OVERLAKE MEDICAL CENTER

Policy

Admission Policy

Patient Access Services | 18659 | (Rev: 4)**Official**

ADMISSION POLICY:

- It is the policy of Overlake Hospital Medical Center to admit and treat all persons without regard to race, color, gender, age, religious creed, ancestry, disability/handicap, or because a patient is covered by a program such as Medicare or Medicaid or any other consideration than the need for care. Admission requirements and assignment of hospital facilities are the same for all persons. There are no distinctions in eligibility for receiving any patient care services. Hospital facilities are available to all patients and visitors. Individuals and organizations having occasion to refer patients for admission or recommend Overlake Hospital Medical Center are advised to do so within the hospitals policy to provide quality healthcare to all persons.

- Admissions to Overlake Hospital Medical Center are made only by the order of a physician who is a member of the hospitals medical staff or has temporary privileges according to the medical staff bylaws.
- Admission takes place in the Main Admitting area, Outpatient Surgery Center, Outlying Clinics, and Emergency Department or at the patients bedside.
- Our Emergency Department is open and available 24 hours per day to anyone in need of immediate medical attention.
- The Patient Access Staff will admit each patient in a professional, empathetic and time efficient manner.

SCOPE OF SERVICE:

The Patient Access Department personnel are directly responsible for pre-admission, insurance verification, front-end financial counseling, and registration of all inpatients and outpatients into the organization. Patient registration can occur in the Main Hospital Admission office, Outpatient registration areas, the Emergency Department or at the bedside according to the needs of the patient. The department provides patients with information regarding their right to make decisions regarding their healthcare, Conditions of Admission, patient rights and financial responsibilities the patients may have. Whenever possible and appropriate to the patients condition, signatures required by law or regulation are obtained. The department is staffed 24 hours per day, seven days per week.

PATIENT INFORMATION

ADMITTING

Overlake Hospital is here to serve you and the community. When you are admitted to Overlake Hospital Medical Center you are asked a number of questions. Some questions are required by law and not related to your medical condition. These questions may seem irrelevant and confusing, but the government regulations provide no alternative for us. Please be patient while we ask you all of the admission questions.

You are also asked to present your insurance card so we can provide your medical insurance carrier with information about your bill. If you have any questions about insurance coverage, please feel free to ask the Patient Access staff. We are happy to answer any questions you may have about your insurance coverage.

You will be given an identification wristband that displays your name, date of birth, and medical record number. The medical record number is very important for documenting all clinical care provided to you in a single file.

What to bring
For most patients in the hospital, a hospital gown and your own robe will be the most comfortable attire for you. We also can provide you with nonskid socks to wear in the hospital. If you bring your own slippers, they should be easy to put on and have rubber soles to prevent slipping.

You may with to bring your own personal toiletries. However, we can provide basic essentials if needed.

Leave your medications at home, unless your doctor tells you otherwise. Bring a complete list of all your medicines for your nurse and doctor to review.

We strongly encourage you to leave all valuables and jewelry at home. If you wish, your valuables may be secured in the hospital safe. You may retrieve them when you are discharged. We recommend that you arrange to have a family member or friend take care of your valuables while staying at Overlake Hospital.

Parking
Hospital patients and visitors can park in the West Parking Garage located north of the main hospital and enter the hospital on the ground floor. Admitting will be straight ahead. The garage is open 24 hours a day. Payment by cash or credit card is accepted at the parking exits and at automated payment stations. Each hospital inpatient is entitled to one 30-day parking permit at a cost of $5, purchased at the time of the admission.

Loading and Unloading
If you are coming to the Emergency Department, use the driveway in front of the Emergency Department for patient loading and unloading only. The driveway to the Main Hospital Entrance is for valet parking and other patient loading and unloading. Please do not leave your car unattended unless you are using the valet service.

Please remember to:
- Arrive on time
- Bring your health insurance card even if you have been here recently.

