

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

AS A PATIENT, YOU HAVE THE RIGHT TO:

1. IMPARTIAL ACCESS TO TREATMENT WITHOUT HARASSMENT OR ABUSE AND WITHOUT REGARD TO RACE, COLOR, AGE, SEX, SEXUAL ORIENTATION, RELIGION, MARITAL STATUS, HANDICAP, NATIONAL ORIGIN, OR SPONSOR.
2. REASONABLE PHYSICAL ACCESS TO CCSC.
3. PERSONAL AND INFORMATIONAL PRIVACY.
4. CONSIDERATE AND DIGNIFIED CARE WITH RESPECT FOR PSYCHOLOGICAL, SPIRITUAL, AND CULTURAL VALUES.
5. A SECURE AND SAFE ENVIRONMENT FOR SELF AND PROPERTY.
6. THE OPPORTUNITY TO COMMUNICATE YOUR CONCERNS TO CCSC STAFF.
7. UN-COMPROMISED CARE REGARDLESS OF THE PRESENTATION OF COMPLAINTS ABOUT THE QUALITY OF PREVIOUS CARE RECEIVED IN THIS CENTER.
8. STRICT CONFIDENTIAL TREATMENT OF DISCLOSURES AND RECORDS AND THE OPPORTUNITY TO APPROVE OR REFUSE THE RELEASE OF SUCH INFORMATION, EXCEPT WHEN REQUIRED BY LAW.
9. THE OPPORTUNITY TO OBTAIN COMPLETE AND CURRENT INFORMATION FROM A MEDICAL STAFF MEMBER CONCERNING THE DIAGNOSIS, TREATMENT, AND PROGNOSIS IN TERMS THAT ARE REASONABLY EXPECTED TO BE UNDERSTOOD. WHEN IT IS NOT MEDICALLY ADVISABLE TO GIVE SUCH INFORMATION TO THE PATIENT, THE INFORMATION WILL BE MADE AVAILABLE TO AN APPROPRIATE PERSON ON THE PATIENT'S BEHALF.
10. TO KNOW, BY NAME, THE MEDICAL STAFF MEMBER RESPONSIBLE FOR COORDINATING YOUR CARE.
11. THE OPPORTUNITY TO PARTICIPATE IN DECISIONS INVOLVING YOUR HEALTH CARE, INCLUDING THE RIGHT TO REFUSE OR ACCEPT MEDICAL OR SURGICAL TREATMENT INCLUDING MEDICATIONS, UNLESS CONTRAINDICATED BY CONCERNS FOR YOUR HEALTH.
12. INFORMATION NECESSARY FROM YOUR DOCTOR TO GIVE AN INFORMED CONSENT PRIOR TO THE START OF ANY PROCEDURE AND/OR TREATMENT INCLUDING: SIGNIFICANT MEDICAL RISKS INVOLVED; INFORMATION AND ALTERNATIVES FOR MEDICAL CARE OR TREATMENT; CONSEQUENCES OF NOT COMPLYING WITH THERAPY; AND, NAME OF THE PERSON RESPONSIBLE FOR PROCEDURES AND/OR TREATMENT.
13. VOICE ANY GRIEVANCES REGARDING YOUR TREATMENT OR CARE THAT IS (OR FAILS TO BE) FURNISHED.
14. BE FREE FROM ALL FORMS OF ABUSE AND HARASSMENT.
15. EXERCISE YOUR RIGHTS WITHOUT BEING SUBJECTED TO DISCRIMINATION OR REPRISAL.

AS A PATIENT, YOU ARE RESPONSIBLE FOR:

1. PROVIDING TO THE BEST OF YOUR KNOWLEDGE, ACCURATE AND COMPLETE INFORMATION ABOUT YOUR PRESENT HEALTH STATUS AND PAST MEDICAL HISTORY AND REPORTING ANY UNEXPECTED CHANGES TO THE APPROPRIATE HEALTH CARE PROFESSIONAL AND INCLUDE USE OF OVER-THE-COUNTER PRODUCTS, DIETARY SUPPLEMENTS AND ALLERGIES OR SENSITIVITIES.
2. COMPLYING WITH THE TREATMENT PLAN RECOMMENDED BY THE PRIMARY PRACTITIONER INVOLVED IN YOUR CARE.
3. PROVIDING AN ADULT TO TRANSPORT YOU HOME FOLLOWING TREATMENT AND AN ADULT TO BE RESPONSIBLE FOR YOU AT HOME FOR THE FIRST 24 HOURS FOLLOWING TREATMENT AS NEEDED.
4. INDICATING THAT YOU CLEARLY UNDERSTAND THE CONTEMPLATED COURSE OF ACTION AND WHAT IS EXPECTED OF YOU.
5. YOUR ACTIONS IF YOU REFUSE TREATMENT, LEAVE CCSC AGAINST THE ADVICE OF YOUR PRACTITIONER, AND/OR DO NOT FOLLOW THE PRACTITIONER'S INSTRUCTIONS RELATING TO YOUR CARE.
6. ASSURING THAT FINANCIAL OBLIGATIONS ASSOCIATED WITH YOUR CARE AT CCSC ARE FULFILLED AS EXPEDIENTLY AS POSSIBLE.
7. PROVIDING INFORMATION ABOUT AND/OR COPIES OF ANY LIVING WILL, POWER OF ATTORNEY, ADVANCE DIRECTIVE, OR OTHER DIRECTIVE YOU DESIRE US TO KNOW ABOUT.
8. BE RESPECTFUL OF THE HEALTHCARE PROFESSIONALS AND STAFF AS WELL AS OTHER PATIENTS.

IF YOU HAVE ANY QUESTIONS REGARDING YOUR RIGHTS OR RESPONSIBILITIES, PLEASE DISCUSS YOUR CONCERNS WITH US.

FILING COMPLAINTS

NC DIVISION OF HEALTH SERVICE REGULATION, COMPLAINT INTAKE UNIT, 2711 MAIL SERVICE CENTER, RALEIGH, NC 27699-2711. TELEPHONE (800) 624-3004 (WITHIN NC) OR 919-855-4500

FOR MEDICARE PATIENTS: IF THERE IS A COMPLAINT/GRIEVANCE REGARDING QUALITY OF CARE, CONTACT THE OFFICE OF MEDICARE BENEFICIARY OMBUDSMAN: WWW.MEDICARE.GOV/CLAIMS-AND-APPEALS/MEDICARE-RIGHTS/GET-HELP/OMBUDSMAN