Patient Rights & Responsibilities

You Have The Right To:
- To the highest quality health care from people whose training makes them experts in their fields.
- To the safest and most effective treatment possible.
- To know the names of your doctors, nurses and others involved in your care and what their jobs are.

Your Right to Respect and Privacy:
- To be treated with respect. It doesn't matter whether you are male or female, what race or religion you are, what country you come from or what your personal beliefs are. You will not be denied care based on the above.

- To privacy about medical care. Your doctors, nurses and others are NOT allowed to talk about your care or write to others about your care unless you say it is okay. This includes all talks and visits with the doctor and caregivers, tests and treatment. Your hospital and doctors ARE allowed to release information to the insurance or government health program paying for your care, or as required by law.

Your Right to Make Decisions About Your Care:
- To understand your care and to have your doctor explain policies and procedures in ways you can understand.
- To be involved in your pain management. You have the right to have your pain controlled.
- To understand what could happen to you and give your okay in writing before you receive any treatment or procedure that may be potentially risky except in an emergency. This is informed consent.
- You have the right to have in place advanced directives,
- To be informed when a facility does not honor advanced directives.
- To say yes in writing whether you want your family or someone else to help make decisions about your care, especially if you become unable to decide for yourself. This is durable power of attorney for health care.
- To say no to any drug treatment or procedure offered to you by your doctor at The Center. However, your doctor must tell you what could happen to your health if you say no to a treatment or procedure.
- To ask another doctor other than your own for an opinion about your medical care. This is a second opinion. You are responsible for paying the doctors bill for the second opinion. If your insurance does not pay for this.

After Your Procedure You Have The Right To:
- Find out from your doctor and other members of your care team about the care you need when you leave the center.

Your Rights Regarding Center Charges:
- To review all billing charges for your procedure
- To meet with someone to help you understand charges and financial programs available to help you pay for your care.

Your Responsibilities:
- Telling your doctors & health care team the truth about your health and any changes in your condition, as best you can.
- Asking questions if you do not understand what your doctor or health care team are telling you about your care, procedures, treatment or anything else they tell you.
- Telling your doctors or health care team if you can't do what they tell you as part or your treatment. You are responsible for what happens to your health if you do not do what your doctors say or if you say no to treatment.
- Treating your doctors and health care team with respect at all times.

Please tell us should you have any concerns regarding patient safety and your care. You may contact The Center's Risk Management Coordinator 920-725-0700.

Should you wish to file a grievance with the state agency, please direct your correspondence to:

Bureau of Quality Assurance
P.O. Box 2969
Madison WI 53701-2969 Phone:
(608) 266-0224

AAAHC
5250 Old Orchard Road, Suite 200
Skokie IL 60077 Phone:
(847) 853-6060
www.aaahc.org

Patient Acknowledgement

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

Patient Initials ______________ **Date** ______________ **Signature** ____

I am fully aware that:
~ The Center for Aesthetics & Plastic surgery does not honor advanced directives of patients having surgery at The Center. However, you may provide The Center with a copy of your advance directives to be kept with your medical records and in the event of a hospital transfer, we will forward a copy to the admitting facility.

Patient Initials ______________

~ I have received a copy of The Patients' Rights and Responsibilities.

Patient Initials ______________

~ I have received a copy of The Center's financial policy and am aware that The Center for Aesthetics and Plastic Surgery is a physician-owned facility. I have been offered the opportunity to have my surgery at a local hospital as well as at The Center for Aesthetics and Plastic Surgery.

Patient Initials ______________ **Date** ______________ **Signature** ____

425 S. Commercial St. Neenah WI 54956 | (920) 725-0700 | www.centerforaps.com