

Patient Name: _____
(Print Name)

Date of Birth (MM/DD/YY): ____-____-____

Your Rights as a Patient at Dartmouth-Hitchcock

We strive to preserve your rights as an individual. We also ask that you and your visitors be considerate of the rights of others.

You, and your property, have the Right to:

- Be treated with respect and dignity. This includes being called by the name you choose, and to feel safe while in the hospital.
 - Your cultural background, spiritual and personal values, beliefs, and preferences should be respected.
 - You and the visitors that you choose will not be discriminated against based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, or gender identity or expression. You will receive appropriate care without discrimination in accordance with a physician's orders, if applicable.
- Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of client/patient property

You have the Right to:

- Be able to identify personnel through proper identification.
- Have your own physician and the person of your choice notified of your admission to the hospital.
 - The person of your choice can be with you for emotional support during your hospital stay, as long as it does not interfere with the rights and safety of others or your agreed upon plan of care.
- Know the names of the doctors and staff on your care team. We encourage you to ask them any questions you might have.
 - You should expect a reasonable response to your questions and requests for help.
 - You may choose a healthcare provider, including an attending physician, if applicable
 - You may inquire about a staff member's job title, ask for proper identification, and speak with a staff member's supervisor if requested
- Know about your diagnosis or illness so that you can take part in the planning of your care and treatment, understand your options, and know how decisions will affect your health and well-being
 - You will be informed, in advance both orally and in writing, of the care being provided.
 - Be informed, in advance both orally and in writing, of the charges, including payment expected from third parties and any charges for which you may be responsible
 - Receive information about the products/services provided and specific limitations on those products/services
 - You may participate in the development and periodic revision of the plan of care
 - You may request to talk with different doctors about procedures, tests and the results, as well as the medical outlook for your future.
 - You may say "no" to any care, tests, or treatments, to the extent permitted by law.
 - You are encouraged to complete Advance Directives which tell your care team the care you want, how you want to be treated and whom you want to make decisions for you if you cannot speak for yourself

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- You have the right to receive information in a manner you will understand and to have the person of your choice involved in making decisions, as you request
- Know about the philosophy and characteristics of the patient management program
 - You may receive information as requested regarding the patient management program.
 - You may receive administrative information regarding changes in, or termination of, the patient management program.
 - You may refuse care or treatment, decline participation, revoke consent, or dis-enroll at any point in time after the consequences of refusing care or treatment have been fully explained to you.
 - Be fully informed in advance about care/service to be provided, including the disciplines that furnish care and frequency of visits, as well as any modifications to the plan of care
 - Receive information about the scope of services that the organization will provide and specific limitations on those services
- Minimize your pain as much as possible during your hospital stay, during a test, or during a treatment.
 - You, your family, the doctors, nurses, and other hospital staff will help you to make and understand a plan to manage your pain.
 - We will check with you about how you are feeling and change the plan to manage your pain as much as possible.
- Be free from restraints or seclusion unless they are necessary to ensure physical safety, and if no less restrictive intervention is possible
- Reasonable privacy.
 - You may expect to talk with your doctors, nurses, social workers, or other healthcare professionals in private, and know that the information you give will be shared only with those people who need it to do their job.
 - Your personal health information will be shared with the patient management program only, in accordance with State and Federal law.
 - Information contained in the patient record and Protects Health Information will be kept private and confidential.
- Know the information in your medical record.
 - You may be informed on D-H's policies and procedures regarding the disclosure of medical records.
 - Your medical records are private. You may look at your records and get a copy or summary within 30 days of our receiving your request. If we are unable to provide you with a copy or summary within 30 days, we will produce what we can and notify you of when your health information will be ready, which will be within 60 days of your request. We may charge a reasonable, cost-based fee for copies of your record.
 - Certain conditions, such as cancer, cases of some infectious diseases, work-related contact with poisons or other dangerous materials, and cases of child abuse, must be reported, even without your permission. In some cases involving concern about the care you receive, the medical center may disclose information in medical records to its own lawyers and agents.
- Receive written notice of how your health information will be used and shared in order for you to receive the highest quality of care. This is called our Notice of Privacy Practices and it contains patient rights and our legal duties regarding your health information. You may request a copy of this Notice from any staff member.

