Centura Health Physician Group

Centura Health

Patient Information
PG-2000 rev. 03/17

YIELD **Complete New Patient Paperwork Online! Visit epic.mycenturahealth.org to complete your Health History Questionnaire and update your information.**

PATIENT INFORMATION

Name: _____ (Last) _____ (First) _____ (MI) SSN: _____

Sex: ☐ M ☐ F DOB: _____ Preferred Name: _____

Address: _____

_____ (City) _____ (State) _____ (Zip)

Mailing address: ☐ Check if same as above

_____ (Address)

_____ (City) _____ (State) _____ (Zip)

Home Phone: _____ Cell: _____

Email: _____

Marital Status: ☐ Divorced ☐ Legally Separated ☐ Married ☐ Significant Other ☐ Single ☐ Widowed ☐ Declined

Would you prefer to speak to your healthcare provider through a translator? ☐ Yes ☐ No

Preferred Language: ☐ English ☐ Other (please specify): _____ Written Language: _____

Religion: _____ ☐ Declined Birthplace: _____

Ethnicity: Do you consider yourself to be Hispanic or Latino? ☐ Yes ☐ No ☐ Declined

Race: ☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander ☐ White
☐ Black or African American ☐ Asian ☐ Declined

Employer: _____ Employer Phone: _____ Occupation: _____

Status: ☐ Part-time ☐ Full-time ☐ Self-Employed ☐ Retired ☐ Active Military ☐ Disabled ☐ Student
☐ Unemployed

PHARMACY

	Address/Cross Streets	Phone Number	Preferred
Local:			☐
Alternative:			☐
Mail Order:			☐

CARE TEAM

Primary Care Provider: _____ Phone Number: _____

Specialist Name: _____ Specialty: _____ Phone Number: _____

Specialist Name: _____ Specialty: _____ Phone Number: _____

EMERGENCY CONTACT

Name: _____ (Last) _____ (First) Relation to patient: _____

Address: _____

Phone: _____

Name: _____ (Last) _____ (First) Relation to patient: _____

Address: _____

Phone: _____

Centura Health Physician Group

Centura Health

Patient Information
PG-2000 rev. 03/17

PARTY RESPONSIBLE FOR PAYMENT ☐ Check if same as patient

Name: _____ DOB: _____
Last First mm/dd/yy

Address: _____
City State Zip

Phone: _____

SSN: _____ Relation to patient: _____

Employer: _____

Advance Directive

Do you have a Living Will / DNR? ☐ Yes ☐ No

Do you have a Durable Power of Attorney? ☐ Yes ☐ No

If yes: _____
Please Print Name Phone Number

Would you like information regarding Advance Directive? ☐ Yes ☐ No

Chief Complaint (Reason for Visit): _____

ALLERGIES ☐ No Known Drug Allergies

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Other (latex, adhesive, food, environment): _____

Other (latex, adhesive, food, environment): _____

MEDICATIONS ☐ None

Please list any medications you are taking (including aspirin, vitamins, supplements or any other over the counter medication).

Name of Medication	Dose	How often do you take	Reason for taking medication

Centura Health Physician Group

Centura Health

Patient Information
PG-2000 rev. 03/17

PATIENT INFORMATION

Name: _____ DOB: _____
Last First MI

PERSONAL MEDICAL HISTORY

Please check all diagnoses that apply to you and add notes as needed.

