

**SUBJECT: Patient Rights and Responsibilities**

**OBJECTIVE:** To support the needs/desires of patients, families, and caregivers in a manner that is consistent with our Philosophy of Care.

**POLICY:** Pullman Regional Hospital shall provide mechanisms that support our philosophy of care, and are responsive to the rights of all individuals.

**Philosophy of Care:**

It is our belief that all individuals are active partners in their own health and healing activities, including a flexible environment in which information is shared, while participation and personal choice are encouraged supports this belief.

**Process for Utilization:**

**Patient Rights:**

**Access to Care:**

1. Individuals shall be accorded impartial access to medically indicated and available treatment or accommodations, without regard to race, creed, sexual orientation, age, national origin, political affiliation, or sources of payment.
2. Patients shall be provided with a reasonable response to requests and/or need for treatment, within the context of the mission of the hospital and applicable laws and regulations.
3. If the hospital is unable to provide the required treatment or accommodation, the patient may be transferred to another facility or organization when medically permissible. Such transfer shall be made only after the patient/kinship caregiver/domestic partner has received an explanation of the needs for a transfer and of the alternatives to a transfer; the transfer must be acceptable to the receiving organization / facility.

**Respect and Dignity:**

1. All patients shall be given considerate, respectful care at all times and under all circumstances. This includes consideration of the individuality of each patient and of the personal value and belief system which may influence response to treatment/care.
2. Patient's spiritual beliefs and cultural practices will be accommodated in a collaborative manner with the planned medical treatment while considering the well-being of others.

**Security, Protection from Abuse, and Access to Protective Services:**

1. All patients have the right to feel safe and secure and be assured that appropriate measures are taken by the hospital to provide the necessary to maintain security.
2. All patients have the right to be protected from abuse from staff, family members, and all individuals accessing the hospital, and have the right to access protective services (See [Abuse Identification and Reporting, Administrative Policy A-1](#)).

**Communication:**

1. All patients have the right to timely and appropriate communication that is respectful.

2. All patients have the right to timely communication regarding unexpected outcomes of care as defined in the [Sentinel Never Event Policy, Administrative Policy S-3](#).

#### **End of Life Care and Organ Donation:**

1. All patients have the right to end of life care in accordance with hospital policy (See [End of Life Care and Decisions, Patient Care Policy E-5](#)) and applicable state and federal laws.
2. Patients have the right to donate organs as defined by hospital policy (See [Death: Organ and Tissue Donation, Patient Care Policy D-2](#)) and applicable state and federal laws.

#### **Privacy and Confidentiality:**

1. All hospital staff shall maintain the privacy of patients' personal information.
2. Education shall be provided to all patients regarding his/her rights to privacy.
3. Patients may wear personal clothing, religious or symbolic articles that do not interfere with medical treatment.
4. During examination, interview, or the delivery of physical care, patients may expect that necessary modifications in the environment will be made to assure reasonable visual and auditory privacy.
5. The presence of a third person during an examination, treatment or procedure will be accommodated, if possible, when requested by the patient or provider.
6. Patients may request a transfer to a different room if another patient or visitor in an adjacent room is unreasonably disruptive, and if another room that is equally suitable for medical care is available.
7. Patients may have access to their medical record and may request amendments, which will be granted as appropriate.
8. Patient authorization will be obtained for non-routine disclosures of information, as required by law. A history of non-routine disclosures will be provided upon request of the patient.
9. The medical record is considered confidential and, other than the patient, may be accessed only by persons involved in treatment, payment, healthcare operations, or if requested by legal authority.
10. Patients have the right to request that certain information not be disclosed.
11. Patients have the right to complain / file a grievance with the hospital without fear of retribution. In addition, patients have the right to timely resolution of the complaint (See [Patient Complaint / Grievance Management, Administrative Policy P-3](#)).

