Norwalk Community Health Center
Patients' Bill of Rights and Responsibilities

Norwalk Community Health Center (NCHC) is committed to providing high quality care that is fair, responsive, and accountable to the needs of our patients and their families. We are committed to providing our patients and their families with a means to not only receive appropriate health care and related services, but to also address any concerns they may have regarding such services. We encourage all of our patients to be aware of their rights and responsibilities and to take an active role in maintaining and improving their health and strengthening their relationships with our health care providers.

We strongly urge anyone with questions or concerns regarding our "Bill of Rights and Responsibilities" to contact the Practice Manager.

EVERY PATIENT HAS A RIGHT TO:

1. Receive high quality care based on professional standards of practice, regardless of his or her (or his or her family's) ability to pay for such services.
2. Obtain services without discrimination on the basis of race, ethnicity, national origin, sex, age, religion, physical or mental disability, sexual orientation or preference, marital status, socioeconomic status or diagnosis/condition.
3. Be treated with courtesy, consideration and respect by all NCHC staff, at all times and under all circumstances, and in a manner that respects his or her dignity and privacy.
4. Be informed of NCHC's Privacy Policies and Procedures, as the policies relate to individually identifiable health information.
5. Expect that NCHC will keep all medical information confidential and will release such information only with his or her written authorization, in response to court order or subpoenas, or as otherwise permitted or required by law.
6. Access, review and/or copy his or her medical records, upon request, at a mutually designated time (or, as appropriate, have a legal custodian access, review and/or copy such records), and request amendment to such records.
7. Know the name and qualifications of all individuals responsible for his or her health care and be informed of how to contact these individuals.
8. Request a different health care provider if he or she is dissatisfied with the person assigned to him or her by NCHC. NCHC will use best efforts, but cannot guarantee, that re-assignment requests will be accommodated.
9. Receive a complete, accurate, easily understood, and culturally and linguistically competent explanation of (and, as necessary, other information regarding) any diagnosis, treatment, prognosis, and/or planned course of treatment, alternatives (including no treatment), and associated risks/benefits.
10. Receive information regarding the availability of support services, including translation, transportation and education services.

11. Receive sufficient information to participate fully in decisions related to his or her health care and to provide informed consent prior to any diagnostic or therapeutic procedure (except in emergencies). If a patient is unable to participate fully, he or she has the right to be represented by parents, guardians, family members or other designated surrogates.
12. Ask questions (at any time before, during or after receiving services) regarding any diagnosis, treatment, prognosis and/or planned course of treatment, alternatives and risks, and receive understandable and clear answers to such questions.
13. Refuse any treatment (except as prohibited by law), be informed of the alternatives and/or consequences of refusing treatment, which may include Norwalk Community Health Center having to inform the appropriate authorities of this decision, and express preferences regarding any future treatments.
14. Obtain another medical opinion prior to any procedure.
15. Be informed if any treatment is for purposes of research or is experimental in nature, and be given the opportunity to provide his or her informed consent before such research or experiment will begin (unless such consent is otherwise waived).
16. Develop advance directives and be assured that all health care providers will comply with those directives in accordance with law.
17. Designate a surrogate to make health care decision if he or she is or becomes incapacitated.
18. Ask for and receive information regarding his or her financial responsibility for the services.
19. Receive an itemized copy of the bill for his or her services, an explanation of charges, and description of the services that will be charged to his/her insurance.
20. Request additional assistance necessary to understand and/or comply with NCHC administrative procedures and rules, access health care and related services, participate in treatments, or satisfy payment obligations by contacting the Chief Operating Officer.
21. File a grievance or complaint about NCHC or its staff without fear of discrimination or retaliation and have it resolved in a fair, efficient and timely manner. This grievance or complaint can be directed to Chief Administrative Officer.

Contact the following agency if you are not satisfied with the outcome of your grievance:

NCHC's Confidential Compliance Line:
203-852-3999

Connecticut Department of Public Health
410 Capital Avenue
Hartford, CT. 06134-308
Phone: (860) 509-7400, (800) 842-0038 TTY: (860) 509-7191
www.dph.state.ct.us

EVERY PATIENT IS RESPONSIBLE FOR:

