THE SURGERY CENTER

PATIENT RIGHTS AND RESPONSIBILITIES

- Personal and informational privacy and security for self and property.
- Considerate, respectful care at all times and under all circumstances with recognition of your personal dignity.
- Have a surrogate (parent, legal guardian, person with medical power of attorney) exercise the Patient Rights when you are unable to do so, without coercion, discrimination or retaliation.
- Confidentiality of records and disclosures and the right to access information contained in your clinical record. Except when required by law, you have the right to approve or refuse the release of records.
- Receive care that meets all federal and state requirements for the support and protection of basic human, civil, constitutional, and statutory rights.
- Information concerning your diagnosis, treatment and prognosis, to the degree known.
- Participate in decisions involving your healthcare and be fully informed of and to consent or refuse to participate in any unusual, experimental or research project without compromising your access to services.
- Make decisions about medical care, including the right to accept or refuse medical or surgical treatment after being adequately informed of the benefits, risks and alternatives, without coercion, discrimination or retaliation.
- Competent, caring healthcare providers who act as your advocates and treats your pain as effectively as possible.
- Know the identity and professional status of individuals providing service and be provided with adequate education regarding self-care at home, written in language you can understand.
- Be free from unnecessary use of physical or chemical restraint and or seclusion as a means of coercion, convenience or retaliation.
- Know the reason(s) for your transfer either inside or outside the facility.
- Impartial access to treatment regardless of race, age, sex, ethnicity, religion, sexual orientation, or disability.
- Receive and itemized bill for all services within a reasonable period of time and be informed of the source of reimbursement and any limitations or constraints placed upon your care.
- File a grievance with the facility by contacting the Director of Nursing, via telephone or in writing, when you feel your rights have been violated.

  Donna Griggs, Administrator
  1720 B Medical Park Drive
  Biloxi, Mississippi 39532
  Phone: 228-702-2000
- Report any comments concerning the quality of services provided to you during the time spent at the facility and receive fair follow-up on your comments.
- Know about any business relationships among the facility, healthcare providers, and others that might influence your care or treatment.
- File a complaint of suspected violations of health department regulations and/or patient rights. Complaints may be filed at:

  Mississippi State Department of Health
  570 East Woodrow Wilson Drive
  Jackson, MS 39216
  1-800-227-7308
  Office of the Medicare Beneficiary Ombudsman
  http://www.cms.hhs.gov/center/ombudsman.asp

AS A PATIENT, YOU ARE RESPONSIBLE FOR:

Providing, to the best of your knowledge, accurate and complete information about your present health status and past medical history and reporting any unexpected changes to the appropriate physician(s).
Following the treatment plan recommended by the primary physician involved in your case.
Providing an adult to transport you home after surgery and an adult to be responsible for you at home for the first 24 hours after surgery.

- Indicating whether you clearly understand a contemplated course of action, and what is expected of you, and ask questions when you need further information.
- Your actions if you refuse treatment, leave the facility against the advice of the physician, and/or do not follow the physician's instructions relating to your care.
- Ensuring that the financial obligations of your healthcare are fulfilled as expediently as possible.
- Providing information about, and/or copies of any living will, power of attorney or other directive that you desire us to know.

Patient Signature: _____ Date: _____

Patient Representative Signature: _____ Date: _____

Witness: _____ Date: _____ Rev. 09/16

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