AIDS	☐ Yes ☐ No	Hepatitis - Type: _____	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	HIV	☐ Yes ☐ No
Angina (Heart pain)	☐ Yes ☐ No	Hyperlipidemia (High cholesterol)	☐ Yes ☐ No
Arrhythmia/Palpitations	☐ Yes ☐ No	Hypertension (High blood pressure)	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Irritable Bowel Syndrome (IBS)	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Kidney Stones	☐ Yes ☐ No
Atrial Fibrillation	☐ Yes ☐ No	Long-Term Steroid Use	☐ Yes ☐ No
Bleeding disorder/tendency	☐ Yes ☐ No	Lupus	☐ Yes ☐ No
Blood Clots	☐ Yes ☐ No	Macular Degeneration	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	MI (Heart attack) - Date: _____	☐ Yes ☐ No
Bone Loss - DEXA: _____	☐ Yes ☐ No	Motor Vehicle Accident	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Oxygen Use	☐ Yes ☐ No
Chronic Fatigue	☐ Yes ☐ No	Peripheral Artery Disease	☐ Yes ☐ No
Chronic Kidney Disease	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No
Chronic Pain	☐ Yes ☐ No	Restless Leg Syndrome	☐ Yes ☐ No
Connective Tissue Disorder	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
COPD/Emphysema	☐ Yes ☐ No	Sciatica	☐ Yes ☐ No
CVA/Stroke	☐ Yes ☐ No	Scoliosis	☐ Yes ☐ No
Diabetes - Type:	☐ Yes ☐ No	Seasonal Allergies: _____	☐ Yes ☐ No
Dialysis (hemodialysis or peritoneal)	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Disabilities: _____	☐ Yes ☐ No	Sinusitis, recurrent	☐ Yes ☐ No
Diverticulitis	☐ Yes ☐ No	Sleep Apnea	☐ Yes ☐ No
Ear Infection, recurrent	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Environmental/Food Allergies: _____	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Fibromyalgia	☐ Yes ☐ No	UTI (Bladder infections)	☐ Yes ☐ No
Genetic/Congenital Condition: _____	☐ Yes ☐ No	Vertigo	☐ Yes ☐ No
GERD (Heartburn)	☐ Yes ☐ No	Other Conditions:	
GI Bleeding	☐ Yes ☐ No	_____	
Glaucoma	☐ Yes ☐ No	_____	
Gunshot Wound	☐ Yes ☐ No	Date of last dental exam: _____	
Head Injury/Concussion	☐ Yes ☐ No	Date of last eye exam: _____	
Hearing Deficit	☐ Yes ☐ No	**Date of last colonoscopy:** _____	
Heart Disease	☐ Yes ☐ No	Doctor: _____	
Heart Failure	☐ Yes ☐ No	History of colon polyps	☐ Yes ☐ No

Centura Health Physician Group

Centura Health

Patient Information
PG-2000 rev. 03/17

Name: _____ DOB: _____
Last First MI mm/dd/yyyy

SURGICAL HISTORY

Please list surgeries/procedures and add notes as needed.

Year	Surgery/Procedure	Hospital/Location	Complications/Additional Comments

Have you ever had a reaction to general anesthesia? ☐ Yes ☐ No

Additional Personal Medical History

_____

_____

_____

FEMALE PATIENTS ONLY

☐ Abnormal Pap smear
☐ Other GYN history (indicate below)
Age of first menstrual period: _____
Date of last menstrual period: _____
Age of menopause: _____

Form of contraception (if any): _____
Last mammogram: _____
Last Pap smear: _____
Currently pregnant? ☐ Yes ☐ No
Currently breastfeeding? ☐ Yes ☐ No

Planning pregnancy? ☐ Yes ☐ No
Number of Pregnancies: _____
Number of Deliveries: _____
Number of Elective abortions: _____
Number of Miscarriages: _____

SOCIAL HISTORY

Tobacco Use: ☐ None Quit Date: _____
☐ Pipe/Cigar ☐ Cigarettes Packs/Day: _____ Number of years smoked: _____
☐ Smokeless tobacco ☐ Electronic or E-Cigarette ☐ Secondhand smoke exposure

Alcohol Use: ☐ None ☐ Daily ☐ Occasional ☐ Trying to cut down ☐ In recovery Amount per week: _____

Drug Use: ☐ None ☐ Past Use ☐ Current

How many times in the past year have you used recreational drugs or prescription medication for nonmedical reasons?
☐ None ☐ One or more