Visitation
Family membersand other visitors are welcome anytime unless it is clinically necessary to restrict visitors. We ask that friends and family who feel ill not visit patients in the hospital.

After Hours Security
To ensure the safety of our patients and staff, we have a special system for visitors entering the main hospital at night. After 9:00p.m., all visitors must enter the hospital through the Emergency Department Entrance. Anyone who needs to go beyond the West Lobby will be requested to sign in with security and wear a visitor pass. This is not required when other entrances to the facility are reopened at 5:00 a.m.

Smoking
Overlake Hospital is a smoke-free facility. As a health care institution, Overlake recognizes the hazards of smoking and enforces a No Smoking Policy for our patients, visitors, medical staff, employees and volunteers. Smoking is permitted only in the southwest courtyard. Smoking is prohibited at or near entrances to the hospital.

Organ Donation
State and Federal law requires Overlake Hospital to provide families with the options or organ and tissue donation. We know it is important to offer these options to those who have the opportunity to donate organs and tissue, and we respect each persons decision. Overlake Hospital partners with the local donation agencies to facilitate donation. Organ and tissue donation is always voluntary and confidential. If you would like more information on organ and tissue donation, ask a staff member for the brochure, Leave a Lasting Legacy-Donate Life.

PATIENT RIGHTS:
Patient Access Services staff is responsible for notifying patients that their Rights and Responsibilities are documented on the registration form. Select Rights and Responsibilities will be discussed with patients during the registration process according to a pre-determined schedule. Patient Access Services staff will respond to any questions patients have about their R&R at the time of registration. Patient Rights and Responsibilities are:

Access to Care
You will receive care with dignity, respect and care without regard to age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.

Healthcare Decision Making/Informed Consent
You have the right to be informed of your health status and/or your representative have the right to make informed decisions in planning your care and in resolving dilemmas about care decisions that may occur. You have the right to give or withhold consent.

Spiritual Health
Have your spiritual needs met through chaplains, visiting clergy or qualified volunteers.

Concerns or Questions
You have the right to voice your questions, concerns or complaints about your care in the hospital. You may do this without fear that it will compromise your care or future access to our services. You may contact the Patient Advocate at 425-688-5191. You may also contact the Washington Department of Health at 1-360-236-4700 or The Joint Commission at 1-800-994-6610. If you are a Medicare beneficiary and have a complaint, you may contact Qualis Health at 1-800-445-6941. You have a right to a timely response to your concerns.

Advanced Directives
You have the right to make important decisions about your own healthcare. It is never to early to make plans about the kind of health care you do or do not want when facing end-of life issues. You have the right to formulate advance directives if you are an adult. You have the right to refuse resuscitation or other life-sustaining treatments.

If you would like to know more, ask us for the free booklet, Starting Points. This booklet has information on living wills, durable powers of attorney, values statements and other resources for making your own health care decisions.

Notification of Admission
You have the right to have your physician, family, or a representative notified upon your admission to the hospital.

Restraint for Acute Medical and Surgical Care
Patients have the right to be free from any form of restraints (physical or chemical) unless needed for your own safety or the safety of others.

Pain Management
You have the right to appropriate assessment and management of pain. As a patient you can expect information about pain management and pain relief measures.

Refusal of Treatment
You may accept or refuse treatment to the extent permitted by law. You will be informed of the medical consequences of refusing treatment or leaving the hospital against medical advice.

You may also accept or refuse to participate in research studies.

Privacy and Confidentiality
Every consideration will be shown for your individual privacy when being interviewed, examined, treated, and requested as appropriate.
You have the right to the confidentiality of your health care information and to expect that all information shared will be done so according to federal and state laws and regulations.
You have the right to access information on any disclosure of your medical record.
You have the right to give or withhold consent to produce or use recordings, films, or other images of you for purposes other than your care.

