



## Patient Bill of Rights and Responsibilities

We want to encourage you, as a patient at Ear, Nose and Throat Clinic of the Northwest and/or Surgery Center, to speak openly with your health care team, take part in your treatment choices, and promote your own safety by being well informed and involved in your care. Therefore, you need to know your rights as well as your responsibilities in order to actively participate in your care.

### Your Rights

- You have the right to receive considerate, respectful and compassionate care in a safe setting regardless of your age, gender, race, national origin, religion, sexual orientation, gender identity, or disabilities.
- You have the right to receive care in a safe environment free from all forms of abuse, neglect, or mistreatment.
- You have the right to be called by your proper name and to be in an environment that maintains dignity and respect.
- You have the right to be told the names of your doctors, nurses, and all health care team members directing and/or providing your care.
- You have the right to be told by your doctor about your diagnosis, and possible prognosis, the benefits and risks of treatment, and the expected outcome of treatment, including unexpected outcomes.
- You have the right to have your pain assessed and to be involved in decisions about treating your pain.
- You can expect full consideration of your privacy and confidentiality in care discussions, exams, and treatments. You may ask for an escort during any type of exam.
- You, family, and friends with your permission, have the right to participate in decisions about your care, treatment and services provided, including the right to refuse treatment to the extent permitted by law.
- You have the right to agree or refuse to take part in medical research studies. You may withdraw from a study at any time without impacting your access to standard care.
- You have the right to communication that you can understand. We will provide sign language and foreign language interpreters as needed at no cost. Information given will be appropriate to your age, understanding, and language. If you have vision, speech, hearing, and/or other impairments, you will receive additional aids to ensure your care needs are met.
- **You have the right to make an advance directive, appointing someone to make health care decisions for you if you are unable. If you do not have an advance directive, we can provide you with information and help to complete one.**
- You have the right to be involved in your post-op care plan. You can expect to be told in a timely manner of the need for planning your discharge or transfer to another facility or level of care. Before your discharge, you can expect to receive information about follow-up care that you may need.
- You have the right to receive detailed information about your facility and physician charges.
- You can expect that all communication and records about your care are confidential, unless disclosure is permitted by law. You have the right to see or get a copy of your medical records. You may add information to your medical record by contacting the Medical Records Department. You have the right to request a list of people to whom your personal health information was disclosed.
- You have the right to give or refuse consent for recordings, photographs, films, or other images to be produced or used for internal or external purposes other than identification, diagnosis, or treatment. You have the right to withdraw consent up until a reasonable time before the item is used.
- You have the right to voice your concerns about the care you receive. If you have a problem or complaint, you may talk with your doctor or our administrator Cheryl Eby at (360) 256-4425.
- A grievance may also be made in writing, again addressed to: Cheryl Eby, Clinic Administrator  
1405 SE 164th Ave, Suite 101  
Vancouver, WA 98683

Initials \_\_\_\_\_ Date \_\_\_\_\_

You should be contacted within one week (5 business days) to discuss your grievance.

**If your concern is not resolved to your liking, you may also contact:**

HSQA Complaint Intake

PO Box 47857

Olympia, Washington 98504-7857

(360) 236-4700

Email: [HSQAComplaintIntake@doh.wa.gov](mailto:HSQAComplaintIntake@doh.wa.gov)

If you are covered by Medicare you may choose to contact the Medicare Ombudsman at:

1-800-MEDICARE (633-4227)

Or online at [www.Medicare.Gov/ombudsman/resources.asp](http://www.Medicare.Gov/ombudsman/resources.asp)

## Your Responsibilities

- You are expected to provide complete and accurate information, including your full name, address, home telephone number, date of birth, Social Security number, insurance carrier and employer, when it is required.
- **You should provide us with a copy of your advance directive if you have one.**
- You are expected to provide complete and accurate information about your health and medical history, including present condition, past illnesses, hospital stays, medicines, vitamins, herbal products, and any other matters that pertain to your health, including perceived safety risks.
- You are expected to ask questions when you do not understand information or instructions. If you believe you can't follow through with your treatment plan, you are responsible for telling your doctor. You are responsible for outcomes if you do not follow the care, treatment and services plan.
- You are expected to actively participate in your pain management plan and to keep your doctors and nurses informed of the effectiveness of your treatment.
- Please leave valuables at home and only bring necessary items for your hospital stay.
- You are expected to treat all staff, other patients and visitors with courtesy and respect; abide by all facility rules and safety regulations; and be mindful of noise levels, privacy and number of visitors.
- You are expected to provide complete and accurate information about your health insurance coverage and to pay your bills in a timely manner.
- You have the responsibility to keep appointments, be on time, and call your health care provider if you cannot keep your appointments.

I have read and understand my rights and responsibilities:

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Name

Signature

Date