☐ Marijuana ☐ Amphetamines ☐ Cocaine ☐ Designer/Club
Route: ☐ Smoke ☐ Inject ☐ Ingest ☐ Topical

Centura Health Physician Group

Centura Health

Patient Information
PG-2000 rev. 03/17

Name: _____ (Last) _____ (First) _____ (MI) DOB: _____ (mm/dd/yyyy)

Sexual Activity: ☐ Not active ☐ Active Number of lifetime sexual partners: _____ ☐ Men ☐ Women ☐ Both

Do you have a caregiver? ☐ Yes ☐ No

Name: _____ Relationship: _____

Diet: ☐ Well Balanced ☐ Diabetic ☐ Vegetarian ☐ Fast food/Fats/Carbs
☐ Weight Loss Products _____ ☐ Vitamins/Herbs

Exercise/Activity Level: ☐ Sedentary ☐ Strength/Wt. Training ☐ Stretch/Balance
☐ Twenty minutes/day exercise ☐ Exercise three times weekly ☐ Aerobic/Cardiac

With whom do you live? ☐ Alone ☐ Children ☐ Spouse/Partner ☐ Parents ☐ Assisted Living: _____

Education: ☐ GED ☐ High School ☐ Did not complete High School ☐ College ☐ Advanced Degree ☐ Technical/Trade

Occupation: _____

Leisure activities: _____

Religion: _____

Do you: ☐ Use seatbelts ☐ Use a helmet ☐ Have guns in home ☐ Have smoke detector in home

Abuse

I feel safe at home: ☐ Yes ☐ No

Is there anyone you are afraid of? ☐ Yes ☐ No

Do you have a history of abuse? ☐ Yes ☐ No

TRAVEL

In the last 30 days, have you traveled to any foreign countries? ☐ Yes ☐ No List: _____

IMMUNIZATIONS

Please provide any known dates or full immunization record(s).

Tetanus or Tetanus/Pertussis: _____ (mm/dd/yy) Influenza: _____ (mm/dd/yy) Shingles: _____ (mm/dd/yy) Meningitis: _____ (mm/dd/yy)

Hepatitis A: _____ (mm/dd/yy) / _____ (mm/dd/yy) Hepatitis B: _____ (mm/dd/yy) / _____ (mm/dd/yy) / _____ (mm/dd/yy)

HPV: _____ (mm/dd/yy) / _____ (mm/dd/yy) / _____ (mm/dd/yy) Pneumococcal 13 or 23: _____ (mm/dd/yy) Other: _____

PLEASE USE THIS SPACE FOR ANY ADDITIONAL INFORMATION

Name: _____ DOB: _____
Last First MI mm/dd/yyyy

FAMILY HISTORY

What illnesses/conditions/diagnoses are in your family? Indicate the age of diagnosis in the boxes below, if known.

Relationship	Name	Status	No Known Problems	Alcohol abuse	Asthma	Blood clots	Breast cancer	Colon cancer	Prostate cancer	Other cancer(s)	Dementia	Diabetes	Heart disease	High blood pressure	High cholesterol	Kidney disease	Liver disease	Lung disease	Mental Illness	Ovarian Cancer	Stroke	Thyroid condition(s)	Other:_____	Other:_____	Other:_____
Mother		☐ Alive ☐ Deceased																							
Father		☐ Alive ☐ Deceased																							
Sister		☐ Alive ☐ Deceased																							
Brother		☐ Alive ☐ Deceased																							
Son		☐ Alive ☐ Deceased																							
Daughter		☐ Alive ☐ Deceased																							
Maternal Grandmother		☐ Alive ☐ Deceased																							
Maternal Grandfather		☐ Alive ☐ Deceased																							
Paternal Grandmother		☐ Alive ☐ Deceased																							
Paternal Grandfather		☐ Alive ☐ Deceased																							
Other:_____		☐ Alive ☐ Deceased																							
Other:_____		☐ Alive ☐ Deceased																							
Other:_____		☐ Alive ☐ Deceased																							