Access to Medical Records

The Washington State Uniform Healthcare Information Act grants patients the right to review their medical records. You may request copies of all or any part of your medical record after you go home. Since your medical record is a legal document, it cannot be removed, deleted or altered. You can, however, request that your record be corrected or amended. For further information, please call the Release of Information Desk at 425-688-5643

Safety
Patients have the right to a safe setting and to be free from all forms of abuse, of harassment, or neglect. You have the right to expect reasonable safety insofar as hospital practices and environment are concerned and to access protective services when considered necessary for your personal safety.

Communication
You have the right to communicate with people outside the hospital by having personal visits and verbal or written communication.

You may refuse to see anyone not officially connected with the hospital or your care.

You have the right to receive information in a way that you can understand. You have the right to an interpreter or other communication aid if you do not speak English, if English is your second language, if you are deaf or hard of hearing, if you have vision issues, have cognitive impairment or have speech difficulties. This service will be provided to interpret medical information free of any charge to you and any communication assistance will be tailored to your needs.

Transfer
You may not be transferred to another facility or organization unless you or your representative has received a complete explanation concerning the need for such a transfer.

Continuing Care
You have the right to receive information about continuing health care requirements following your discharge.

Unexpected Outcomes
You have the rigth to be informed of unexpected outcomes of care, treatment or services.

End of Life Care
You have the right to receive end of life care in accordance with you or your representatives wishes.

Identity of Physicians and Staff
You will be told the name of the physician who has primary responsibility for authorizing and performing any procedures or treatment, and the names of other physicians and staff who will provide care.

You have the right to be informed of unexpected outcomes of care, treatment or services.

You have the right to receive end of life care in accordance with you or your representatives wishes.

Explanations of Hospital Charges
You have the right to receive an itemized and detailed explanation of your hospital bill when requested.

PATIENT RESPONSIBILITIES

Provision of Information
You have the responsibility to provide, to the best of your ability, accurate and complete details about your illness, hospitalization, medications and present conditions. You are responsible for reporting to your physician or nurse, if you do not understand your treatment or what you are expected to do.

You must tell your physician about a change in your condition or if problems arise.

You have the responsibility to follow instructions and rules of the hospital to ensure your safety and the safety of others.

You have the responsibility to maintain appropriate and civil conduct in interactions with physicians and staff.

Payment of Charges

You are responsible for providing accurate information for the hospital to file insurance claims and notifying the hospital about whom is responsible for your bill if you are not paying.

Pay your bill promptly or tell the hospital if you are unable to pay your bill.

DISCHARGE

Your physician will let you know when you will be discharged from the hospital. Please make arrangements for transportation as early as possible. If you need a taxi or to arrange special transportation to your home, please ask nursing to help you.

Patient care staff or trained volunteers will help take you and your belongings to the hospital entrance to meet your transportation. It is our policy to escort patients when leaving the hospital. You may use a wheelchair if you need one.

Insurance and Billing:

As a courtesy to you, Patient Financial Services will submit bills to your insurance carrier, provided you have given us the name and policy number of your insurance carrier and have signed our financial agreement authorizing your insurance company to pay us directly. If you have not done this and would like to, please let us know immediately.

Any balances remaining after insurance payment are due and payable to Overlake Hospital Medical Center within 30 days of receipt of the Explanation of benefits statement from your carrier. If you do not have insurance, we will look to you for payment on the full balance of the bill within 30 days of our itemized billing to you. Either upon admission or discharge, you will be asked to pay your insurance deductible, co-insurance and any costs associated with non-coverage. If you cannot pay for services or if you have questions about your account, please contact our financial counselor at 425-688-5115. A financial counselor can assist you in making arrangements for paying your bill.

Medical Services Reimbursement Assistance Programs

We want your experience with Overlake Hospital to be as pleasant as possible, from the time that you register for services to the time that your patient account is resolved. We recognize that financial difficulties may accompany the receipt of health care services and we want you to know that we offer programs to assist you. We also employ Financial Counselors who are happy to answer any questions you may have about our programs and to help you apply for a program that is best for you.