#### **Informed Decision Making:**

1. During the admitting process, all patients shall be informed of their rights and responsibilities. Including the freedom from restraints and seclusion in any form when used as a means of coercion, discipline, retaliation, or convenience for the staff.
2. Patients shall be accorded the opportunity to participate in a collaborative decision making process with their physician(s). They shall be provided with a clear, concise explanation of the condition, proposed clinical treatment and/or procedures, the relative risks involved, including the possibility of mortality or side effects, problems related to recovery, and probability of success.
3. Patients have the right to accept or refuse treatment/care to the extent permitted by law, and to be informed of the medical consequences of refusal. A patient is responsible for his/her healthcare outcome if he/she refuses treatment or does not follow the practitioner's instructions.
4. Patients may formulate advance directives, and appoint a designee to make health care decisions, in accordance with the Patient Care Policy.

5. Patients may express concerns/complaints regarding their care. The appropriate individual department shall manage all patient complaints. These complaints may be referred to administration if not resolved at the departmental level.
6. In the event that a patient is incompetent to make decisions, unable to communicate his/her wishes, or is incapable of understanding the proposed treatment or procedure, the patient's guardian, next of kin, kinship caregiver, domestic partner, or legally appointed designee is accorded the opportunity to participate in the decision making process, on behalf of the patient, as prescribed by law.
7. Before participating in any experimental, research, or educational activities in connection with his/her treatment, the patient shall be asked to sign a consent authorizing such activities. The patient shall also be informed of the right to refuse to participate in any such activities.

### **Parental/Guardian Rights:**

When care is provided to newborns, children or adolescents, the family, domestic partner, and/or kinship caregiver shall have the right to involvement throughout the course of treatment, unless restricted by law. This involvement shall include, but is not limited to, input into assessment, treatment, continuing care, education needs, discharge planning, and ongoing communication between staff and family.

### **Visitation/Support Rights:**

- Patients may receive visitors whom s/he designates, including but not limited to spouse, a domestic partner, another family member, or a friend.
- Patients may withdraw this consent at any time during the hospitalization.
- Justified clinical restrictions or limitations may be imposed on a patient's visitation rights. These may include the following: restraining order, behavior presenting a direct risk to patients or staff, disruptive behavior, a reasonable limitation on number of visitors at any given time, patient's risk of infection, visitor's risk of infection, substance abuse treatment protocols, patient's need for rest or privacy, or when a patient is undergoing a clinical intervention or procedure.
- Patients may verbally designate a support person; this designation does not extend to medical decision-making. The support person, in the event the patient cannot speak for herself/himself, may define who may or may not be admitted as visitors.
- An inpatient has the right to have a family member or representative of his or her choice and his or her own physician notified promptly of his or her admission to the hospital. This will be documented in the medical record.

### **Patient Responsibilities:**

#### **Provision of Information:**

- A patient or kinship caregiver/domestic partner has the responsibility to provide, to the best of his/her knowledge, accurate demographic information, complete information regarding present complaint, previous illnesses and hospitalizations, medications, and other relevant medical information, as needed by healthcare practitioners for the provision of care.
- A patient or kinship caregiver/domestic partner has the responsibility to participate in his/her care and discharge planning, to the extent possible.

- A patient or kinship caregiver/domestic partner has the responsibility to report to the responsible healthcare practitioner, any unexpected change in his/her medical status.
- A patient or kinship caregiver/domestic partner has the responsibility to report whether or not he/she understands the information provided by the healthcare team, including proposed course of treatment, relative risks of treatments, expected outcomes of treatment, required participation, and discharge instructions for home care.

**Compliance with Instructions:**

- A patient is responsible for complying with instructions necessary to implement a proposed plan of care.
- A patient is responsible for complying with appropriate hospital rules and regulations which address patient care and conduct.

**Financial Obligations:**

- A patient is responsible for assuring that the financial obligations of his/her healthcare are fulfilled as promptly as possible.

**Respect and Consideration:**

- The patient is responsible for being considerate of the rights of other patients and hospital personnel.
- The patient is responsible for respecting the property of other persons, and of the hospital.

