Patient Rights and Responsibilities

Administration

Type: Policy
Status: Official
Last Reviewed:

PURPOSE

Patient care outcomes are influenced by the degree to which the rights of each patient are communicated, understood and respected during each patient encounter with the organization. The purpose of this policy is to ensure patient rights are effectively communicated, understood, and respected for each patient during each visit. To ensure an ongoing relationship of public trust and respect, this policy aligns with the professional and ethical standards governing the rights of patients in the state of Washington.

For the purpose of this policy, organization is defined as the hospitals inpatient and outpatient service areas, Urgent Care and Emergency Department.

POLICY

I. The employees of Kittitas Valley Healthcare (KVH) are accountable to espouse the professional standards, ethics and the laws governing patient rights in Washington State.
II. At the time of registration, each patient will receive written notification of their rights and responsibilities while under the care and treatment of KVH.
III. Documentation of the patient's receipt of their written rights and responsibilities will be entered electronically on the *visit maintenance field* of Paragon Registration.
IV. Registration staff will use scripted communication with each patient to ensure patient understanding of their rights, and to direct them to their care provider regarding any subsequent questions arising throughout their visit.

Patient Rights

- The right to be cared for with dignity and respect and to treatment that is available and medically indicated regardless of race, creed, color, sex, sexual orientation, gender identity, national origin, religion, age, marital status, disability, source of payment or ability to pay.
- The right to spiritual care and to have your personal, cultural and spiritual values and beliefs supported when making a decision about treatment.
- The right to access to an interpreter or communication aid if you do not speak English, English is your second language, or you are deaf, hard of hearing or have speech disabilities.
- The right to receive safe patient care in a safe environment, and freedom from abuse or neglect.
- The right to immediate access to protective services.
- The right to personal and informational privacy and confidentiality to the extent authorized by them, the courts or the law.
- The right to be informed of and agree or disagree to, and participate in, the development and implementation of your plan of care, including the right to a support person to provide input in your plan of care decisions.
- The right to refuse care or treatment including the resolution of problems regarding their care decisions; and the right to leave the hospital and be informed of the expected consequences of such decision.

- The right to be informed of unanticipated outcomes of care, treatment and services. The right to be informed of experimental or research based treatments and the right to refuse such treatment.
- The right to verbal and/or written complaint resolution, without fear of retribution, denial, or alteration in safe quality care and service; and the right to complaint resolution in a timely and responsive manner.
- The right to formulate an Advance Directive (including Mental Health Advance Directives); such as a *Physician Order for Life Sustaining Treatment* (POLST) form, *Living Will* or *Durable Power of Attorney for Health Care*, and to have caregivers follow your wishes regarding your end of life care.
- The right to request no resuscitation or life-saving treatment.
- The right to information regarding birth control, termination of pregnancy and any other care or treatment related to reproductive health and to make an individual, informed decision regarding treatment for reproductive health issues without discrimination.
- The right to organ and tissue donation options with the input from your physician(s) and, when indicated, under the direction of family or surrogate decision maker's.
- The right to examine and receive an explanation of the patient's hospital/clinic bill, regardless of payment source.
- The right to receive or restrict visitors as you choose, unless visitors could compromise your treatment plan or clinical condition. These visitors may include, but are not limited to, a spouse, a state-registered or non-state registered domestic partner, other family members or friends regardless of their race, color, national origin, religion, sex, sexual orientation, gender identity or disability.
- The right to be informed of the reason for any restrictions or limitation on visitors, should visitors need to be restricted.
- The right to have a support person for making decisions on your behalf regarding your receipt of visitors, or visitor restrictions should your become incapacitated. The support person does not need to be an authorized surrogate decision maker or provide documentation of patient representation by a legal document unless there is a conflict between two visitors or there is a dispute as to who the patient support person is.

Patient Responsibility

- Provide accurate and complete information about present illnesses, past complaints, hospitalizations, medications and other matters relating to their health.
- Promptly report changes in their condition to their nurse and/or the physician.
- Follow their collaboratively agreed upon plan of care.
- Comply with hospital policies designed to ensure the safety of patients, staff and visitors.
- Understand their acceptance of responsibility for their actions if they choose to refuse medically recommended treatment or instructions.
- Ensure their financial obligation to the organization and medical providers is fulfilled as required under hospital policy.
- Respect and protect to the extent of their ability the property, materials and equipment of other persons and that of the organization.
- Be considerate of the rights of other patients and hospital personnel by actively participating, to the extent they are able, in controlling personal visitor noise, smoking, lights, telephone, television, and radio to avoid disturbing others or violating organizational policy.
- Adhere to and respect organizational rules and regulations affecting patient care and conduct.

