AS A PATIENT OF THE **VALLEY DIGESTIVE HEALTH CENTER**, YOU HAVE THE RIGHT TO RECEIVE THE FOLLOWING INFORMATION IN ADVANCE OF THE DATE OF YOUR PROCEDURE.

PATIENT'S BILL OF RIGHTS:

EVERY PATIENT HAS THE RIGHT TO BE TREATED AS AN INDIVIDUAL WITH HIS/HER RIGHTS RESPECTED. THE FACILITY AND MEDICAL STAFF HAVE ADOPTED THE FOLLOWING LIST OF PATIENT'S RIGHTS:

PATIENT'S RIGHTS:

To receive treatment without discrimination as to race, color, religion, sex, national origin, disability, or source of payment.

To be treated with respect, consideration, and dignity in receiving care, treatment, procedures, surgery, and/or services.

To be provided privacy and security of self and belongings during the delivery of patient care service.

To receive information from his/her physician about his/her illness, his/her course of treatment and his/her prospects for recovery in terms that he/she can understand.

To receive as much information about any proposed treatment or procedures as he/she may need in order to give informed consent prior to the start of any procedure or treatment.

When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient, or to a legally authorized person.

To make decisions regarding the health care that is recommended by the physician. Accordingly, the patient may accept or refuse any recommended medical treatment. If treatment is refused, the patient has the right to be told what effect this may have on their health, and the reason shall be reported to the physician and documented in the medical record

To be free from mental and physical abuse, free from exploitation, and free from use of restraints. Drugs and other medications shall not be used for discipline of patients or for convenience of facility personnel.

Full consideration of privacy concerning his/her medical care program. Case discussion, consultation, examination and treatment are confidential and shall be conducted discretely.

Confidential treatment of all communications and records pertaining to his/her care and his/her stay in the facility. His/her written permission shall be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care. The facility has established policies to govern access and duplication of patient records.

To leave the facility even against the advice of his/her physician

Reasonable continuity of care and to know in advance the time and location of appointment, as well as the physician providing the care

Be informed by his/her physician or a delegate of his/her physician of the continuing health care requirements following his/her discharge from the facility

To know the identity and professional status of individuals providing services to them, and to know the name of the physician who is primarily responsible for coordination of his/her care.

To know which facility rules and policies apply to his/her conduct while a patient

To have all patients' rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient. All personnel shall observe these patient's right

To be informed of any research or experimental treatment or drugs and to refuse participation without compromise to the patient's usual care. The patient's written consent for participation in research shall be obtained and retained in his/ her patient record

To examine and receive an explanation of his/her bill regardless of source of payment

To appropriate assessment and management of pain

PATIENT'S RESPONSIBILITIES

To provide complete and accurate information to the best of their ability about their health, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities

To follow the treatment plan prescribed by their provider

To provide a responsible adult to transport them home from the facility and remain with them for 24 hours, if required by their provider

To inform their provider about any living will, medical power of attorney, or other directive that could affect their care

To accept personal financial responsibility for any charges not covered by their insurance

To be respectful of all the health care providers and staff, as well as other patients

If you need an interpreter:

If you will need an interpreter, **please let us know prior to the day of your procedure,** and one will be provided for you. If you have someone who can translate confidential, medical and financial information for you please make arrangements to have them accompany you on the day of your procedure.

Rights and Respect for Property and Person

The patient has the right to:

• Exercise his or her rights without being subjected to discrimination or reprisal.

• Voice grievance regarding treatment or care that is, or fails to be, furnished.

• Be fully informed about a treatment or procedure and the expected outcome before it is performed.

• Confidentiality of personal medical information.

Privacy and Safety

The patient has the right to:

• Personal privacy

• Receive care in a safe setting

• Be free from all forms of abuse or harassment

Advance Directives / Facility Policy

You have the right to information on the center's policy regarding Advance Directives.

Advance Directives will not be honored within the center. In the event of a life-threatening event, emergency medical procedures will be implemented. Patients will be stabilized and transferred to a hospital where the decision to continue or terminate emergency measures, in accordance with advance directives, can be made by the physician and family.

If the patient or patient's representative wants their Advance Directives to be honored, the patient will be offered care at another facility that will comply with their wishes.

An "advance health care directive" lets your physician, family and friends know your health care preferences, including the types of special treatment you want or don't want at the end of life, your desire for diagnostic testing, surgical procedures, cardiopulmonary resuscitation and organ donation.

If you request, an official state Advance Directive Form will be provided to you.

Complaints/Grievances: If you have a problem or complaint, please speak to one of our staff to address your concern. If necessary, your problem will be advanced to center management for resolution. You have the right to have your verbal or written grievances investigated and to receive written notification of actions taken.
The following are the names and/or agencies you may contact:

ABBY QUITZON, RN—CENTER DIRECTOR
488 E. SANTA CLARA STREET SUITE 102
ARCADIA, CA 91006
(626) 359-9555

For complaints regarding a physician or facility, contact:

Medical Board of California
Central Complaint Unit
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

Or:

AAAHC
5250 Old Orchard Road, Suite 200
Skokie, IL 60077
(847) 853-6060

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the Medical Board of California

(800) 633-2322

www.mbc.ca.gov

Sites for address and phone numbers of regulatory agencies: **Medicare Ombudsman Web site** www.medicare.gov/Ombudsman/resources.asp
Medicare: www.medicare.gov or
Call 1-800-MEDICARE (1-800-633-4227)
Office of the Inspector General: http://oig.hhs.gov
Physician Financial Interest and Ownership: The physician(s) who referred you to this center and who will be performing your procedure(s) may have a financial and ownership interest. Patients have the right to be informed regarding such interest and to be treated at another health care facility if they so desire. *(Please see attached list of physician owners or those with financial interest in the Center.)* We are making this disclosure in accordance with federal regulations.

Last Reviewed: 1/12/2011

Patient's Rights and Notification of Physician Ownership

VALLEY DIGESTIVE HEALTH CENTER, INC.

(626) 359-9555

PLEASE BRING THIS FORM WITH YOU ON THE DAY OF YOUR PROCEDURE

By signing below, you, or your legal representative, acknowledge that you have received, read and understand this information (verbally and in writing) in advance of the date of the procedure and have decided to have your procedure performed at this center.

_____
Signature of Patient or Patient Legal Representative

Date _____