1. Providing accurate personal, financial, insurance, and medical information (including all current treatments and medications) prior to receiving services from NCHC and its health care providers.
2. Following all administrative and operational rules and procedures posted within NCHC facilities.
3. Behaving at all times in a polite, courteous, considerate and respectful manner to all NCHC staff and patients, including respecting the privacy and dignity of other patients.
4. Supervising his or her children while in NCHC facilities.
5. Refraining from abusive, harmful, threatening, or rude contact towards other patients and NCHC staff.
6. Not carrying any type of weapons or explosives into NCHC facilities.
7. Keeping all scheduled appointments and arriving on time.
8. Notifying NCHC no less than 24 hours (or as soon as possible within 24 hours) prior to the time of an appointment that he/she cannot keep the appointment as scheduled. Failure to follow this policy may result in being charged for the visit and/or being placed on a waiting list for the next visit.
9. Participating in and following the treatment plan recommended by his or her health care providers, to the extent he or she is able, and working with providers to achieve desired health outcomes.
10. Asking questions if he or she does not understand the explanation of (or information regarding) his or her diagnosis, treatment, prognosis, and/or planned course of treatment, alternatives or associated risks/benefits, or any other information provided to him or her regarding services.
11. Providing an explanation to his or her health care providers if refusing to (or unable to) participate in treatment, to the extent he or she is able, and clearly communicating wants and needs.
12. Informing his or her health care providers of any changes or reactions to medication and/or treatment.
13. Familiarizing himself or herself with his or her health benefits and any exclusions, deductibles, co-payments, and treatment costs.
14. As applicable, making a good faith effort to meet financial obligations, including promptly paying for services provided.
15. Advising NCHC of any concerns, problems, or dissatisfaction with the services provided or the manner in which (or by whom) they are furnished.
16. Utilizing all services, including grievance and complaint procedures, in a responsible, non-abusive manner, consistent with the rules and procedures of NCHC (including being aware of NCHC's obligation to treat all patients in an efficient and equitable manner).

If you would like a copy of the Patient's Bill of Rights in another language, please ask the front desk staff.
Si desea una copia de la Declaración de Derechos del Paciente en otro idioma, consulte al personal de la recepción.
Si ou ta renmen yon kopi Dwa Pasyan an nan yon lòt lang, tanpri mande anplwaye nan biwo devan.

LEFT BLANK INTENTIONALLY

Acknowledgement of Receipt

Patient Name:

_____

(Last) **(First)** **(Middle)**

Date of birth: _____

By signing this form, I am acknowledging that:

- I am either the patient or the patient's legal guardian or personal representative;
- I have received a copy of the "Notice of Privacy Practices" for Norwalk Community Health Center, Inc.;
- I have received the Norwalk Community Health Center's Patient's Bill of Rights in a language I can understand;
- I understand that I may contact Norwalk Community Health Center Inc. at any time in the future if I have questions about the content of the Notice of Practice and/or the Patient's Bill of Rights.

Please sign and date this acknowledgement form.

_____ _____

Print Patient Name/Parent or Guardian (for children under 18) Date

_____ _____

Signature of Patient or Parent/Guardian (for children under 18) Date

NORWALK COMMUNITY HEALTH CENTER
PATIENT FINANICAL RESPONSIBILITY FORM

1. **Individual's Financial Responsibility**
    - I understand that I am financially responsible for my medical, behavioral health and/or dental insurance deductible, copay and non-covered service.
    - Co-payments are due at the time of service.
    - If my plan requires a referral, I must obtain it prior to my visit.
    - In the event that my medical, behavioral health and/or dental insurance determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
    - If I am uninsured, I agree to meet with an eligibility counselor to determine if I qualify for the sliding fee scale discount program
2. **Insurance Authorization for Assignment of Benefits**
    - I hereby authorize and direct payment of my medical, behavioral health and dental benefits to Norwalk Community Health Center, Inc. on my behalf for any services furnished to me by the providers.
3. **Authorization to Release Records**
    - I hereby authorize Norwalk Community Health Center Inc. to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.
4. **Medicare Request for Payment**
    - I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in Norwalk Community Health Center Inc. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

_____ _____

Signature of Patient, Authorized Representative or Responsible Party **Date**

_____ _____

Print Name of Patient, Authorized Representative or Responsible Party **Relationship to Patient**

General Consent
for Treatment and Billing

I give Norwalk Community Health Center (NCHC) permission to provide necessary medical, behavioral health and/or dental evaluation and treatment.

1. I allow NCHC to file for insurance benefits to pay for the care received. I understand that:

    - Norwalk Community Health Center may have to send my medical/dental record information to my insurance company
    - I must pay my share of the costs
    - I must pay for the cost of these services if my insurance does not pay or I do not have insurance

2. I understand:

    - I have the right to refuse any procedure or treatment.
    - I have the right to discuss all medical/dental treatments with my provider.

I declare that the information listed above is accurate and complete. I understand that I may be asked for evidence to verify the statement of income and family size.

_____ _____

Print Patient Name/Parent or Guardian (for children under 18) Date

_____ _____

Signature of Patient/Parent or Guardian (for children under 18) Date