PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

PATIENT BILL OF RIGHTS

- You may not be denied appropriate hospital care because of your race creed, color, national origin, religion, sex, sexual orientation, marital status, age, disability, or source of payment.
- You shall be treated with consideration, respect, and recognition of your individuality, including the need for privacy in treatment.
- Your individual medical records, including all computerized medical information, shall be kept confidential in accordance with applicable federal, state and local laws.
- You or any person authorized by statute or in writing by you shall have access to your medical record but access to your psychiatric records may be limited by treating professionals when specific hospital policies specify requirements for limiting access.
- You shall be entitled to know who has overall responsibility for your care.
- You or your legally authorized person or any person authorized in writing by you, shall receive from the appropriate person within the facility, information about your illness, course of treatment and prognosis for recovery in terms you can understand.
- You, or your designated representative, where appropriate, shall have the opportunity to participate to the fullest extent possible in planning your care and treatment.
- You, or your designated representative, shall be given, at the time of admission, a copy of the Patient's Bill of Rights and Responsibilities.
- Except in emergencies, the consent of your, or your legally authorized representative, shall be obtained before treatment is administered.
- You may refuse treatment to the extent permitted by law and shall be informed of the medical consequences of the refusal.
- You, your legally authorized representative, or person granted the power to authorize medical treatment, shall be fully informed and give consent for your participation in any form of research or experimentation.
- Except in emergencies, you may be transferred to another facility only with a full explanation of the reason for the transfer, provision for continuing care, and acceptance by the receiving institution.
- You may examine and receive an explanation of your hospital bill regardless of the source of payment, and may receive upon request, information relating to financial assistance available through the hospital.
- You shall be informed of your responsibility to comply with hospital rules, cooperate in your own treatment, provide a complete and accurate medical history, be respectful of other patients, staff, and property, and provide required information concerning payment of charges.
- You shall be informed in writing about the hospital's policies and procedures for initiation, review, and resolution of patient complaints, including the address where complaints may be filed with the department (Hospital's Responsibility to You).
- You shall be allowed to designate who may be permitted to visit during the hospital stay in accordance with the hospital visitation policy.
- You shall have freedom from physical or verbal abuse, harassment, and inappropriate physical and chemical restraints.
- Sierra Vista Hospital must be in compliance with CMS's patient rights condition of participation.

PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

PATIENT RESPONSIBILITIES

- You have the responsibility to comply with hospital rules.
- You have the responsibility to provide, to the best of your knowledge, information about your health, past and present, information about your present medications and any treatment you may be under.
- You have the responsibility to cooperate with your doctor, our staff and other caregivers in the treatment program agreed upon.
- You have the responsibility to provide requested insurance and financial information, and sign required consents and releases.
- It is your responsibility to be reasonable in making requests for care and assistance.
- You have the responsibility to be considerate of other patients, staff, and property.
- You have the responsibility to settle hospital bills promptly.

HOSPITAL'S RESPONSIBILITY TO YOU

- Our responsibility to you is to provide you, the patient, with quality health care in an atmosphere where physical, emotional, and spiritual recovery and growth can take place.
- Hospital staff assigned to provide direct patient care shall be informed of, and demonstrate their understanding of, the policies on patient rights and responsibilities through orientation and appropriate in-service training activities.
- To be in compliance with CMS's condition of participation.
- Provide Prompt, considerate attention to all complaints from you and or your family.
- Grievances, complaints, or any other appropriate comments should be addressed to the hospital Risk Manager at 575-894-2111, Ext. 220, Sierra Vista Hospital, 800 E. Ninth Ave, Truth or Consequences, NM 87901.
- Concerns not resolved to your satisfaction may be addressed to the Chief Executive Officer at 575-894-2111, Ext. 202, Sierra Vista Hospital, 800 E. Ninth Ave, Truth or Consequences, NM 87901.
- You may address complaints or questions about Sierra Vista Hospital to the Director of the New Mexico Licensing and Certification Bureau, at 1-800-752-8649, 525 Camino del los Marquez, Suite 2, Santa Fe, NM 87501, between the hours of 8:00 AM and 5:00 PM, Monday through Friday except Holidays.
- Sierra Vista Hospital will not tolerate ill treatment of patients. If you suspect physical abuse, sexual abuse, emotional or psychological abuse, neglect, or exploitation you may report through the Department of Health Division of Health Improvement.
    - Intake Hot Line: 1-800-752-8649
    - Reporting Fax: 1-888-576-0012
    - Reports may be submitted online at: www.nmhealth.org/about/dhi/ane/
    - New Mexico Long-Term Care Ombudsman: 1-800-432-2080

SIERRA VISTA HOSPITAL AND CLINICS

PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

ACKNOWLEDGMENT OF RECEIPT

By my signature I acknowledge receipt of a copy of the Patient's Bill of Rights and Responsibilities provided to me by Sierra Vista Hospital.

Please Print Name of Patient or Representative	Signature of Patient or Representative
Relationship to Patient	Date
Please Print Name of Witness	Signature of Witness
Hospital Department Name	Date

THIS DOCUMENT IS TO BE PART OF THE PATIENT'S HOSPITAL MEDICAL RECORD.

PATIENT LABEL