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PATIENT RIGHTS FORM

Doctors, their staff, neighborhood clinics, hospitals, and many others are volunteering their services to help you get and stay well. **This is not insurance or a government program**. Our help may end at any time, for any reason and may be limited. Emergency room expenses and ambulance services **are not covered**. Your responsibilities, the assistance available and other conditions may change at any time. By signing this form, or by using these cards in any way, you agree to follow the Patient Responsibilities below, and you give Cumberland HealthNET (CHN) permission to verify with state and other agencies what you have told us. Providing false information or neglecting to provide important information regarding your healthcare insurance, income, residency or illness will result in loss of CHN benefits and you having to pay for the services received.

CLICK TO ACCEPT EACH OF THESE

_____ 1. I have the right to be treated with dignity and respect.

_____ 2. I have the right to medical treatment provided through Cumberland HealthNET (CHN) regardless of sex, race, religion or national origin.

_____ 3. I have the right to confidential treatment of all records pertaining to my care and the right to approve or disapprove of the release of any information that identifies me except as required by law.

_____ 4. I have the right to expect reasonable continuity of care and to be informed of continuing health requirements upon discharge from CHN.

_____ 5. I have the right to receive complete information regarding my condition, how to manage it, the benefits and risks of receiving treatment or failing to do so and the expected outcome of my condition after proper treatment and management.

_____ 6. I have the right to be informed of any CHN rules or regulations that relate to my conduct as a patient.

_____ 7. I have the right to obtain information about the relationship between CHN to any other health care and educational institutions as it relates to my involvement with CHN.

_____ 8. I have the right to ask questions and voice grievances or concerns about my care and treatment by CHN staff and any other professionals involved in my care.

_____ 9. I have the right to be given the names, qualifications and experience of providers and other CHN staff who are directly involved in my medical care.

_____10. I have the right to participate fully in decisions about my care and treatment.

_____ 11. I have the right to know the cost of care in advance to the extent possible.

_____ 12. I have the right to have my mental, social, spiritual and cultural beliefs about health, injury and illness respected by everyone involved in my care.

By signing below, I confirm that I understand and agree to the above conditions. I also understand that if I do not follow all the Patient Responsibilities listed, then I will lose my CHN benefits. If you have any questions please call 910.483.6869.

_____ _____

Patient Signature **Date**