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Medical Staff President

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Administration

Reference:

Washington Administrative Code (WAC) 246-320-245  
Washington State Legislature Senate Bill 5336

Effective: 4/19/78  
Reviewed: 4/13 JE:bmc  
Revised: 5/12 JE:klv; 9/12 DAH:bmc

**SUBJECT:           Advanced Directives**

**POLICY:**

It is the policy of Pullman Regional Hospital to inform all inpatients, observation patients, outpatient surgeries, and emergency room patients of their rights regarding advanced directives (Durable power of attorney for Healthcare / Living Will):

1. Inquire at the time of registration if the patient has completed an advanced directive, if applicable. If yes, request a copy be brought in for the patient's medical record.
2. If the patient is unaware of the advanced directive, furnish a pamphlet with detailed information.
  - Obtain signatures of acknowledgement and route to nursing along with the registration form.
  - All information regarding advanced directives should be maintained in the patients' medical record.

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Director of Patient Registration Services

Effective: 1/03  
Reviewed: 1/12 EO:klv  
Revised: 1/13 EO:bmc

**SUBJECT: Consent to Treatment**

**POLICY:** All Patient Registration Representatives will be familiar with the terms of the "Consent to Treatment" form. All patients will sign a "Consent to Treatment" form upon registering as a patient at Pullman Regional Hospital.

**Process for Utilization:**

**Condition of Admission:**

1. It is important the Patient Registration Representatives be informed of the principles and requirements for completing the "Consent to Treatment" form.
2. Every patient has a legal right to decide upon the medical treatment he/she is to be given. Therefore, every patient who is registered to the hospital must sign a "Consent to Treatment" form granting consent for hospital services prior to medical treatment except in the event of an emergency. In the event that the patient's medical/mental condition does not allow the patient to sign, the patient's legal representative may sign. If the patient cannot sign the "Consent to Treatment" and does not have a legal representative, the staff member registering the patient should write "patient unable to sign due to (condition which prohibits patient from signing) below the underlined space. The Patient Registration Representative needs to sign and date and obtain a witness signature. The witness must be a clinical person.
3. In a medical emergency, treatment may be given without consent if a Physician determines that the treatment is immediately necessary. Since this must be documented in the patient's medical record, the physician must be notified that the signature for consent for treatment has not been obtained. Patient Registration will continue to follow-up with the nursing staff until the patient's condition improves and a signature on the "Consent to Treatment" form can be obtained.
4. It is important that all Patient Registration Representatives are familiar with the terms of the "Consent to Treatment" form in order to explain each and every condition to the patient before he/she signs.

**The following are the terms of the "Consent to Treatment":**

1. Consent to Medical and Surgical Procedures: Allows hospital personnel to perform test and procedures ordered by the Physician such as laboratory procedures, x-ray examinations, or other hospital services.
2. Nursing Care: The hospital provides only general duty nursing care to the patient. It does not provide private duty nursing care. Bedrails will be utilized on all patients for their protection.
3. Legal Relationship between Hospital and Physician: All physicians providing services are not employed by the hospital. The physicians are responsible for giving information to the patient regarding treatment and procedures needed.
4. Release of Information: Allows the hospital to release information for billing purposes and general conditions of the patient his/her location within the hospital, also the patient's name, address, age and sex.
5. Financial Agreement: The patient will be responsible for any portion of the bill not covered by a third party payer, and will be responsible for additional fees should the account be referred for collection.
6. Assignment of Insurance Benefits: Allows the hospital to release information for billing purposes and to collect direct reimbursement for hospital charges.

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Director of Patient Registration Services

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Director of Patient Financial Services

Effective: 1/03  
Reviewed: 1/12 EO:klv  
Revised: 12/09 JZ:klv

**SUBJECT: Financial Policy for Patient Services**

**POLICY:** It is the policy of Pullman Regional Hospital to be committed to providing the highest quality of patient care within a framework of sound fiscal management. To attain this objective, patients receiving services at Pullman Regional Hospital are expected to pay for the services provided.

**Definitions:**

1. Acceptable insurance shall be defined as:
  - Assignable Health Insurance.
  - Governmental contracts and payers specific to Pullman Regional Hospital such as Medicare, Medicaid, and other insurances and contracts listed in the insurance master file.
2. Acceptable “cash” includes:
  - United States currency and coin.
  - Personal checks pre-printed with bank name, branch, address, as well patient/family name and address.
  - Certified checks, cashiers checks, bank drafts, money orders, and travelers checks.
  - Visa, Master Card, and Discover transactions with limit approval.