Are you adopted?: ☐ Yes ☐ No

Centura Health Physician Group

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Review of Systems
PG-2001 rev. 03/17

Patient Label

Please check any symptoms you've experienced over the **LAST ONE TO TWO WEEKS:**

General/ Constitution
- ☐ Activity Change
- ☐ Appetite Change
- ☐ Chills
- ☐ Diaphoresis (Sweating)
- ☐ Fatigue
- ☐ Fever
- ☐ Irritability
- ☐ Unexpected Weight Change

Ear, Nose & Throat
- ☐ Congestion
- ☐ Dental Problems
- ☐ Drooling
- ☐ Ear Discharge
- ☐ Ear Pain
- ☐ Facial Swelling
- ☐ Hearing Loss
- ☐ Mouth Sores
- ☐ Nosebleeds
- ☐ Postnasal Drip
- ☐ Rhinorrhea (Runny Nose)
- ☐ Sinus Pressure
- ☐ Sneezing
- ☐ Sore Throat
- ☐ Tinnitus (Ringing in the Ears)
- ☐ Trouble Swallowing
- ☐ Voice Change

Eyes
- ☐ Eye Discharge
- ☐ Eye Itching
- ☐ Eye Pain
- ☐ Eye Redness
- ☐ Photophobia (Sensitivity to Light)
- ☐ Visual Disturbance (Blurred Vision)

Respiratory
- ☐ Apnea
- ☐ Chest Tightness
- ☐ Choking
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Stridor (Airway Obstruction)
- ☐ Wheezing

Cardiovascular
- ☐ Chest Pain
- ☐ Leg Swelling
- ☐ Palpitations (Irregular Heart Beat)

Gastrointestinal
- ☐ Abdominal Distention (Bloating)
- ☐ Abdominal Pain
- ☐ Anal Bleeding
- ☐ Blood in Stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Rectal Pain
- ☐ Vomiting

Endocrine
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Polydipsia (Abnormal Thirst)
- ☐ Polyphagia (Abnormal Hunger)
- ☐ Polyuria (Abnormal Urination)

Genitourinary
- ☐ Difficulty Urinating
- ☐ Dysuria (Painful Urination)
- ☐ Enuresis (Involuntary Urination)
- ☐ Flank Pain (Low Back Pain)
- ☐ Frequency Change (Urinary)
- ☐ Genital Sores
- ☐ Hematuria (Blood in Urine)
- ☐ Menstrual Problems
- ☐ Pelvic Pain
- ☐ Penile Discharge
- ☐ Penile Pain
- ☐ Penile Swelling
- ☐ Scrotal Swelling
- ☐ Testicular Pain
- ☐ Urinary Urgency
- ☐ Changes in Urine Stream
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge
- ☐ Vaginal Pain

Musculoskeletal
- ☐ Arthralgias (Joint Pain)
- ☐ Back Pain
- ☐ Gait Problems
- ☐ Joint Swelling
- ☐ Myalgias (Muscle Pain)
- ☐ Neck Pain
- ☐ Neck Stiffness

Skin
- ☐ Color Change
- ☐ Pallor (Paleness)
- ☐ Rash
- ☐ Wounds

Allergy/Immunologic
- ☐ Environmental Allergies
- ☐ Food Allergies
- ☐ Immunocompromised

Neurologic
- ☐ Dizziness
- ☐ Facial Asymmetry
- ☐ Headache(s)
- ☐ Light Headedness
- ☐ Numbness
- ☐ Seizures
- ☐ Speech Difficulty
- ☐ Syncope (Loss of Consciousness)
- ☐ Tremors
- ☐ Weakness