Related Documents/Forms:

KVH Visiting Policy: Last Revision same date as this one

Legal & Other Authority: 42 CFR 482.13(h); 42 CFR 485.635 (f); RCW 7.70.065; RCW 26.60.070; WAC 246-320-141; RCW 9.02.160

KVH Patient Rights Information Sheet: Last Rev. Nov2010

Effective Date:	12/02/2005	**Document Owner:**	Storlie, Franki	**Revision Date(s):**	09/2010
Print Date:	3/25/2014	**Revised By:**	Craig Wilson, CNO		03/2011 03/2014

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CONSENT FOR TREATMENT

The undersigned hereby consents to diagnostic procedures, anesthesia, medical-surgical treatment or hospital services that may be rendered, as ordered by a healthcare professional. I understand that my care is under the control of my attending provider, his or her assistants or designees, and that the hospital is not liable for any act or omission of treatment when following the instructions of that physician.

RELEASE OF HEALTHCARE INFORMATION

I permit the healthcare organization and the physicians or other health professionals involved in the inpatient or outpatient care to release my healthcare information for purposes of treatment, payment or healthcare operations. Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions or for any purpose related to benefit payment.

FINANCIAL AGREEMENT

I hereby assign and authorize payment directly to Kittitas Valley Healthcare for all hospital and medical insurance benefits otherwise payable to me, in an amount not to exceed the hospital's charges for its services. I understand I am financially responsible to KVH for any charges not paid under this assignment. Should legal action become necessary to collect this bill, I understand that I will be held responsible for collection expenses.

OTHER ACKNOWLEDGEMENTS

I hereby consent to the release of my name, my presence in the hospital, and my condition as part of the general hospital directory, available to those who ask for me by name.

I authorize my healthcare information to be disclosed for purposes of communicating results, findings and care decisions to my family members and other responsible for my care or designated by me.

I understand and agree that personal property such as money and jewelry should not be brought into the hospital and understand and agree that KVH shall not be liable for loss or damage to any personal property.

CERTIFICATION BY RESPONSIBLE PARTY

The signature below certifies that the above statements have been read and that the patient (or person authorized by the patient as their agent), accepts their terms. It also certifies that information provided by me is accurate and complete.

Date	Signature of patient or responsible party	Relationship, if not patient

Date	Signature of Witness

CONSENT FOR TREATMENT

Financial Assistance Policy

Patient Financial Services

Policy:

Kittitas Valley Healthcare is committed to the provision of health care services to all persons in need of medical attention regardless of ability to pay. In order to protect the integrity of the operations and fulfill this commitment, the following criteria for the provision of financial assistance, consistent with the requirements of the Washington State Hospital Association, are established. These criteria will assist staff in making consistent objective decisions regarding eligibility for financial assistance.

This program helps support individuals and families with healthcare expenses. Our program provides financial assistance in the form of free or reduced-price healthcare, depending on income.

Communications to the Public:

Kittitas Valley Healthcare's Financial Assistance Program shall be made publicly available through the following elements:

1. A notice advising individuals and families that the hospital has financial assistance available shall be posted in key areas of the hospital including Registration, Emergency Department, Emergency Department waiting area and the Outpatient waiting area.
2. The hospital will distribute a written notice of the hospital's financial assistance program and sliding payment schedule to individuals and families at the time the hospital requests information pertaining to third party coverage. If for some reason, for example in an emergency situation, the patient is not notified of the existence of the financial assistance program before receiving treatment, he/she will be notified in writing thereafter. All uninsured patients will receive the financial assistance notice in their first billing from the hospital.
3. The hospital shall train front-line staff to answer financial assistance questions effectively or direct such inquiries to the Patient Financial Department.
4. Written information about the Financial Assistance Program and the sliding payment schedule shall be made available to *any person* who requests the information, either by mail, telephone, e-mail or in person.

Eligibility Criteria:

Individuals and families with incomes that meet the guidelines are eligible if they: do not have financial resources to pay for care; are not generally insured, i.e., covered by a group or individual medical plan, Worker's Compensation, Medicare, Medicaid, or any other state, federal, or military program; and are not involved in a situation where someone else has a legal responsibility to pay for the costs of medical services (e.g. an auto accident).

In situations where appropriate primary payment sources are not available or have been exhausted, individuals and families shall be provided financial assistance under this hospital policy based on one of the following standards:

- The full amount of hospital charges will be adjusted for a patient whose gross family income is at or below 100% of the current federal poverty level; or
- A sliding payment schedule will be used to determine the amount of hospital charges that will be adjusted for patients with incomes between 101 and 300 percent of the current federal poverty level; or
- The hospital may adjust the full amount of hospital charges for patients with family income in excess of 100% of the current federal poverty level when circumstances indicate severe financial hardship or personal loss.