**Financial Policy for Patient Service:**

1. Patients whose insurance pays less than 100 percent of the charges will be expected to pay the balance within 30 days of receiving their bill. Patients that are able to pay the balance of the bill within 10 days of receiving the bill or that pay online could be eligible for a discount.
2. If the patient is unable to pay their portion within 30 days, a financial screening of the patient could be completed to determine if there is other assistance available.
3. When patients are unable to meet our financial requirements, the following guidelines should be observed depending on the type of services:
  - **Elective:** Financial evaluation of the admission should be documented. Following managerial and/or supervisor review and in consultation with the service department manager, a determination should be made as to the urgency of the admission versus postponing the case until financial matters can be reviewed further. The physician’s office may also need to be notified.
  - **Urgent:** Financial evaluation should be documented as described under “Elective Admission.” The urgent admission should be reviewed for medical necessity and recommended for immediate or alternative care. The physician’s office may also need to be notified.
  - **Emergent:** As defined by Emergency Department protocol and EMTALA regulations, “A hospital shall not delay providing appropriate medical screening examination or treatment to persons who come to the hospital requesting an examination or treatment of a medical condition by qualified medical personnel in order to inquire about the individual’s method of payment or insurance status.” Pullman Regional Hospital will provide emergency services and care to any person for whom services or care is requested. The hospital will not discriminate in providing these services based on race, ethnicity, religion, national origin, citizenship, age, sex, pre-existing medical condition, physical or mental handicap, insurance status, and/or economic status, ability to pay for medical services except to the extent that a circumstances such as age, sex, pre-existing

medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

**Resources for Patient Financial Assistance:**

1. Patient Financial Services will refer the patient needing financial assistance for medical care to county, state and/or federal agencies as appropriate. Pullman Regional Hospital also has Financial Assistance available for patients who may qualify under specific Federal guidelines. These resources must be verified in advance by the Patient Financial Services Director or a designee before a determination is made.
2. Pullman Regional Hospital Assistance Program is defined as healthcare provided at no charge or at reduced charges to patients who do not have or cannot obtain adequate financial resources or other means to pay for their care. Partial and full assistance would be based solely on ability to pay and will not be based on race, ethnicity, religion, national origin, citizenship, age, sex, pre-existing medical condition, physical or mental handicap, insurance status, and/or economic status. Pullman Regional Hospital Assistance Program would be considered only when a reasonable effort has been made to seek other financial resources. Assistance will not be approved for non-medical necessary services (cosmetic surgery, patient convenience hospital days and services, or elective services, etc.). Every reasonable effort is to be made to secure Financial Assistance approval or denial prior to admission. See Charity Care Policy for additional details.

**Administration Exceptions:** In cases when an individual does not qualify for financial assistance, or cannot pay the patient liability portion, or establish reasonable payment options, the Patient Financial Services Director or a designee can make exceptions.

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Director of Patient Registration Services

Effective: 1/03  
Reviewed: 6/11 JZ:klv  
Revised: 3/12 EO:klv

# DURABLE POWER OF ATTORNEY FOR HEALTH CARE

## Notice to Person Executing This Document

**This is an important legal document. Before executing this document you should know these facts:**

- This document gives the person you designate as your Health Care Agent the power to make MOST health care decisions for you if you lose the capability to make informed health care decisions for yourself. This power is effective only when you lose the capacity to make informed health care decisions for yourself. As long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions.
- You may include specific limitations in this document on the authority of the Health Care Agent to make health care decisions for you.
- Subject to any specific limitations you include in this document, if you do lose the capacity to make an informed decision on a health care matter, the Health Care Agent *GENERALLY* will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the Health Care Agent to make health care decisions for you *GENERALLY* will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. You can limit that right in this document if you choose.
- A Health Care Agent can only act under state law. "Mercy killing" is not allowed under Washington state law. A Health Care Agent will **NEVER** be allowed to authorize "mercy killing," euthanasia or any procedure which would actually speed up the natural process of dying.
- When exercising his or her authority to make health care decisions for you when deciding on your behalf, the Health Care Agent will have to act consistent with your wishes, or if they are unknown, in your best interest. You may make your wishes known to the Health Care Agent by including them in this document or by making them known in another manner.
- When acting under this document the Health Care Agent *GENERALLY* will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records.

