Patient Bill of Right and Responsibilities

As a patient, you have the right to:

- Be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment, care for personal needs and respect for property.
- Exercise your rights as a patient of BeLoved Hospice, Inc. and voice grievances regarding care that is (or fails to be) furnished, or lack of respect for property, by anyone furnishing services on behalf of BeLoved Hospice, Inc., without being subject to discrimination or reprisal for exercising those rights.
- Be fully informed of services available from the agency under the Medicare Hospice Benefit, Medicaid and/or private health insurances, and of any costs that you may be responsible for.
- Be free from mistreatment, neglect or verbal, mental, sexual and physical abuse, including injuries of unknown source and misappropriation of patient property.
- Receive appropriate information from a physician, within the limits determined by the physician, law or regulation, regarding the diagnosis, prognosis and treatment.
- Be informed of the scope of service that will be provided and the specific limitations on those services.
- Be instructed regarding the illness so that you can help yourself and your family so they can help you.
- Have a confidential clinical record (in accordance with 45 CFR 160 and 164).
- Be able to participate in the planning of your medical treatment (and Hospice Plan of Care), refuse to participate in research and to choose your own attending physician.
- Refuse care or treatment and be informed of the medical consequences of such refusal.
- Receive effective pain management and symptom control from the hospice for conditions related to the terminal illness.
- Be advised that BeLoved Hospice, Inc. complies with Subpart 1 of 42 CFR 489 and receive a copy of our written policies and procedures regarding advance directives, including a description of an individual's right under applicable state law and how such rights are implemented by the organization.
- Receive written information describing BeLoved Hospice, Inc.'s grievance procedure which includes contact information, contact phone number, hours of operation and mechanisms for communicating problems.
- Receive an investigation by BeLoved Hospice, Inc. of complaints made by yourself or your representatives regarding treatment or care and that the organization will document the existence of the complaint and the resolution of the complaint.
- Receive information addressing any beneficial relationship between BeLoved Hospice, Inc. and referring entities.

You have the right to expect that BeLoved Hospice, Inc. will:

- Protect and promote your rights to exercise the rights listed above.
- Ensure that all alleged violations involving mistreatment, neglect or verbal, mental, sexual and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone furnishing services on behalf of the hospice, are reported immediately by hospice employees and contracted staff to the Administrator of BeLoved Hospice, Inc.
    - BeLoved Hospice, Inc. ensures that all verified violations are reported to the State, Federal, local agencies and accrediting bodies within 5 working days of becoming aware of the violation.
- Immediately investigate all alleged violations involving anyone furnishing services on behalf of BeLoved Hospice, Inc. and immediately take action to prevent further potential violations while the alleged violation is being verified.

Print Patient Name: _____ MR#: _____

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As a patient, you have the responsibility to:

- Remain under the physician's care while receiving agency services.
- Provide the agency with a complete and accurate health history.
- Provide the agency all requested financial and insurance records.
- Sign the required consent for treatment and release for insurance billing.
- Participate in your plan of care.
- Provide a safe home environment in which your care can be given.
- Cooperate with your physician and agency staff.
- Treat agency personnel with respect and consideration.
- Notify the agency when unable to keep an appointment.
- Accept the consequences of any refusal or choice of non-compliance.
- Provide the agency with a copy of your advance directives, if applicable

Patient or Representative Signature: _____ Date: _____ /_____ / _____

Indicate relationship if signed by other than patient: _____

Reason patient unable to sign: _____

Hospice Representative Signature: _____ Date: _____ /_____ / _____

Print Patient Name: _____ MR#: _____