The responsible party's remaining financial obligation after the application of the sliding payment schedule will be payable at minimum monthly payment of 10% of remaining balance. The responsible party's account will not be referred to a collection agency unless the responsible party defaults on the minimum payment or the hospital is unable to make mail or telephone contact with the responsible party.

Process for Eligibility Determination:

A. Initial Determination:

1. The hospital will use an application process for determining eligibility for financial assistance. Requests to provide financial assistance will be accepted from either the patient, responsible party, physicians, community or religious groups, social services and/or patient financial personnel, provided that any further disclosure of the information contained in the request shall be subject to the Health Insurance Portability and Accountability Act, Privacy Regulations and the hospital's Privacy Policies.
2. The initial determination of eligibility for financial assistance can be completed prior to admission, at the time of admission, following completion of treatment or as soon as possible after receiving the original billing.
3. Pending final eligibility determination, the hospital will not initiate collection efforts or request deposits, provided that the responsible party is cooperative with the hospital's efforts to reach a final determination.

B. Final Determination:

1. Financial Assistance applications shall be furnished to the responsible party when financial assistance is requested, when need is indicated, or when financial screening indicates potential need. All applications, whether initiated by the responsible party or the hospital, should be accompanied by documentation to verify information indicated on the application form. Any one of the following documents will be considered sufficient evidence on which to base the final determination:

- Pay stubs from employment; and
- A "W-2" withholding statement; or
- Last year's income tax return; or
- Letters approving or denying WA Apple Health, medical assistance; or
- Letters approving or denying unemployment compensation; or
- Written statements from employers or welfare agents.

2. During the initial request period, the patient and the hospital will pursue other sources of funding, including Medicaid and legal liability situations. The responsible party will be required to provide written verification of eligibility for all other sources of funding.

3. Usually, the relevant time period for which documentation will be requested will be three months prior to the date of application. However, if such documentation does not accurately reflect the applicant's current financial situation, documentation will only be requested for the period of time after the patient's financial situation changed.

4. In the event that the responsible party is not able to provide any of the documentation described above, the hospital will rely upon written and signed statements from the responsible party for making a final determination of eligibility.

5. The hospital will allow a patient to apply for financial assistance at any point from pre-admission to final payment of the bill, recognizing that a patient's ability to pay over an extended period may be substantially altered due to illness or financial hardship, resulting in the need for financial assistance.

6. In the event that the responsible party's identification as an indigent person is obvious to hospital personnel, and the hospital can establish that the applicant's income is clearly within the range of eligibility, the hospital will grant financial assistance based solely on the initial determination. In these cases, the hospital is not required to complete full verification or documentation.

C. Time frame for final determination and appeals:

1. Each financial assistance applicant who has been initially determined eligible for financial assistance, will be given at least fourteen calendar days, or such time as may reasonably be necessary, to secure and present documentation in support of his or her financial assistance application prior to receiving a final determination.

2. The hospital will notify the applicant of its final determination within twenty-one days of receipt of the application and supporting documentation.

D. Adequate notice of denial:

1. When an application for financial assistance is denied, the responsible party will receive a written notice of denial, which includes:
- The reason or reasons for the denial;
- The date of the decision; and
- Instructions for appeal or reconsideration.

2. The responsible party may appeal the determination of eligibility for financial assistance by providing verification of income or family size to the Patient Financial Representative within thirty days of receipt of notification.

3. The Patient Financial Manager and the Chief Financial Officer will review all appeals. If this review affirms the previous denial for financial assistance, written notification will be sent to the responsible party and the Department of Health.

Documentation and Records:

1. If a patient has been determined to be eligible for financial assistance and continues receiving services for an extended period of time, the hospital will re-evaluate the patient's eligibility for financial assistance at least annually to confirm that the patient remains eligible. The hospital may require the responsible party to submit a new financial assistance application.
2. Confidentiality: All information relating to the application will be kept confidential. Copies of documents that support the application will be kept with the application form.
3. Documents pertaining to the financial assistance shall be retained for five years.

Effective Date:	04/17/2007		Dept: of Record:	PFS			
			Policy Owner:	Deb Brunner			
Print Date:	03/20/2014		Revision By:	Deb Brunner		Revision Date:	03/20/2014
			Reviewed By:			Review Date:	
			Committee Review:			Date Approved:	
			Committee Review:			Date Approved:	

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