Patient Rights and Responsibilities

Welcome to Pace Healthcare LLC

Your therapy will be provided by experienced professionals in the comfort of our injection and infusion suite. It is our goal to provide you with the best care possible and to provide an affordable alternative to hospital or home-based care. **Please call 330-625-4900 any questions or concerns**. If there is a medical emergency, please call 911 or go to the nearest emergency facility.

Patient Rights

- You can exercise your rights as a patient of Pace Healthcare.
- Your family or guardian may exercise your rights if you have been judged incompetent.
- You have the right to have your property treated with respect.
- You have the right to voice grievances regarding your treatment or care that is or may fail to be furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of Pace Healthcare LLC and must not be subjected to discrimination or reprisal for doing so.
- Pace Healthcare will investigate your (or your family's) complaints and will document both the existence of the complaint and the resolution of the complaint.
- You have the right to be informed in advance of who will be providing and is responsible for your care, and the frequency of your proposed visits/treatments at our center.
- You have the right to a prompt and reasonable response to questions and requests.
- You have the right to know what support services are available, including whether or not an interpreter is available if you do not speak English.
- You have the right to be given by the healthcare provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- You have the right to refuse any treatment, except as otherwise provided by law.
- You have the right to be given, upon request, full information, and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- You have the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- You have the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- You have the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- You have the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- You have the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- You have the right to confidentiality of your clinical records maintained by this agency.

  Information from your clinical record will not be released without your consent unless required by law.

PACE HEALTHCARE LLC

Patient Responsibilities

- The patient should recognize a Medical Emergency and call proper support if a medical emergency occurs. The patient should not wait for Pace staff to respond.
- The patient is responsible for providing to the healthcare provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- The patient is responsible for reporting unexpected changes in his or her condition to the healthcare provider.
- The patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- The patient is responsible for following the treatment plan recommended by the healthcare provider.
- The patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- The patient is responsible for assuring that the financial obligations of his or her healthcare are fulfilled as promptly as possible.
- The patient is responsible for following healthcare facility rules and regulations affecting patient care and conduct and is expected to treat the staff with dignity and respect.
- The patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the healthcare provider or health care facility.
- The patient is responsible for notifying Pace Healthcare of any changes or potential changes to the insurance.
- **The patient is responsible for notifying the office if the patient is going to be 15 minutes or more late and the patient recognizes that the office may or may not be able to keep the patient's current appointment and the patient may need to reschedule the appointment.**

PATIENT CONSENT FOR TREATMENT FORM

1. CONSENT TO INJECTION OR INFUSION THERAPY, MEDICAL CARE AND TREATMENT

I voluntarily consent to any and all health care treatment and diagnostic procedures, including but not limited to infusion and injection therapy, medical examinations, and tests, provided by Pace Healthcare LLC (the "Infusion Center") and its associated physicians, providers, nurses, and clinicians (collectively, the "Clinicians"). I understand that in many instances the Clinicians are carrying out orders from my referring health care provider. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. I also understand that if I do not follow my referring provider's or the Clinicians' recommendations as they may relate to my health that the Infusion Center and the Clinicians will not be responsible for any injuries or damages that are the result of my non-compliance. I understand that if any employee or any individual associated with the Infusion Center is exposed to my blood or body fluids, I will be tested for the hepatitis viruses and the Human Immunodeficiency Virus (HIV). I also understand that I will receive education related to this testing and that I will not be charged for testing and education related to the exposure. Finally, I understand that I may refuse to sign this Patient Consent, however, I understand that without my legal signature, the Infusion Center cannot provide me with treatment and my appointment will be cancelled.

2. CONSENT TO TREATMENT IN AN OPEN TREATMENT AREA

I acknowledge and understand that the Infusion Center provides infusion and injection therapy and medical care in an open treatment environment. Despite safeguards and using reasonable care, it is always possible in the Infusion Center that I may learn information regarding other patients or they may inadvertently learn something about me. In all cases, the Infusion Center expects and requires that its patients maintain strict confidentiality of any inadvertently disclosed health information of others.

3. CONSENT TO PHOTOGRAPH, VIDEOTAPE OR RECORD

I authorize the Infusion Center to photograph, videotape, or record me and agree that the images, video, or recordings may be used for medical reasons (including training, education, or research). I hereby release the Infusion Center, its employees, Clinicians, and other authorized persons from any responsibility which might arise from the taking and authorized use of such images, video, or recordings. Further, video surveillance on the premises may be used for safety and security purposes. In the event of a suspected crime, such video may be subpoenaed by law enforcement.