## 1. Creation of Durable Power of Attorney for Health Care

I intend to create a power of attorney (Health Care Agent) by appointing the person or persons designated herein to make health care decisions for me to the same extent that I could make such decisions for myself if I was capable of doing so, as recognized by RCW 11.94.010. This designation becomes effective when I cannot make health care decisions for myself as determined by my attending physician or designee, such as if I am unconscious, or if I am otherwise temporarily or permanently incapable of making health care decisions. The Health Care Agent's power shall cease if and when I regain my capacity to make health care decisions.

## 2. Designation of Health Care Agent and Alternate Agents

If my attending physician or his or her designee determines that I am not capable of giving informed consent to health care, I \_\_\_\_\_, designate and appoint:

Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

as my attorney-in-fact (Health Care Agent) by granting him or her the Durable Power of Attorney for Health Care recognized in RCW 11.94.010 and authorize her or him to consult with my physicians about the possibility of my regaining the capacity to make treatment decisions and to accept, plan, stop, and refuse treatment on my behalf with the treating physicians and health personnel.

In the event that \_\_\_\_\_ is unable or unwilling to serve, I grant these powers to

Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

In the event that both \_\_\_\_\_ and \_\_\_\_\_

are unable or unwilling to serve, I grant these powers to

Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Your name (print) \_\_\_\_\_

**3. General Statement of Authority Granted.**

My Health Care Agent is specifically authorized to give informed consent for health care treatment when I am not capable of doing so. This includes but is not limited to consent to initiate, continue, discontinue, or forgo medical care and treatment including artificially supplied nutrition and hydration, following and interpreting my instructions for the provision, withholding, or withdrawing of life-sustaining treatment, which are contained in any Health Care Directive or other form of "living will" I may have executed or elsewhere, and to receive and consent to the release of medical information. When the Health Care Agent does not have any stated desires or instructions from me to follow, he or she shall act in my best interest in making health care decisions.

The above authorization to make health care decisions does not include the following absent a court order:

- (1) Therapy or other procedure given for the purpose of inducing convulsion;
- (2) Surgery solely for the purpose of psychosurgery;
- (3) Commitment to or placement in a treatment facility for the mentally ill, except pursuant to the provisions of Chapter 71.05 RCW;
- (4) Sterilization.

I hereby revoke any prior grants of durable power of attorney for health care.

**4. Special Provisions**

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\_\_\_\_\_

DATED this \_\_\_\_\_ day of \_\_\_\_\_, (Year)

GRANTOR \_\_\_\_\_

STATE OF WASHINGTON )  
 )ss.

(COUNTY OF \_\_\_\_\_)

I certify that I know or have satisfactory evidence that the GRANTOR, \_\_\_\_\_ signed this instrument and acknowledged it to be his or her free and voluntary act for the uses and purposes mentioned in the instrument.

DATED this \_\_\_\_\_ day of \_\_\_\_\_, (Year)

\_\_\_\_\_  
 NOTARY PUBLIC in and for the State of Washington,  
 residing at \_\_\_\_\_  
 My commission expires \_\_\_\_\_



## Notice of Privacy Practices

**This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access to This Information. Please Review It Carefully.**

*Pullman Regional Hospital respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorized or requires us to do so.*

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment; health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

### **Examples:**

#### **Use and Disclosures of Protected Health Information for Treatment, Payment and Health Operations.**

##### ***For Treatment:***

- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing you care. This will help them stay informed about your care.

##### ***For Payment:***

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses; procedures performed, or recommended care.

##### ***For Health Care Operations:***

- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualification and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may contact you to raise funds.
- We may use and disclose your information to conduct or arrange for services, including:
  - Medical quality review by your health plan;
  - Accounting, legal, risk management, and insurance services;
  - Audit functions, including fraud and abuse detection and compliance programs.

