



6160 Windhaven Parkway, Suite 220
Plano, Texas 75093

PATIENTS'S RIGHTS AND RESPONSIBILITIES

We, at Windhaven Surgery Center present a Patient's Bill of Rights and Patient Responsibilities with the expectation that they will contribute to more efficient patient care and greater satisfaction for the patient, family, physician and center organization. Patients shall have the following Rights and Responsibilities without regard to age, sex, religion, culture, physical handicap, and personal values or beliefs.

PATIENT'S RIGHTS

You, the patient, have the right to accept or refuse medical care or treatment to the extent of the law. You will be informed of the medical consequences of such refusal. You are responsible for your actions should you refuse treatment or fail to follow your physician or surgery center's instructions. You will be requested to sign a release of responsibility form.

You have the right to approve or refuse the release of your medical record to an individual outside the surgery center. The exceptions being in case of a transfer to another medical facility, required by law or third party payment contract (your insurance company). You and or your designated representative have the right to be fully informed before transfer to another facility. The care rendered reflects consideration of you as an individual with personal values and a belief system. You are allowed to express your spiritual beliefs and cultural practices that do no harm to others or interfere with your planned care/medical interventions.

Your designated representative has the right to participate in the consideration of ethical issues that arise during your care.

You will be treated with consideration, respect, and full recognition of individuality, including privacy in treatment and care. The surgery center will keep records and all personal matters that relate to you confidential.

You will be provided with complete information to the extent of the physician's knowledge regarding diagnosis, treatment, and prognosis as well as alternative treatment for procedures and the possible risks and side effects associated with the treatment process.

You will be informed about pain and pain relief measures. You can expect a concerned staff who are committed to pain prevention and effective pain management who believe your reports of pain and who respond quickly to your reports of pain.

You or a designated representative will be fully informed on the services and provisions for after-hours and emergency care available at the surgery center.

You have the right to information regarding fees, payment policies, and may request an explanation of your bill regardless of the source of payment.

You have the right to inquire about the professional status of individuals providing your care.

You will receive the care needed to help you regain or maintain your maximum state of health.

You have the right to present an Advance Directive, Living Will or Power of Attorney. However, it is our policy that if an adverse event occurs during your treatment at this surgery center we will initiate resuscitative or other stabilizing measure and transfer you to an acute care hospital for further evaluation. Should you request information on Advance Directives, information will be then provided to

you.

PATIENT'S RESPONSIBILITIES

You have the responsibility to observe the rules and regulations of the center for your stay and treatment IF the instructions by the surgery center staff are not followed, you may forfeit the right to care at the center and you will be responsible for your own outcomes. You are responsible for promptly fulfilling your financial obligations to the surgery center.

You have the responsibility to be considerate of other patients, families, and personnel by assisting in the control of noise, smoking, and other distractions.

You and your family are expected to respect the property of others.

You are responsible for reporting to the staff whether or not you understand the planned course of your treatment and what is expected of you.

You have the responsibility to ask your doctor or nurse any questions you have concerning pain management or pain relief options and to assist your doctor or nurse in assessing your pain. You are expected to tell our doctor or nurse about any concerns you have about taking pain medication.

You are responsible for notifying the center or your physician if you can not keep your appointment.

You and your family are responsible for providing the caregivers with accurate and complete information regarding present conditions, past illnesses, hospitalizations, medications or any other pertinent medical history.

It is your responsibility to fully participate in decisions involving your care and to accept the consequences of these decisions.

You are expected to follow up on your doctor's instructions, take medications when prescribed, and ask questions concerning your health care that you feel are necessary.

GRIEVANCE POLICY STATEMENT

Windhaven Surgery Center provides for and welcomes the expression of grievances/complaints and suggestions by the patient and patient's family at all times. This feedback allows the center to understand and improve the patient's care and environment. Every patient has the right to file a grievance with the facility's Director of Nurses. If the patient is not satisfied the process is given to the Medical Director. In the event the problem is still not resolved the patient has the right to file a complaint with the:

Texas Department of Health.
Health Facility Licensing and Compliance Division
1100 West 49th Street
Austin, TX 78756
1488-973-0022

Or

<http://www.medicare.gov/Ombudsman/activities.asp>

Complaints may be registered with the department by phone or writing. A complainant may provide his/her name, address, and phone number to the department. Anonymous complaint may be registered. All complaints are confidential. The main goal of the surgery center is to provide excellent care to every patient. Every patient is encouraged to ask questions. By signing this document, I acknowledge that I have read and understood its contents and agree to this document as described.

Patient Signature

Date

Printed Name

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