient** has the right to obtain information as to any relationship of this facility to other health care and educational institutions insofar as his/her care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, who are treating him/her.
11. **The patient** has the right to be advised if this ambulatory surgery facility proposes to engage in or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse to participate in such research projects.
12. **The patient** must consent prior to having photographs taken.
13. **The patient** has the right to expect reasonable continuity of care. The patient has the right to expect that this facility will provide a mechanism whereby he/she is informed by his/her physician of the patient's continuing health care requirements following discharge.
14. **The patient** has the right to examine and receive an explanation of his/her bill regardless of the source of payment and to be informed regarding the fees for procedures performed at the Center. The patient has a right to be informed of third party coverage including Medicare and Arizona Health Care Cost Containment System.
15. **The patient** has the right to know what facility rules and regulation apply to his/her conduct as a patient.
16. **The patient** has the right to request information about the grievance process at the Center. If a patient has a grievance with the Center, he/she has the right to speak immediately with the Nursing Director or the substitute person assigned to answer to grievances. A formal written grievance may be completed for further review of the grievance.
17. **The patient** has the right to be free from chemical, physical and psychological abuse or neglect. This facility shall ensure that the patient is not subjected to the intentional infliction of physical, mental or emotional pain unrelated to the patient's condition. This facility shall also ensure that the patient is not subjected to any exploitation, coercion, manipulation, sexual abuse, sexual assault, seclusion, restraint, if not necessary to prevent imminent harm to self or others, retaliation for the submission of any complaint or the misappropriation of personal/private property by the facility's medical staff, personnel members, employees, volunteers or students.
18. **The patient** has the right to timely and appropriate pain management.
19. **The patient** has the right to receive assistance from a family member, representative or other individual in understanding, protecting or exercising the patient's rights.

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Please print

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Patient Responsibilities

It is the patient's responsibility to:

1. Fully participate in decisions involving his/her own healthcare and to accept the consequences of these decisions if complications occur.
2. Provide complete and accurate information to the best of his/her ability about his/her health, any medications, including over-the-counter products and dietary supplements and allergies or sensitivities.
3. Provide a responsible adult to transport him/her home from the facility.
4. Inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.
5. Accept personal financial responsibility for any charges not covered by his/her insurance.
6. Be respectful of all health care providers and staff, as well as other patients.
7. Follow up on his/her doctor's instructions, take medication when prescribed, and ask questions concerning his/her own health care that he/she feels is necessary.

For Medicare Beneficiaries, complaints may be reported to the Office of Medicare Ombudsman at:

<http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html>

Complaints may also be reported to:

Arizona Department of Health Services, Assistant Director, Division of Licensing Services at 150 N. 18<sup>th</sup> Avenue, 4<sup>th</sup> Floor Phoenix, AZ 85007, 602-364-2536

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Please Print

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **Explanation of Grievance Policy**

All patients, or patient's representatives, have the right to file a grievance to request resolution of any complaints regarding a patient's care or other issues relating to abuse, neglect or ASC compliance. All grievances will be fully investigated and documented in writing by the Quality Assurance Committee. The Quality Assurance Committee will then advise the Board of Directors of findings and recommended actions. The Board of Directors will have final authority/responsibility for all grievance resolution. Patients will be informed, in writing, of the final resolution within 10 days of receipt of the grievance. The decision will contain the name of a contact person, the steps taken to investigate the grievance, the results of the grievance process and the date the process was completed. Patients, or patient's representatives, should not fear punitive action or discrimination by exercising this or any other patient right.

## **How to File a Grievance**

- Request a grievance form.
- Fill out form as completely as possible.
- Return form to front desk or mail to Tucson Gastroenterology Institute.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Please Print

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **Financial Disclosure**

The total cost of medical services at Tucson Gastroenterology Institute is comprised of the following three fees:

- The Endoscopy Center’s fee, the Physician’s fee and the Pathologist’s fee. Each fee is billed separately by the provider of the service.
  - ❖ The Endoscopy Center’s fee covers the cost of providing the technicians, nurses, equipment, and supplies involved in the performance of your procedure.
  - ❖ The physician’s professional service fee is for performing the procedure, supervising, interpreting and consulting with you and your referring physician.
  - ❖ If there are biopsies taken during your procedure, you will be billed by the pathologist reviewing the tissue. If you have any questions regarding your pathology bill, please contact them directly. If you do not have any specimens sent to pathology you will not be billed for the pathology fee
- TUCSON GASTROENTEROLOGY INSTITUTE is owned by John J. McNerney, MD.

### **Advanced Directives**

The State of Arizona regulations require that your medical chart contain the following information.

**Please complete this information and acknowledge your response by signing below.**

- \_\_\_\_\_ I have a Living Will \_\_\_\_\_  
(Where is your living will located?)
- \_\_\_\_\_ I have a Medical Power of Attorney \_\_\_\_\_  
(Name of your medical power of attorney)
- \_\_\_\_\_ I have designated a “surrogate” Agent \_\_\_\_\_  
(Name of your surrogate agent)
- \_\_\_\_\_ I have none of the above and do not wish to complete one at this time.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Please Print

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please note: If you, as a patient of Tucson Gastroenterology Institute, experience a life threatening emergency while at the center, it is our policy to resuscitate and maintain life until an appropriate and timely transfer can be made to the nearest hospital. This policy is in place regardless of any of the above stated arrangements.**