STATE OF NEW JERSEY PATIENT RIGHTS

As a patient of **Pilgrim Medical Center, Inc.**, (heretofore referred to as "the center" you have the following rights (under state law and regulations).

MEDICAL CARE

To receive the care and health services that the center is required by law to provide
To exercise your rights without being subject discrimination or reprisal
To have the right to personal privacy and to receive care in a safe setting
To receive an understandable explanation from your physician of your complete medical condition, recommended treatment, expected results, risks involved and reasonable medical alternative. If your physician believes that some of this information would be detrimental to your health or beyond your ability to understand, the explanation must be given to your next of kin.
To give informed written consent prior to the start of specified, non-emergency medical procedures or treatments. **Your** physician should explain to you, in words you understand, specific details about the recommended procedure or treatment, any risks involved, time required for recovery, and any reasonable medical alternatives.
To refuse medication and treatment after possible consequences of this decision have been explained clearly to you, unless the situation is life-threatening or the procedure is required by law.
To be included in experimental research only if you give informed, written consent. You have the right to refuse to participate.

COMMUNICATION AND INFORMATION

To be informed of the names, functions and credentials of all health care professionals providing you with personal care
To receive, as soon as possible, the services of a translator or interpreter if you need one to help you communicate with the Center's health care personnel.
To be informed of the names and functions of any outside health care and educational institutions involved in your treatment. You may refuse to allow their participation.
To receive, upon request, the Center's written policies and procedures regarding life-saving methods and the use or withdrawal of life support mechanisms and the use of or information regarding an Advance Directive.
To be advised in writing of the Center's rules regarding the conduct of patients and visitors.
To receive a summary of your patient rights that includes the name and phone number of the Center staff member to whom you can ask questions or complain about a possible violation of your rights.

MEDICAL RECORDS

To have prompt access to the information in your medical record. If your physician feels that this access is detrimental to your health, your next of kin or guardian has the right to see your record.
To obtain a copy of your medical record, at a reasonable fee, within 30 days after a written request to the Center.
To expect that your medical record will be held in strict confidentiality and released only with your permission as per State and Federal laws.

COST OF AMBULATORY SURGICAL CENTER CARE

To be notified if your physician has a financial interest in the Center
To receive a copy of the Center's payment rates. If you request an itemized bill, the Center must provide one, and explain any questions you may have. You have the right to appeal any charges.
To be informed by the Center if part or your entire bill will not be covered by insurance. The Center is required to help you obtain any public assistance and private health care benefits to which you may be entitled.

DISCHARGE PLANNING

To receive information and assistance from your attending physician and other health care providers if you need to arrange for continuing health care after your discharge from the Center.

TRANSFERS

To be transferred to another facility only when you or your family has made the request, or in instances where the Center is unable to provide you with the care you need.
To receive an advanced explanation from a physician of the reasons for your transfer and possible alternatives

PERSONAL NEEDS

To be treated with courtesy, consideration, and respect for your dignity and individuality.
To have access to storage space for private use. The Center must also have a system to safeguard your personal property.

PATIENT RIGHTS CONTINUED

FREEDOM FROM ABUSE AND RESTRAINTS

To be free from physical and mental abuse.
To be free from restraints, unless they are authorized by a physician for a limited period of time to protect the safety of you or others.

PRIVACY AND CONFIDENTIALITY

To have physical privacy during medical treatment and personal hygiene functions, unless you need assistance.
To confidential treatment of information about you. Information in your records will not be released to anyone outside the Center without your approval, unless it is required by law.

LEGAL RIGHTS

To treatment and medical services without discrimination based on age, religion, national origin, sex, sexual preference, handicap, or diagnosis.
To exercise all your constitutional, civil, and legal rights.

As a patient, you are responsible for:

1. Providing physicians and Center personnel with accurate information related to your condition and care.
2. Following your treatment plans. Patients are responsible for medical consequences which result from refusing treatment or not following instructions of physicians and the Center's personnel.
3. Being considerate of the Center's staff who are committed to excellence in patient care.
4. Supplying accurate insurance information and pay bills promptly so that your Office Based Surgical Center can continue to serve you effectively.

N.J. Department of Health & Senior Services **Healthcare systems Analysis** **Complaint Program** **Room 601** **PO Box 360** **Trenton, NJ 08625** ***Complaints Hotline 800-792-9770***	**Nicholas Campanella, MD** **393 Bloomfield Ave.** **Montclair, NJ 07042** **973-746-1500**

QUESTIONS AND COMPLAINTS

Medicare Ombudsman Center Web Site
http://www.cms.hhs.gov/center/ombudsman.asp

Medicaid
7 Quakerbridge Plaza
Trenton, NJ 08619
609-588-2751

Hasbrouck Heights Surgery Center, LLC
Advance Directive/Living Will Declaration

Instructions: Consult this column for guidance	To my family, Doctors, and all those concerned with my care
This declaration sets forth your directions regarding medical treatment	I, _____, being of sound mind, make this statement as a directive to be followed if I become unable to participate in decisions regarding my medical care. If my death is near and cannot be avoided, or if I become comatose and lose the ability to interact with others and have no reasonable chance of regaining this ability, or if my suffering is intense and irreversible due to my mental or physical condition, I direct my attending physician to withhold or withdraw treatment that merely prolongs my dying. I further direct that treatment be limited to measures to keep me comfortable and to relieve pain.
You have the right to refuse the treatment you do not want, and you may request the care you do want	These directions express my legal right to refuse treatment. Therefore, I expect my family, doctors, and everyone concerned with my care to regard themselves as legally and morally bound to act in accordance with my wishes, and in so doing to be free of any legal liability for having followed my directions.
You may list specific treatment you do not want: e.g. CPR, cardiac resuscitation-Mechanical respiration-Feeding Tubes-Intravenous Fluids. Your general statement above will suffice.	I especially do not want
You may want to add other instructions directing the care you do want: e.g. pain management-to die at home	Other instructions/comments
If you want, you can name someone to see that your wishes are carried out, but you do not have to do this	**PROXY DESIGNATION CLAUSE:** In order to carry out my instructions as stated above and to interpret them, I designate the following person to act on my behalf Name:_____ Address:_____ Home Phone #:_____ Work Phone #_____
	If the person named above, is unable to act on my behalf, I authorize the following person to do so: Name:_____ Address:_____ Home Phone #:_____Work Phone #_____

Patient's Signature:_____ Witness:_____

Date:_____ Date:_____

Notice to Patients: Please note that it is the policy of the Hasbrouck Heights Surgery Center, LLC, not to honor a "Do Not Resuscitate Request." In the event of a life threatening emergency, all patients will be treated, stabilized and transferred to the Hackensack University Medical Center. If this is not acceptable to you, the patient, please understand that you have a choice to change physicians and be treated at another facility.