MAGNOLIA MEDICAL GROUP

NOTICE OF PRIVACY PRACTICES AND BILL OF RIGHTS ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

THE PATIENT BILL OF RIGHTS AND RESPONSIBILITIES - The goal of Magnolia Medical Group is to provide all patients with high quality health care in a manner that clearly recognizes individuals' needs and rights. To accomplish this goal effectively, the patient and the health care provider must work together to develop and maintain optimum health. To promote this goal, the following rights and responsibilities have been identified:

AS A PATIENT, YOU HAVE THE RIGHT:

1. To receive considerate care that is respectful of your personal beliefs, your cultural, and your spiritual values;
2. To have all things explained to you in terms that you can understand and to have any questions answered concerning your diagnosis, prognosis, and treatment;
3. To know what the diagnosis is; what your prognosis is; what treatment options are available to you; how risky the treatments are; and whether they will hurt, and for how long;
4. To have all the common side effects of a drug explained;
5. To know the contents of your medical records through interpretation by the provider; 6. To know who it is that is interviewing and examining you;
6. To know who it is that is interviewing and examining you;
7. To have explained to you ways that you can prevent your medical problem from recurring;
8. To refuse to be examined or treated by a health practitioner and to be informed of the consequences of such a decision;
9. To be assured of the confidential treatment of disclosures in your record and to have the opportunity to approve or refuse the release of such information, except when the release of specific information is required by law or is necessary to safeguard you or the university community;
10. To be informed and asked whether you wish to participate in medical research that is being conducted at Health Services;

11. To participate in the consideration of ethical issues that arise in the provision of your care;
12. To receive care in a secure and private environment so that the treatment experience is positive and supportive;
13. To receive care in a timely and professional manner within available resources from a provider with whom you are comfortable;
14. To be heard when you have a concern regarding quality of care or patient safety with resolution by empowered staff or through submission of a formal Patient Care Survey or a more formal Incident Report to the Director;
15. To designate a Partner in Care (surrogate) decision-maker to participate with you and the provider in care decisions and delivery;
16. To have information provided regarding the health service fee, insurance requirements, cost of treatment, and payment options;
17. To have appropriate assessment and management of pain.

AS A PATIENT, YOU HAVE THE RESPONSIBILITY:

1. To provide Health Services with information about past illnesses, hospitalizations, and medications;
2. To follow the plan of care or to express concern regarding your ability to comply;
3. To ask questions if you do not understand the directions or treatment being given to you by a provider;
4. To take responsibility for the outcome of your care if you have refused treatment;
5. To keep your appointment or to telephone Health Services, with reasonable notice, if you need to cancel;
6. To be respectful of others and others' property while in a Magnolia Medical facility;
7. To provide current and accurate insurance information to Magnolia Medical;
8. To be an active partner in arranging transition of care when no longer eligible for care. This includes arranging for recommended follow-up care and requesting copies of appropriate records be forwarded to a provider of your choice.

I have received, read and understand your Notice of Privacy Practices and Patient Rights containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change this Notice of Privacy Practices and Patient Rights from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices and Patient Rights.

I understand that I may request in writing that you restrict how my private information is used or Disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Printed

Name:_____

Signature (Patient, Parent/Guardian, Representative):_____

Date:_____