DESCHUTES RIM
HEALTH CLINIC

Procedure Description	DEPARTMENT	Procedure
Patient Rights, Responsibilities, consents & Financial Agreement	Operating	OP 05
ORIGINAL DATE: 1/20/2021	RESPONSIBLE PARTY: Clinic Manager	shelby Dumire	REVISED DATE: 5 /17 /2023
APPROVAL DATE: 5 /25 /2023	DATE REVIEWED: 5 /25 /2023		APPROVED BY: BOARD OF DIRECTORS
RESOLUTION NO:		BOARD CHAIR:	suzanne Knapp

1605 George Jackson Road, Maupin OR 97037 541-395-2911 Fax 541-395-2912

Patient Rights, Responsibilities, Consents and Financial Agreement

Patient Rights- We believe that patients have the right to:

- Be treated with consideration, courtesy and respect in a way that fully recognizes your dignity, individuality, and cultural background.
- Be Given information about the Clinics services offered, as well as service limitations, our fees, and our policies for paying your bill.
- Be given a copy of the Clinics Notice of Privacy Practices and information in accordance with Federal HIPPA laws and regulations.
- Receive a copy of your medical records and information concerning your diagnosis, treatment and prognosis without fear or consequences.
- Participate in the development/decisions, evaluation, and revision of your health care/treatment plans.
- Request an itemized copy of your account upon request.
- Ask the Clinic Manager about anything that you may not understand regarding our services, policies or procedures and grievance/complaint process regarding concerns for care at our Clinic.

Patient Responsibilities- We believe that patients have the responsibility to:

- Respect the privacy, confidentiality, and safety of all the Clinics patients, visitors, staff, volunteers, and property.
- Arrive on time for all scheduled appointments or when cancelling appointments to provide a least a 24-hour notice.
- Participate with all caregivers in their treatment and rehabilitation while providing accurate information regarding your current and past health.
- Accept the responsibility for the consequences of refusing treatment.
- Accept the responsibility for all uninsured financial obligations.
- Know your insurance benefits and coverage prior to your services at the Clinic. If you have questions concerning coverage/financial responsibility, please contact your insurance carrier.
- Not bring alcohol, marijuana, or illegal drugs into our Clinic. To not smoke, vape or use any type of tobacco products on the property.
- Not bring weapons inside the Clinic. If your job requires you to carry a weapon, you must alert the front desk and keep your weapon out of sight.
- Not bring non-service animals into the Clinic.
- Comply with all the Clinics policies, procedures, and guidelines. Not doing so may affect your ability to receive services at Deschutes Rim Health Clinic.

Consent for Care-

I, with my signature, authorize Deschutes Rim Health Clinic, and any employee working under the direction of the health care provider, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventative, mental health status, function of the body and the sale or dispensing of drugs, devices, equipment, or

other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent for Release of Information and Assignment of Benefits-

I also authorize this practice to furnish information to the identified insurance carrier(s) for all payment activities. I consent to assign all payments for services directly to this practice. I further consent to the use for any practice operational needs as identified in the Privacy Practices Notice.

HIPAA Consent and Notice of Privacy Practices- The patient understands that-

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payments, and health care operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. Deschutes Rim Health provides this form to comply with the Health Insurance and Portability Act of 1996 (HIPPA).

- Protected health information may be disclosed or used for treatments, payments, or health care operations.
- Deschutes Rim Health Clinic has a Notice of Confidentiality Policy and that the patient can review this Notice. Deschutes Rim Health Clinic reserves the right to change the Notice of Confidentiality Policies.
- The patient has the right to restrict the uses of their information, but Deschutes Rim Health Clinic does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- Deschutes Rim Health may condition treatment upon the execution of this consent.

Financial Agreement-

Deschutes Rim Health Clinic will adhere to the following financial policy to consistently deliver high quality care and services. The patient/responsible party assumes responsibility to ensure that the financial obligation is fulfilled for the health care services received. By signing this form, I acknowledge that I understand the following:

- I am responsible for all co-payments, deductibles and any other amounts that may be deemed my responsibility by the payment sources. I am expected to pay co-payments at the time of service.
- My insurance carrier may or may not cover some services as Insurance policies may vary by each individual policy. If I seek care outside of my insurance contract terms, I am aware that I may be responsible for all charges that are incurred.
- If uninsured, then payment is expected at the time of service or a minimum deposit of $75.00.
- That all private pay balances, are eligible for a pay in full discount of 10% if paid within 30 days of date of service or 30 days from Insurance payment.
- Accounts will be turned over to collections if unpaid after 120 days.
- Deschutes Rim Health offers a sliding scale discount. If qualified, your office visits and procedures will be billed at a discounted rate. Payment Plan programs are also available. Please ask for assistance for either program.

I have read and I understand the above listed Patient Rights and Responsibilities, Consents, Notice of Privacy Practices and Financial Policy for Deschutes Rim Health Clinic. I agree to accept the full responsibility as described above.

_____ _____

Patient/Responsible Party Date

Person/Persons with whom the clinic may discuss PHI(Protected Health Information) with:

_____ _____

Name Relationship

_____ _____

Name Relationship

Passed by a majority of the Board of Directors of White River Health District, with a quorum in attendance the _____ day of _____, 2023.

White River Health District dba Deschutes Rim Health Clinic

Wasco County, Oregon

By _____

Suzanne Knapp, Chairman of the Board

Attest:

By _____

Julie Whetzel, Secretary of the Board