Hematologic
- ☐ Adenopathy (Swollen Glands)
- ☐ Bruising Tendency
- ☐ Bleeding Tendency

Behavioral
- ☐ Agitation
- ☐ Behavioral Problems
- ☐ Confusion
- ☐ Decreased Concentration
- ☐ Dysphoric Mood (Mood Changes)
- ☐ Hallucinations
- ☐ Hyperactive
- ☐ Nervousness
- ☐ Anxiety
- ☐ Self Injury
- ☐ Sleep Disturbance
- ☐ Suicidal Thoughts

Any other symptoms: _____

Patient or Guardian Name (please print) _____ Patient or Guardian Signature _____ Date _____

Centura Health
Physician Group

Centura Health

Consent for Medical Treatment
PGCT-001 rev. 04/17

Patient Label

1. **CONSENT FOR HEALTH CARE SERVICES.** I authorize physicians(s), therapists(s), their assistants and/or designees to administer any treatment as may be necessary or advisable in my diagnosis and treatment at Centura Health practices. This authorization includes, but is not limited to, medical services, diagnostic procedures, intravenous therapy, medications, injections, laboratory services, and other services or procedures, which my physician or provider considers necessary in person or telehealth. My health care providers will discuss with me the risks, benefits and alternatives to recommended treatments. I understand that health care services may be rendered by students, interns or residents under supervision. I understand that the Centura Health practice may release copies of my medical records to other physicians, practitioners and healthcare facilities for treatment and other purposes, as permitted by law. I acknowledge that no promises or guarantees have been made to me regarding treatment or services rendered in by the practice. I further acknowledge Centura Health facilities and providers do not provide medical aid in dying medication or related services. I understand that my rights and responsibilities with regard to my care are described in more detail on the Patient Bill of Rights document. I understand that failure to comply with scheduled appointment times will put me at risk for discontinuation of medical care.

2. **NON-CENTURA PRACTITIONERS.** I understand that I may receive services from professionals who provide care to me who are not employees or agents of a Centura Health practice. These professionals may include other physicians requested by my physician to participate in my care as well as radiology, pathology and laboratory services. As a result, I understand that I may receive bills for these services that are separate from the bills I receive from the Centura Health practice. I understand that, in some cases, these non-Centura professionals or facilities may not be participating providers under my insurance plan. I understand it is my responsibility to verify whether professionals providing my care are participating providers under my insurance, and that I may be responsible for any out of network costs incurred due to non-participation.

3. **MEDICARE and/or MEDICAID CERTIFICATION.** I certify that the information given by me in applying for payment under the Medicare and/or Medicaid programs is correct, and I authorize the release of all information needed to act on this request. I request that payment of authorized benefits be made to the practice on my behalf for the charges for which the practice is authorized to bill in connection with these health care services.

4. **FINANCIAL AGREEMENT.** I understand that there is no guarantee of reimbursement or payment from any insurance company or other payer. I understand this Agreement is a contract and that it obligates me to pay all charges for my treatment not paid by my insurer or any other payor source. I understand the practice has pre-determined the charges for certain procedures, supplies, and treatments, that these charges are listed in the Centura Health Physician Group fee schedule and that these prices are incorporated by reference into this Contract. I acknowledge it may not be possible to state in advance which specific supplies and services will be part of my treatment. I agree to pay these current pre-determined rates for each supply and service I receive as part of my treatment. I acknowledge this Contract means I personally have full financial responsibility for, and agree to pay, all charges of the practice and of physicians rendering services not otherwise paid by my health insurance or other payer. I acknowledge that estimated patient responsibility is due at the time of service and that any remaining charges are due and payable upon receipt of the bill. I understand the practice may request and use data from third parties such as credit reporting agencies in order to verify demographic data or evaluate financial options. If payment is not made within 180 days after receipt of the bill, a delinquent charge or interest at the maximum legal rate may be added. I agree to pay all reasonable legal expenses necessary for the collection of any debt or any action on this Contract. I acknowledge and understand that any refund that I may be owed will first be applied to any outstanding balance, and the remainder will be forwarded to the address on file with the practice.