## **Your Health Information Rights**

*The health and billing records we create and store are the property of Pullman Regional Hospital. The protected health information in it, however, generally belongs to you. You may have a right to:*

- Receive, read, and ask questions about this Notice.
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request. But we will comply with any request granted.
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information (Notice).
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
- When you request a copy of your protected health information, it must be provided within 30 days, with one 30-day extension permissible. Electronic PHI must be in a "readily reproducible" format. Otherwise, it must be provided in a mutually agreeable electronic format. Paper copies are permissible only if you reject all e-formats. The cost of portable media (i.e. CD, USB memory stick) and hard copies may be charged to you. Under Washington State guidelines, a processing fee of \$12 and .65 per page or \$10 for USB is permitted.
- If you wish to receive your PHI by email, you must be advised of the risk and agree to assume that risk.
- Have us review a denial of access to your health information – except in certain circumstances.
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record and included with any release of your records.
- You have the right to restrict disclosure to Health Plans for treatments you pay for in cash.
- You have the right to "opt out" of disclosure for purposes of fund-raising.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third party payers. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.
- In the event of a breach (acquisition, access, or disclosure) of your protected health information, you will be notified by Pullman Regional Hospital within 60 days of the date the breach was discovered. In addition, the hospital is obligated to notify the US Department of Health and Human Services in accordance with HIPAA Omnibus Final Rule.

For help with these rights during normal business hours, please contact Health Information Management at (509) 336-7410.

## **Pullman Regional Hospital's Responsibilities**

*We are required to:*

- Keep your protected health information private;
- Give you this Notice;
- Follow the terms of this Notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it, or by picking one up at the Patient Registration area, or checking our Web site at [www.pullmanhospital.org](http://www.pullmanhospital.org).

## **Who to Contact with Questions or Concerns**

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact our Privacy Officer by calling (509)336-7523

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to the Compliance Officer at Pullman Regional Hospital. You may also file a complaint with the US Secretary of Health and Human Services. We respect your right to file a complaint with us or with the US Secretary of Health and Human Services. If you complain, we will not retaliate against you.

## **Other Disclosures and Uses of Protected Health Information**

### **Notification of Family and Others**

- Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. In addition, we may disclose health information about you to assist in disaster relief efforts.
- Pullman Regional Hospital may release immunization records to schools required to obtain proof of immunization prior to admitting the student with the "informal consent" from the patient or patient representative. This should be documented in the medical record.
- Relevant disclosures to the family/friends of the deceased if these individuals were involved in providing care or payment for care and the hospital is unaware of any expressed preference (by the decedent) to the contrary.
- The sale of protected health information requires patient authorization.
- Pullman Regional Hospital Information may be provided to people who ask for you by name. We may use and disclose the following information in a hospital directory, unless you have chosen to "opt out":
  - Your name
  - Location
  - General condition and
  - Religion (only to clergy)

*You have the right to object to this use of disclosure of your information. If you object we will not use or disclose it.*

**We may use and disclose your protected health information without your authorization as follows:**

- **With medical researchers** if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- **To Funeral Directors/Coroners** consistent with applicable law to allow them to carry out their duties.
- **To Organ Procurement Organizations (tissue donation and transplant)** persons who obtain, store or transplant organs.
- **To the Food and Drug Administration (FDA)** relating to problems with food, supplements, and products.
- **To comply with workers' compensation laws** if you make a workers' compensation claim.
- **For public Health and Safety purposes as allowed or required by law;**
  - To prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
  - To public health or legal authorities
  - To protect public health and safety
  - To prevent or control disease, injury or disability
  - To report vital statistics such as births or deaths.
- **To report suspected Abuse or Neglect** to public authorities
- **To Correctional Institutions** if you are in jail or prison, as necessary for your health and the health and safety of others.
- **For Law Enforcement purposes** such as when we receive a subpoena, court order or other legal process, or you are the victim of a crime.
- **For Health and Safety oversight activities.** For example, we may share health information with the Department of Health.
- **For Disaster Relief Purposes.** We may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- **For Work-Related Conditions That Could Affect Employee Health:** An employer may ask us to assess health risks on a job site.
- **To the Military Authorities of Foreign Military Personnel and US.** The law may require us to provide information necessary to a military mission.
- **In the Course of Judicial / Administrative Proceedings.** At your request, or as directed by a subpoena or court order.
- **For Specialized Government Functions.** We may share information for national security purposes.

