AS A PATIENT OF THE ST. CLOUD CENTER FOR OPHTHALMIC SURGERY, 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 patient's 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 rights.

•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.

If you need a translator:

If you will need a translator, **please let us know** 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

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 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.

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

Submission and Investigation of Grievances: You have the right to have your verbal or written grievances submitted, investigated and to receive a written notice of the Center's decision.

The following are the names and/or agencies you may contact:

Paula A. Schleppenbach, Director SCCOS
2055 North 15th St., Ste B
St. Cloud, MN 56303
(320) 258-6620
You may contact your state representative to report a complaint;
www.cdc.gov/mmwr/about.html
MDH Office of Health Facility Complaints
85 East Seventh Place, Suite 300 P.O. Box 64970
St. Paul, MN 55164-0970
(651) 201-4201 or 1-800-369-7994
State Web site:
http://www.health.state.mn.us
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 center is owned, in part, by the physicians. 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 treated at another health care facility of their choice. We are making this disclosure in accordance with federal regulations.

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:_____

Patient's Rights and Notification of Physician Ownership

St. Cloud Center for Ophthalmic Surgery
2055 North 15th St., Suite B
(320) 258-6620

Label for Medical Records

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