5. **COMMUNICATIONS CONSENT.** By providing my cell or other phone number(s), I expressly consent to receive communications from the practice, its agents (including any collection agencies) or business associates at

Centura Health
Physician Group
Centura Health.

Consent for Medical Treatment
PGCT-001 rev. 04/17

Patient Label

any numbers I provide or that are later acquired, to be used to contact me by live agent, voice mail, text message, using an auto dialer or other computer-assisted technology, pre-recorded message, or by any other form of electronic communication for any purpose, including scheduling, notifications, confirmations, reminders, instructions, accounting, billing, assignment of benefits, and/or collections. I understand that depending on my phone plan, I could be charged for these calls or text messages. I agree to provide new numbers if my numbers change. Providing these numbers is not a condition of receiving healthcare services. I consent to be contacted by regular mail, or by e-mail regarding any matter related to my account by the practice or any entity to which the practice assigns my account, including any collection agency. I also consent to the use of any updated or additional contact information that I may provide by the practice or any entity to which the practice assigns my account. I hereby acknowledge and agree that the practice has not made any implied representations about the charges I am personally obligated to pay.

6. **PREAUTHORIZATION REQUIREMENTS.** I understand that it is my sole responsibility to verify all pre-authorizations are in place and to comply with all requirements of any insurance plan upon which I am relying for coverage of the practice's and physicians' charges. I also understand that my insurance may require an office visit referral from my primary care physician to see a specialist. It is my responsibility to contact my primary care physician and acquire the necessary referral prior to my scheduled appointment. If a referral is not obtained prior to my appointment, I may be financially responsible for the charges incurred during the visit.

7. **ASSIGNMENT FOR DIRECT PAYMENT.** I authorize and direct that payment of any insurance or healthcare benefits otherwise payable to me for health care services or goods be made directly to the practice and my physicians. I understand that I am financially responsible to the practice or my physicians for charges not covered or paid pursuant to this authorization.

8. **ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES.** I acknowledge that Centura Health has offered me a copy of its Notice of Privacy Practices. I understand that the Notice of Privacy Practices is also electronically available on Centura Health's web-site. I understand this acknowledgment in no way affects the care I shall receive.

Acknowledge: (Initials)_____

Practice Representative Comments: _____

I ACKNOWLEDGE I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS AND HAVE RECEIVED A COPY HEREOF. I FURTHER ACKNOWLEDGE THAT I AM THE PATIENT, OR PERSON DULY AUTHORIZED EITHER BY THE PATIENT OR OTHERWISE, TO SIGN THIS AGREEMENT, CONSENT TO, AND ACCEPT ITS TERMS.

SIGNATURE OF PATIENT OR LEGALLY RESPONSIBLE PERSON NAME (PRINT) DATE TIME

RELATIONSHIP / REASON WHY PATIENT IS UNABLE TO SIGN

ADDRESS OF PATIENT

Centura Health Physician Group

Centura Health

Patient Bill of Rights
PGPR-001 rev. 04/17

PATIENT BILL OF RIGHTS

Patient Rights:
Centura Health facilities support the rights of all patients across the lifespan including geriatric, adult, adolescent, pediatric, infant and neonatal populations. These rights may be exercised through the patient individually or through their authorized surrogate decision maker.

You have the right to. . .