OVERLAKE MEDICAL CENTER

Protocol

Advance Directives

Nursing Administration 12261 (Rev: 13)**Official**

PURPOSE

To address the management of Advance Directives in the designated settings they will be honored.

All patients in the inpatient setting will honor Advance Directives and manage them as outlined in policy. For patients in these setting, should they not have an Advance Directive, they will be informed of their rights to formulate advance directives and provided information.

All surgical patients (inpatient and outpatient) with an Advance Directive will have a conversation with the physician with regards to suspending their Advance Directive during their surgical phase of care. Should they not have an Advance Directive they will be informed of their rights to formulate one and provided information if they wish it.

All patients in the outpatient setting except Outpatient Surgery will be informed that Advance Directives are not honored in these setting with a posted notice to inform patients that should they experience a medical emergency, emergency medical treatment will be provided. Exception is the emergency department, where if the patient presents with an Advance Directive, it will be honored if needed.

DEFINITIONS

Adult Patient: Any person at least 18 years of age.

Advance Directive *(AD):* Any written document representing the wishes and values of an adult. The document can be written when an adult is a patient or prior to becoming a patient. The Advance Directive designates another person (surrogate) to make health care decisions on his/her behalf if he/she is unable to make decisions for him/ herself. The Advance Directive gives instructions to health care professionals as to the patient's desires regarding health care decisions.

Mental Health Advance Directive For use in Behavioral Health Services: Inpatient Psychiatry and 23 hour Day Hospital or Outpatient Program.

Types of Advance Directives

A. **Living Will (Health Care Directive):** A written declaration of a patient's wishes regarding the use of life-sustaining medical care should they become terminally ill and unable to communicate. A Living Will:
   1. Must be written/signed by a competent adult 18 years of age or older.
   2. Must be witnessed by 2 persons who are not:
      - Related by blood or marriage
      - The patient's attending physician or employee of physician
      - An employee, volunteer or physician of the health care facility where the patient is receiving care
      - Heirs to the patient's estate
   3. May be witnessed by a friend, neighbor, clergy, etc. who personally knows the patient and believes the patient is capable of making health care decisions.
   4. Should state that the patient is emotionally and mentally competent and is voluntarily executing the document.
   5. May be revoked by the patient or surrogate at any time, by destroying it or instructing others to do so.

B. **Values Statement:** A written statement of patient's beliefs and values regarding health care

decisions. If the patient is incapacitated, this can help health professionals and/or the surrogate(s) choose among available treatment options.

C. **Durable Power of Attorney for Health Care:** A written document by the patient appointing another person as his/her agent (attorney-in-fact) to make health care decisions for the patient should he/she become incapacitated
   1. Must be written / signed by a competent adult 18 years of age or older.
   2. Must state that authority is "durable," i.e., is in effect regardless of the capacity of the patient.
   3. Should state that it is for health care decisions.
   4. May not appoint as agent the patient's physician, employee of physician, or employee of the health care facility where the patient is receiving care, UNLESS the individual is also a spouse, registered domestic partner, child, or sibling of the patient.
   5. Does not need to be notarized or witnessed in the state of Washington.
      - **Key Point → It is advisable to have the document notarized in order to meet requirements of other states where the patient may travel**
   6. May be revoked by the patient at any time, by destroying it or instructing others to do so.

D. **POLST (Physician Orders for Life Sustaining Treatment):** A MD order that describes patients wishes concerning resuscitation and other medical interventions. The form is used in addition to and not as a substitute for, any Advance Directive that a patient may have completed. It is intended to be "portable" and travel with the patient from one care setting to another.

SUPPORTIVE INFORMATION

An Advance Directive need not comply with any particular form or formalities, as long as it is in written form, is signed and appears to be authentic.

An adult patient who is capable of making his/her own health care decisions supersedes the effect of an Advance Directive at all times.

The patient/family/representative is informed that Overlake Hospital will provide care whether or not he/she has an Advance Directive.

