

## ***PATIENT RIGHTS AND RESPONSIBILITIES***

### **YOUR RIGHTS**

- Impartial access to treatment regardless of race, sex, religion, or national origin.
- The right to quality care and treatment consistent with available resources and generally acceptable standards of medical care.
- The right to refuse medical care to the extent permitted by law and government regulations, and to be informed of the consequences of your refusal.
- The right to respectful and timely medical attention.
- The right to privacy during your visit and confidential handling of your medical records.
- The right to information concerning the name and professional status of your medical provider.
- The right to be advised in understandable terms, of information needed to make knowledgeable decisions, when considering consent or refusal of invasive treatments or procedures.
- The right to care and treatment in a reasonable safe environment.
- The right to information concerning the need for a transfer to an alternate facility.
- The right to be informed of charges for care and their obligation for payment.

### **YOUR RESPONSIBILITIES**

- The responsibility to provide, to the best of his/her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, changes in his/her condition and other matters relating to his/her health.
- The responsibility for being considerate of the rights of other patients and Clinic personnel.
- The responsibility to follow medical instructions thoroughly.
- The responsibility to respect the Clinics policies and procedures.
- The responsibility for assuming all pertinent financial obligations.
- The responsibility to seek prompt medical attention.
- The responsibility to report any significant symptoms or failure to improve.
- The responsibility for asking the medical providers questions to help insure proper communication.
- The responsibility to keep appointments or cancel in advance.
- The responsibility to provide to the Clinic, all health insurance coverage information needed to file claims.

**PATIENT RIGHTS AND RESPONSIBILITIES ACKNOWLEDGEMENT**

I \_\_\_\_\_, have read and agree to the Patient Rights and Responsibilities Policy of Madison Family Clinic.

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_.