THE PATIENT'S BILL OF RIGHTS

The patient has the right to:

- Considerate and respectful care.
- Knowledge of the name of the physician who has primary responsibility for coordinating the care and the names and professional relationships of the other physicians and non-physicians who will see the patient.
- Receive as much information about any proposed treatment or procedure as the patient may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternate courses of treatment or non-treatment and the risks involved in each and to know the name of the person who will carry out the treatment.
- Participate actively in any decisions regarding medical care. To the extent permitted by the law, this includes the right to refuse treatment.
- Full consideration of privacy concerning the medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual.
- Confidential treatment of all communications and records pertaining to his/her care.
- Reasonable continuity of care and to know in advance the time and location of appointment as well as the identity of persons providing the care.
- Be advised if the physician proposes to engage in or perform human experimentation affecting care or treatment. The patient has the right to refuse to participate in such research projects.
- Have all patient's rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
- Have complaints forwarded to Administrative personnel for appropriate response.
- Know that all the Clinic/Office personnel will observe these patient's rights.

______________________________ ______________________

Signature **Date**

Acknowledgement of Confidentiality Policy

I hereby acknowledge receipt of the policy regarding confidentiality of protected health information. I have read and understand this policy and will abide by it.

_________________________________ _____________________
Printed Name Date

_________________________________ _____________________
Signature Date

I, ______________________ give permission to ____________,____________
(Your Name) (Name) (Relationship)
any information from my personal medical records in case of emergency or continuation of care.

Physician Information

Primary Care Physician:_______________________

City:_______________ State:___________ Phone Number: __________

Referring Physician or Hospital :_______________________

City:_______________ State:___________ Phone Number: __________

Specialty Physician:_______________________

City:_______________ State:___________ Phone Number: __________