4. CONSENT TO USE OF INFORMATION

Release of Health Records. I understand that the Infusion Center may collaborate with other health care providers to coordinate, manage, and provide health care to me, and I voluntarily consent to the Infusion Center's sharing my health information and records electronically or otherwise for the purposes of treatment, payment, and operations and other purposes as outlined in the Infusion Center's Notice of Privacy Practices. I consent to the inclusion in my electronic health record of any sensitive diagnoses and related information such as HIV/AIDS status, sexually transmitted diseases, genetic information, and mental health and substance abuse, etc. I understand that my electronic health records will be accessible by our Clinicians and other Infusion Center personnel and individuals approved to access such records for purposes related to treatment, payment, and health care operations and other purposes as outlined in the Infusion Center's Notice of Privacy Practices. I understand that any/all information contained in my health records is property of the Infusion Center.

Use and Disclosure of Information. In addition, I acknowledge and agree that the Infusion Center may use and disclose my health information for a range of purposes, including but not limited to: treatment, eligibility verification, and payment to private and public payers or their agents including insurance companies, managed care organizations, my employer (if I am injured at work), state and federal government programs, Workers' Compensation programs, quality of care assessment and improvement activities, evaluating the performance of qualifications of Clinicians, conducting medical and nursing training and education programs, conducting or arranging for medical review, audit services, ensuring compliance with legal, regulatory, and accreditation requirements, and public health and health oversight services. All of these uses and disclosures are more fully outlined in the Infusion Center's Notice of Privacy Practices.

Request for Information from Others. I consent to Infusion Center's request of my health information from other providers of care to me, receipt of and release of my health information, whether written, verbal, or electronic, for the uses described above, and Infusion Center's participation in any health information exchange described in the Infusion Center's Notice of Privacy Practices.

Communication with Infusion Center. I consent to receiving automated and other calls, text messages, emails and other communications from the Infusion Center. This may include reminders about upcoming appointments, questions about insurance coverage and service experience.

5. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received or been offered a copy of the Infusion Center's Notice of Privacy Practices, which provides information on how the Infusion Center may use or disclose my health information. I understand that my signature below represents my consent to the Infusion Center's Notice of Privacy Practices.

6. ASSIGNMENT OF BENEFITS

I hereby assign to and authorize payment of all insurance and health care benefits available to me directly to the Infusion Center for services provided to me. I understand that benefits may be payable to me directly if I do not provide this authorization.

7. FINANCIAL RESPONSIBILITY

I understand and agree that I am financially responsible for payment of all charges incurred which are not paid by insurance or health care benefits, including any and all products (e.g. medications) provided or services rendered to me which are not eligible for payment (non-covered) under health care plans, Medicare, Medicaid, or other insurance or payers (e.g., services rendered by health care providers who do not participate with my insurance plan). Non-covered products and non-covered services also may include those products and services the Infusion Center and the Clinicians initially determine to be medically necessary but are later determined unnecessary or denied by my insurance or payer. We reserve the right to refuse to provide services on accounts that are delinquent.

8. PERSONAL VALUABLES

I understand that the Infusion Center does not accept responsibility for any lost, stolen, or damaged personal items while I am at the Infusion Center.

HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Us or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164) I authorize Pace Healthcare LLC to use and disclose the protected health information described below to my referring physician and any others necessary for coordination of my care.

This authorization for release of information covers the period of healthcare from (**please circle one**):

_____ till consent is revoked in writing **OR** _____ till the following date (mm/dd/yy): _____

Extent of Authorization (**please circle one**):

_____ I authorize the release of my complete health records (including records relating to mental health, communicable disease, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

_____ I authorize the release of my complete health record except f or the following information:

Mental health records Alcohol/drug abuse treatment

Communicable diseases (incl. HIV & AIDS) Other (please specify): _____

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing, or claim payment or other purposes as I may direct. This authorization shall be in force and effect unless revoked by the patient or legal representative.

- I understand that I have the right to revoke this authorization, in writing, at any time.
- I understand that revocation is not effective to the extent that any person or entity has already acted in reliance or on my authorization or if my authorization with obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

EMERGENCY CONTACT INFORMATION

Name: _____ Name: _____

Relationship to Patient: _____ Relationship to Patient: _____

Phone:_____ Phone: _____

Email: _____ Email: _____

This authorization grants permission to the Emergency Contacts named above to (**please circle all that apply**): access my medical record information and scheduling Have access to my billing & insurance information

Signature page:

I have read and reviewed the following forms

Rights and Responsibility Form
Consent for treatment
Emergency contact and information release
HIPAA Privacy Authorization Form

I (Print) _____ affirm that I have read and understand the Consent for Treatment, Patient Rights and Responsibilities and HIPAA Authorization forms and have been offered a copy of each document.

Patient Signature:_____ Date: _____

Witness Signature:_____

Our Company has a complaint policy & procedure; please contact us at (330)-625-4900 if you experience any problems. In the event your complaint remains unresolved you may file a complaint with our Accreditor, The Compliance Team Inc., via their website www.thecomplianceteam.org or phone, 888-291-5353.