STEPS → KEY POINTS

1. All inpatients, observation and surgical outpatients, 18 years or older, and Senior Health Center patients will be asked if they have an Advance Directive.
   a. If the patient has an Advance Directive with them, PAS(Patient Access Services) will scan the copy to archive it for retrieval at a future hospitalization. If advance directive does not accompany the patient and PAS is able to retrieve a prior copy, the copy is attached to the admitting paperwork.

Key Points → Any retrieved copy is reviewed by the patient for accuracy and dated/signed by patient.

Key Point → Copies of Advance Directives are kept in the "Advance Directive" section of the chart and the original copy is returned to the patient or their representative.

Key Point → Both original and copy of POLST forms for a patient admitted from a SNF, adult home, care facility, will be kept on the chart until transfer to next care facility at which time original copy is sent with the patient. This may also be done for other patients and returned to them at discharge.

Key Point → To ensure that all copied pages of an Advance Directive are not separated from each other, it is recommended that all pages be stapled together.

b. **Key Point → Each page of the Advance Directive will have patient identification information.** For Senior Health Centers: patients are asked and if available, a copy is made and placed in their chart.
c. If the patient does not have an Advance Directive, PAS will offer the patient a copy of the patient education booklet "Starting Points" which informs the patient about Advance Directives. Patient questions will be directed to their nurse upon arrival to the unit.

2. Upon arrival on the nursing unit, the Advance Directive Questionnaire may be completed by the patient or by the nurse with the patient or family representative.
   a. If the patient brings an Advance Directive documentation to the hospital, RN confirms AD is current and has patient sign and date the AD copy and placed in the chart.
      - If AD is not present but is being brought in, document this on care plan. When form is received, make a copy and fax to PAS department. Place copy in the chart. Give the original back to the patient.
      - **Key Point → Every attempt should be made to obtain a hard copy of the AD within 24 hours of admission.**

   b. If no AD, confirm the patient received a copy of "Starting Points". If not received, offer the booklet. Document acceptance or declination of booklet on Advance Directive Questionnaire.

3. If the patient is critically ill and unable to verbalize, or does not have a spokesperson that is aware of an AD, health care providers will provide care as if there is no AD executed.
   - **Key Point → AD Questionnaire will be completed and signed by the nurse to reflect the above situation.**

4. If a patient is unable to give information or answer question regarding the existence of an AD, the nurse will notify the legal next of kin to provide an AD, if one exists. Follow-up documentation will be added to the care plan to ensure that an AD is obtained.
5. The nurse will inform Licensed Independent Practitioner (LIP) Advance Directives, (including a POLST form), are present on the chart.
   - **Key Point** → The original green POLST form is not used as an order form. The LIP must needs to write the patient wishes as an order on Physician Order form or Code Status form.
   - **Key point** → Within 24 hours of admission, the LIP needs to write code status orders either on Physician Order or Code Status form for this hospital admission. to reflect known wishes of patient.
   - **Key Point** → "If a patient is admitted with documentation of their wishes not to be resuscitated in a Living Will or an original POLST form, and no physician order has been written at the time of arrest, a Code Blue is to be initiated. It is the responsibility of the Registered Nurse caring for the patient to inform the responding Physician at the time of arrival of the existence of the documented no code wishes

6. If a patient decides to revoke the AD, document this in the medical record and notify the Physician.
7. Referrals for assistance with health care decisions or completing the forms during hospitalization may be directed to Care Management, Chaplain, Palliative Care Team or Senior Care.
8. Refer to Mental Health Advance Directive policy for information related to persons with mental illness.

DOCUMENTATION

1. Advance Directive Questionnaire is completed by the patient, surrogate and/or nurse on admission.
2. Completion or follow up needs of this process is documented on the care plan within 24 hours of admission.

Documents referenced by this document

Referenced Documents	Mental Health Advance Directive

Documents which reference this document

Referenced Documents	Patient Admission Data Documentation

OVERLAKE MEDICAL CENTER

Z-Policy

Mental Health Advance Directive

Psychiatric Services 13614 (Rev: 1)**Official**

BACKGROUND:

Persons with mental illness may fluctuate between periods of capacity and incapacity. Mental health advance directives (MHAD) provide a method of expressing instructions and preferences for treatment in advance of a period of incapacity and providing advance consent to or refusal of treatment.