1. Be informed of your patient rights in advance of receiving or discontinuing care when possible.
2. Receive care, treatment and visitation regardless of disability, national origin, culture, age, color, race, religion, sex, gender identity, sexual orientation. No one is denied examination or treatment of an emergency medical condition because of their source of payment.
3. Give informed consent for all treatment, procedures, and/or production of recordings, films or other images when used for other than identification, diagnosis or treatment.
4. Be informed of your health status/prognosis, including unanticipated outcomes of care and the treatment and services related to serious preventable adverse events.
5. Participate in all areas of your care plan, treatment, care decisions, and discharge plan.
6. Receive appropriate assessment and prompt management of your pain.
7. Be treated with respect and dignity.
8. Experience personal privacy, comfort and security to the extent possible during your visit/ stay.
9. Experience confidentiality of all communication and clinical records related to your care. You will receive a copy of our Notice of Privacy Practices to inform you how your personal medical information can be used and disclosed and your rights related to your medical information.
10. Be communicated with in a manner you can understand which is tailored your age, language, understanding and ability including access to interpreter services and communication aides, at no cost.
11. Receive care in a safe setting.
12. Be free from all forms of abuse, neglect, mistreatment, or exploitation.
13. Have access to protective services (e.g., guardianship, advocacy services, and child/ adult protective services).
14. Request medically necessary and appropriate care and treatment.
15. Refuse any drug, test, procedure, or treatment and be informed of the medical consequences of such a decision.
16. Consent to or refuse to participate in teaching programs, research, experimental programs, and/or clinical trials.
17. Receive information about Advance Directives. Set up or provide Advance Directives and have them followed.
    Designate an authorized surrogate decision-maker as permitted by law and as needed.
18. Participate in decision-making regarding ethical issues, personal values or beliefs.
19. Know the names, professional status and experience of your caregivers.
20. Have access to your medical records within a reasonable timeframe.
21. Be examined, treated, and if necessary, transferred to another facility if you have an emergency medical condition or are in labor, regardless of your ability to pay.
22. Be informed of the facilities complaint and grievance procedure and whom to contact to file a concern, complaint or grievance. Note: if you have financial issues or questions, please contact Centura Consumer Operations at (303) 715-7000. Toll free: 888-269-7001
    a. Our priority is for you to have a positive patient experience. If your concerns are not being resolved with your immediate care giver or the department manager or administrative staff, please call the Patient /Advocate. They can be reached at 303-643-1000. b. You may also contact The Health Facilities Division of the Colorado Department of Public Health and Environment or the Kansas Department of Health and Environment and the Office of Civil Rights directly regardless of whether you first used the facilities complaint and grievance process.

    The Colorado Department of Public Health and Environment
    4300 Cherry Creek Drive South Denver, CO 80222-1530
    Telephone: (303) 692-2827

    The Kansas Department of Health and Environment
    1000 SW Jackson, Topeka, Kansas 66612
    Telephone: (785) 296-1500

    The Office for Civil Rights
    Department of Health and Human Services
    999 18th Street, South Terrace, Suite 417
    Denver, Colorado 80202

Telephone: 303-844-2024
TDD 303-844-3439
Fax: 303-844-2025

You also have the right to file a complaint with the appropriate oversight boards including the Colorado Board of Medical Examiners, the Colorado Dental and Podiatry Boards and the Colorado Department of Regulatory Agencies. For Kansas hospitals, this includes the Kansas State Board of Healing Arts, the Kansas Board of Nursing and the Kansas office of Health Occupations Credentialing. Contact information will be provided by the facility patient advocate upon request.

Patient Responsibilities:
You have the responsibility to . . .

1. Ask questions and promptly voice concerns.
2. Give full and accurate information as it relates to your health, including prescription and non-prescription medications.
3. Report changes in your condition or symptoms, including pain, and request assistance of a member of the health care team.
4. Educate yourself. Learn about the medical tests that are being performed and understand your treatment plan.
5. Follow your recommended treatment plan.
6. Be considerate of other patients and staff.
7. Secure your valuables.
8. Follow facility rules and regulations.
9. Respect property that belongs to the facility or others
10. Understand and honor financial obligations related to your care, including understanding your own insurance coverage.

Signature: _____
Date: _____ Time: _____

Patient Barcode Label
Must be placed in this space