**Other Uses and Disclosures of Protected Health Information**

- Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.
- Pullman Regional Hospital has a Web site that provides information about us. For your benefit, this notice is on the web site at this address: [www.pullmanhospital.org](http://www.pullmanhospital.org)



**CONSENT TO TREATMENT, PROMISSORY NOTE, AND**

**AUTHORIZATION TO PAY MEDICAL & SURGICAL BENEFITS**

1. The patient named below has been informed of the nature and purpose of his/her hospitalization, treatment, and procedures and is aware of the risk and medical complications that may occur. The patient understands and acknowledges that no guarantee or assurance has been made as to the results that may be obtained. The patient voluntarily consents to the hospitalization, care, treatment and procedures, including, but not limited to, anesthesia, x-ray procedures, blood tests, psychological and/or drug and alcohol related diagnoses and procedures, and laboratory tests as the attending physician(s) consider being necessary.
2. Pullman Regional Hospital will use and disclose protected health information for the purposes of treatment, payment, and health care operations as authorized by law.
3. The patient hereby promises to pay for hospital and physician services rendered to the patient registered hereon. I understand that I will receive a bill from Pullman Regional Hospital, and possibly separate bills from individual physicians or other organizations for any services performed. This may include charges from specialists. Should account be left unpaid, account will be referred for collection. The undersigned shall pay all court costs, reasonable attorney's fees and collection expense. It is agreed by the parties involved that Washington has jurisdiction and that venue in any action taken to collect this account will be Whitman County.
4. The patient understands that the physician in attendance, are not employees or agents of the hospital, with the exception of Emergency Department physicians and the Hospitalists, but rather, are independent contractors who have been granted the privilege of using its facilities for the care and treatment of their patients. Furthermore, the patient realizes that among those who attend patients at this hospital are sometimes medical, nursing, and other health care personnel in training who, unless requested otherwise, may be present during patient care.
5. Medicare Certification and Payment: If I am applying for payment under Medicare or Medicaid, I certify that the information given by me is correct. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physicians or organizations furnishing the services or authorize them to submit a claim to Medicare and/or Medicaid.
6. The patient, if applicable, has received a copy of the "Important Message from Medicare".  Yes  No
7. The patient, under state and federal law, has the right to make decisions concerning his/her medical care including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives regarding these rights. I have Advance Directives  Yes  No, if Yes, I have provided the hospital with a copy  if No, I would like more information regarding Advance Directives.  I have a Physicians Order for Life Sustaining Treatment (POLST) form, the form is intended for any individual with an advanced life-limiting illness  Yes  No, if Yes, I have provided the hospital with a copy  if No, I would like more information regarding the POLST form.
8. The patient, if applicable, elects to have a "Birth Announcement" listed in the *Moscow/Pullman Daily News & Whitman County Gazette*.  Yes  No
9. The patient, if applicable, has given consent to Pullman Regional Hospital billing staff to discuss the hospital bill in its entirety with patient's parents or legal guardian.  Yes  No
10. The patient understands that Pullman Regional Hospital is a non-smoking facility.
11. This consent will expire 90 days from end of event. Event described as: \_\_\_\_\_

**Pullman Regional Hospital does not discriminate on the basis of age, sex, sexual preference, marital status, race, religion, creed, color, national origin, source of payment, or the presence of any sensory, mental, or physical handicap. The patient or authorized representative has read this form and is satisfied that he/she understands its content and significance.**

Pullman Regional Hospital keeps a record of the health care services we provide you. You may ask to see and copy that record (copy fees apply). You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Health Information Management. The hospital's Notice of Privacy Practices describes in more detail how your protected health information may be used and disclosed, and how you can access your information. Pullman Regional Hospital encourages patients to read this policy in full. Changes to this policy will be posted on the Pullman Regional Hospital's web site: [www.pullmanhospital.org](http://www.pullmanhospital.org).

**By my initials, I acknowledge a copy of the hospital's Notice of Privacy Practices, Patient Rights and Responsibilities have been offered to me, and if applicable, I have been asked about Advance Directives.** \_\_\_\_\_

Patient Name	Medical Record No.	Account Number	Date
Signature of Patient	Date	Signature of Hospital Representative	Date
Patient's Agent or Authorized Representative	Date	Relationship to Patient	