POLICY:

Mental health advanced directives that meet state law requirements, medical and ethical practice standards, and the policies of procedures of this hospital will be honored for any patient receiving psychiatric services, including psychiatric consultation services provide by the hospital. These patients will be questioned about the existence of a mental health advance directive that will be presumed to be a properly executed and valid even if one or more provisions of the directive are deemed to be invalid. However, in those circumstances where it is not appropriate or permissible to honor mental health advanced directives, the patient and/or their designated agent will be advised and appropriate documentation made in the patient's medical record.

PURPOSE:

The purpose of this policy is to describe how the hospital, hospital staff, and medical staff will comply with their legal, ethical, and other obligations concerning mental health advance directives. This policy does not address all aspects of the law governing mental health advance directives, but attempts to focus on ensuring relevant patients are questioned about the existence of a mental health advance directive. Additionally, the purpose of this policy is to identify clinical,administrative, and legal resources to assist hospital and medical staff to comply with chapter 11.94 RCW, chapter 7.70 RCW, 42 CFR Part 417 et. seq.

DEFINITIONS:

Mental health advance directive: a written document in which a patient makes a declaration of instructions or preferences or appoints an agent to make decisions on behalf of the patient regarding the patient's mental health treatment, or both, and that is consistent with the provisions of Washington's mental health advance directive statute.

PROCEDURE:

1. Patients receiving behavioral health services, including psychiatric consultation provided by the hospital shall be asked whether he or she has made a mental health advance directive. This process will be achieve through the completion of the "mental health advance directive" questionnaire **prior to** the initiation of treatment. The signed, dated, and witness MHAD questionnaire will be placed in the patient medical record.
    a. **Emergency Department:** the emergency department social worker will complete the MHAD questionnaire on all patient receiving a psychiatric assessment.
    b. **Inpatient Units:** the unit social worker will complete the MHAD questionnaire on all patients receiving a psychiatric assessment/consultation.
    c. **Behavioral Health Services:**
        i. Inpatient & 23-hour bed programs - the admitting RN will complete the MHAD questionnaire on all patients
        ii. Day Hospital programs - the program specific coordinator will complete the MHAD questionnaire on all patients.
        iii. Outpatient program - the outpatient coordinator will complete the MHAD questionnaire on all patients.

d. **Note:** Patient will be directed to their outpatient providers regarding question related to creation of a MHAD.

2. On receipt of a mental health advance directive, a copy of the directive shall be placed in the patient's chart.
3. If the patient does not have a current copy of the MHAD with them but submitted on previous admission, a copy of the MHAD will be retreived from the old medical record and reviewed with the patient.
4. On receipt of a directive a medical staff member will determine the validity of the directive. For assistance in determining validity contact a hospital designated resource in section 7 of this policy:
    a. MHAD must include all of the items below:
        i. Be in writing.
        ii. Include language that shows an intent to create a mental health advance directive.
        iii. Be dated and signed by the patient or be dated and signed in the patient's presence at his or her direction.
        iv. State whether the directive may or may not be revoked during periods a period of incapacity
        v. Contain the signatures of two witnesses following a declaration that the witnesses personally know that patient, were present when the patient dated and signed the directive, and that the patient did not appear to be incapacitated or acting under fraud, undue influence, or duress.

    b. The following areas of the directive shall also be reviewed for validity:
        i. Appointment of an agent: If the directive includes appointment of an agent it must contain the words "This power of attorney shall not be affected by the incapacity of the principal(patient)," or "This power of attorney shall become effective upon the incapacity of the principal(patient)," or similar words.
        ii. Effective date: A directive may be effective immediately after it is executed or it may become effective at a later time. Mental health advance directives validly executed before the effective date of the law relating to MHAD's (July 27, 2003) are effective until they are revoked, superseded, or expire.
        iii. Directives created outside Washington State: A directive validly executed in another political jurisdiction is valid to the extent it is permitted under Washington state law.
        iv. Witnesses: Hospital staff and employees, medical staff members or any other person involved in the patient's care are not permitted to witness a mental health advance directive.