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- Speak with any member of your healthcare team, [Patient and Family Relations](#) (603-650-4429) or specially trained volunteers called Patient Voices Volunteers if you are unhappy with your care. Your care will not be affected in any way.
 - Voice grievances/complaints regarding treatment or care or lack of respect of property, or recommend changes in policy, personnel, or care/service without restraint, interference, coercion, discrimination, or reprisal
 - Have grievances/complaints regarding treatment or care that is (or fails to be) furnished, or lack of respect of property investigated
 - We will make every effort to resolve your concern. If this cannot be resolved in a timely manner it will become a grievance. You will receive communication as to the status of the grievance, including a final letter including the name of the hospital contact, steps taken for the review, results of the review, and the completion date.
 - If we cannot meet your needs, you can contact:
 - [NH Department of Health and Human Services - Health Facilities Administration](#) at 603-271-9499/800-852-3345 x9499
 - [Joint Commission](#) 1-800-994-6610
Physician issues are referred to:
 - [NH Board of Medicine](#) 603-271-1203/1-800-780-4757
- Be told fully about any research study in which you are asked to take part. This discussion should occur before you agree to enter the study.
 - If you are under the age of 18, your parent or guardian must give permission before any tests or treatments can be carried out in the course of the research study.
 - You have the right to refuse to take part in a research study. If you refuse to take part, it will not affect receiving treatment here in the future.
- Understand instructions you will receive before leaving the hospital or clinic.
 - These instructions will describe how you and your family can participate in your recovery and ongoing health care plan once you are at home.
- Leave the hospital, even if your doctor advises against it. You may not leave if you have certain infectious diseases that could affect the health of others, if you are not able to provide for your own health and safety or other people's safety is at risk, as defined by law.
 - You must sign a form saying the Medical Center is not responsible for any harm that comes to you as a result of leaving the facility.
- Be informed of any financial benefits for D-H when referred to an outside organization
- Be informed, in advance both orally and in writing, of care being provided, of the charges, including payment for care/service expected from third parties and any charges for which the client/patient will be responsible
- In order to reduce concerns about paying your bill, you will be told of services available to help in paying for your care prior to being billed.
 - You have the right to look at and receive an explanation of your bills. This information can be obtained through [Patient Financial Services](#) at (800) 368-4783.

Your Responsibilities as a Patient at Dartmouth-Hitchcock

When you are a patient at Dartmouth-Hitchcock, you, your family and your visitors have the responsibility to:

- Be honest and tell us all you know about your past and present health including:
 - Sharing with your doctor or nurse if you think you are at risk, if your health has changed and what medications you are taking.
 - Information about Advanced Directives (Living Will and/or Durable Power of Attorney for Healthcare) and who will speak for you if you are unable to speak for yourself.
- Share all updates regarding contact information with the organization.
- Appropriately submit all forms that are necessary for receiving services to the organization
- Ask questions about anything you do not understand, including your treatment plan or what is expected of you. This includes making sure you understand the potential risks, benefits and side effects of your treatment.
 - Notify the organization of any concerns about the care or services provided
- Follow the plan that is developed by you and your treatment team.
 - If you have a concern about the plan, it is your responsibility to talk about it with your doctors and nurses.
- Notify the treating provider of participation in organization provided services.
- Accept responsibility for your actions if you refuse treatment or do not follow instructions.
 - Your treatment plan may include recommendations about exercise, not smoking and eating a healthy diet.
- Follow the rules and regulations of Dartmouth-Hitchcock, including the no smoking policy.
- Be respectful at all times to the staff, other patients, visitors and Dartmouth-Hitchcock property.
 - Maintain any D-H provided equipment
- Make a good faith effort to pay your medical bills in a timely fashion or ask for appropriate assistance.

Reporting

- Violations of the above rights are to be reported immediately to the Administrator or appropriate designee.
- Dartmouth-Hitchcock will immediately investigate all alleged violations involving anyone furnishing services on behalf of Dartmouth-Hitchcock and will take action to prevent further potential for violations while the alleged violation is being verified.
- Investigations and/or documentation of all alleged violations are conducted in accordance with established policies and procedures.
- Dartmouth-Hitchcock will take appropriate corrective action in accordance with state law if the alleged violation is verified by the Dartmouth-Hitchcock administration or an outside body having jurisdiction.

Dartmouth-Hitchcock will report verified violations to the accrediting, state, and local bodies having jurisdiction within five working days of becoming aware of the verified violation, unless state regulations are require a more stringent timeline for reporting any such violations.

My signature below acknowledges that I have established and understand my rights and responsibilities as a patient, here at Dartmouth-Hitchcock Pharmacy. If you have questions about your rights as a patient, or if you would like a copy of the New Hampshire state law which lists your rights, please call [Care Management](#) at (603) 650-5789.

Patient Name: _____
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eSignature: _____
(Patient/Patient Representative) *By typing your name here, you are signing this acknowledgement electronically.*

_____ Date

Pharmacy Representative

_____ Date