Disclosure of Patient Rights

You have the following rights:

[1] The right to considerate and respectful care that is free of discrimination on the basis of sex, gender identity/expression, sexual orientation, marital status, age, genetic information, economic status, educational background, race, color, religion, ancestry, national origin, citizenship, primary language, disability, and medical condition.

[2] The right to receive information about your health status in terms you can understand.

[3] The right to access your medical records.

[4] The right to effective communication and to participate in the development and implementation of your plan of care. You will receive as much information as you need in order to give informed consent or refusal to the medical treatments offered to you.

[5] The right to participate in ethical questions that arise in the course of your care.

[6] The right to accept or refuse treatment. Assuming you have the capacity to make an informed medical decision, you have this right even when your medical team feels it would be better to make a different decision. However, you do not have the right to demand inappropriate or medically unnecessary services.

[7] The right to refuse to participate in experimental clinical trials and research projects;

[8] The right to appropriate assessment and management of your pain including information about pain and pain relief measures. This does not

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include the right to treatment with opioids or other controlled and potentially addictive substances.

[9] The right to formulate advance directives. This includes designating a decision maker if you become unable to understand the risks, benefits, and alternatives of a proposed treatment. This person would also advise your medical team of your anticipated wishes if you became unable to communicate them. All patients' rights apply to the person who has legal responsibility to make decisions regarding medical care on your behalf. Complaints about the advance directive requirements may be made to the California Department of Public Health (see contact information below);

[10] The right to have personal privacy respected. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. You have the right to be told the reason for the presence of any individual. You have the right to have visitors leave prior to an examination and when treatment issues are being discussed;

[11] The right to confidential treatment of all communications and records pertaining to your care. You will receive a separate "Notice of Privacy Practices" that explains your privacy rights in detail and how I may use and disclose your protected health information;

[12] The right to receive care in a safe setting, free from mental, physical, sexual, or verbal abuse and neglect, exploitation, or harassment. You have the right to access protective and advocacy services including notifying government agencies of neglect or abuse;

[13] The right to be free from restraints and seclusion of any form as used as a means of coercion, discipline, convenience, or retaliation by staff;

[14] The right to reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of the persons providing the care;

18) The right to designate a support person of your choosing unless it is reasonably determined that the presence of a particular visitor would

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endanger the health or safety of a patient, a member of the health facility staff or other visitor to the health facility, or would significantly disrupt the operations of the health facility.

[19] The right to examine and receive an explanation of your bill regardless of the source of payment;

[20] The right to file a complaint with the California Department of Public Health.
Phone number is 800-228-5234
Address: 681 S Parker St., Suite 200 Orange, CA 92868.

BY SIGNING BELOW, YOU ATTEST THAT YOU HAVE RECEIVED, READ AND UNDERSTAND THE ABOVE PATIENT RIGHTS. YOU HAD THE OPPORTUNITY TO ASK ANY QUESTIONS AND HAD THOSE QUESTIONS ANSWERED TO YOUR SATISFACTION.

SIGNATURE: _____

NAME: _____

DATE: _____

RELATIONSHIP TO PATIENT (mark one):

_____ SELF

_____ MEDICAL POWER OF ATTORNEY

INITIAL HERE: _____