5. On admission the admitting medical staff member shall ascertain whether compliance with the directive or portions of it is possible. For assistance in determining whole or partial compliance contact a hospital designated resource in section 7 of this policy:
    a. If the unable or unwilling to comply with any part or parts of the directive **for any reason**, an objection can be made to that part or those parts of the directive.
    b. Notify the patient of the objection, and, if applicable his or her agent and document the parts or parts of the directive that are objectionable and the reason in the patient's medical record.

6. In addressing any of the issue that is not included in this policy (examples below), a hospital designated resource in section 7 of this policy **must be contacted:**
    a. Interpretation related to the Washington state MHAD law
    b. Process and determination of incapacity
    c. Issues related to a MHAD being revoked, superseded, or expiration
    d. Agent's notice of withdrawal of MHAD
    e. Objections "once acting under the authority of a directive". i.e. not address in initial objections
    f. Being detained or committed for involuntary treatment
    g. Conflicting directives
    h. Scope of an agent's authority

7. Hospital designated resources:
    a. Director of Risk Management Services
    b. Director of Behavioral Health & Social

Patient's Rights and Responsibilities

You have the **RIGHT**:

. To receive information in a way you can understand. To an interpreter or communication aid if you do not speak English, English is your second language, or you are deaf, hard of hearing, have vision issues, cognitive impairment, or have speech difficulties. Communication will be tailored to your age and your needs.

. To have family or your representative and your physician be told of your admission to the hospital.

. To be treated with dignity, respect and care without regard to age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.

. To be told of your health status and to include your family or representative in planning your care, and to discuss and resolve care issues.

. To have you or your representative participate in and agree with decisions about your care, treatment or services.

. To receive visitors of your choice unless it is clinically necessary to restrict visitors.

. To make advance directives if you are an adult and to have your advance directives respected and followed. You have the right to refuse resuscitation or other life-sustaining treatments.

. To know who is responsible for your care, and who is performing a procedure or treatment.

. To accept or refuse the care and treatment offered.

. To have personal privacy.

. To give or withhold consent to produce or use recordings, films or other images of you for purposes other than your care.

. To make a complaint and file a grievance and to its timely resolution without fear of retribution.

. To receive proper pain management.

. To pastoral care and other spiritual services.

. To be free from all abuse, neglect, exploitation or harassment.

. To be free from restraints or seclusion unless needed for your own safety or the safety of others.

. To expect reasonable safety and access to protective services when necessary for your personal safety and security.

. To accept or refuse to be in a research study.

. To be informed of unexpected outcomes of care, treatment or services.

. To a copy of all or any part of your medical record.

. To keep your medical record confidential and to ask for an amendment or correction to your medical record.

. To access information on any disclosures of your medical record.

. To be sent to another facility after you have received a complete explanation of the need for such a transfer.

. To receive information about your treatment needs after your discharge.

. To end of life care.

. To donate tissues and organs after consultation with medical staff and your representative.

. To receive an itemized and detailed explanation of your hospital bill when requested.

. To give and withhold informed consent.

You have the **RESPONSIBILITY**:

. To provide accurate and complete details about your illness, hospitalization and medications.

. To tell your doctor or nurse about a change in your condition or if problems arise.

. To tell your doctor or nurse if you do not understand your treatment or what you are expected to do.

. To follow instructions and rules of the hospital to ensure your safety and the safety of others.

. To maintain appropriate and civil conduct in interactions with physicians and staff.

. To give accurate information about insurance or other business matters.

. To pay your bill promptly and tell the hospital if you need to make special payment arrangements.

Under certain legal situations, all rights may not apply.