TotalWell Health Clinic

A MULTISPECIALTY ORGANIZATION WITH A SINGULAR FOCUS: YOU

TotalWell Health Clinic
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PATIENT RIGHTS AND RESPONSIBILITIES

At **TotalWell Health Clinic**, we are committed to providing high-quality healthcare in a respectful, compassionate, and professional manner. We believe that understanding your rights and responsibilities as a patient will help ensure that you have a positive experience with our healthcare services.

PATIENT RIGHTS

As a patient, you have the right to:

1. **Respectful Care**:
   - Receive care that is considerate, respectful, and free from discrimination based on race, ethnicity, gender, age, sexual orientation, disability, or any other factor.
2. **Privacy and Confidentiality**:
   - Have your personal health information kept confidential in accordance with **HIPAA** (Health Insurance Portability and Accountability Act) and other applicable privacy laws.
3. **Access to Information**:
   - Be provided with information regarding your diagnosis, treatment options, and the risks and benefits of treatment in a way that you can understand.
4. **Informed Consent**:
   - Make decisions regarding your healthcare, including the right to refuse or consent to any treatment or procedure.
5. **Participation in Care**:
   - Participate in decisions about your care, including treatment plans and alternative options, and ask questions if you don’t understand the plan or procedure.

6. **Second Opinion**:
    - Request a second opinion regarding your diagnosis or treatment plan, and choose to seek care from another physician or specialist.
7. **Access to Medical Records**:
    - Access your medical records upon request, in accordance with applicable laws, and request corrections to any inaccurate information.
8. **Timely Care**:
    - Receive timely, appropriate, and safe medical treatment without unnecessary delays.
9. **Right to File Complaints**:
    - File a grievance or complaint if you feel that your rights have been violated or if you are dissatisfied with the care or service provided, and to have that complaint addressed in a timely manner.

PATIENT RESPONSIBILITIES

As a patient, you have the responsibility to:

1. **Provide Accurate Information**:
    - Provide truthful and accurate information regarding your health history, medications, allergies, and any other pertinent medical information.
2. **Follow Treatment Plans**:
    - Follow the treatment plans or instructions provided by your healthcare provider, including taking medications as prescribed and attending follow-up appointments.
3. **Ask Questions**:
    - Ask questions if you do not understand your diagnosis, treatment plan, or any instructions related to your care.
4. **Respect Others**:
    - Treat healthcare providers, staff, and other patients with courtesy and respect, ensuring a positive and collaborative healthcare environment.
5. **Financial Responsibilities**:
    - Ensure payment for healthcare services rendered, including paying any co-pays, deductibles, or out-of-pocket expenses. Notify the office if you have any issues with your financial responsibility.
6. **Keep Appointments**:
    - Arrive on time for scheduled appointments. If you need to cancel or reschedule, do so at least 24 hours in advance, whenever possible.

7. **Notify About Changes**:
    - Inform your healthcare provider about any changes to your health, medications, or treatment plans, including changes in insurance or contact information.
8. **Follow Office Policies**:
    - Adhere to the office policies, including providing the necessary documentation for insurance claims, completing required forms, and adhering to clinic hours and protocols.
9. **Be Honest About Concerns**:
    - Be open and honest with your healthcare provider regarding any concerns about your care, treatment options, or potential risks.

ACKNOWLEDGEMENT

By signing below, I acknowledge that I have received a copy of my **Patient Rights and Responsibilities** and understand the rights I have as a patient, as well as my responsibilities in participating in my care.

- **Patient's Name (Printed)**: ______________________________
- **Patient's Signature**: __________________________________
- **Date**: ____

If the patient is a minor or unable to sign, the following section must be completed:

- **Legal Guardian's Name (Printed)**: _______________________
- **Legal Guardian's Signature**: ___________________________
- **Date**: ____

FOR OFFICE USE ONLY

- **Received By**: ________________________________
- **Date**: _______________________________________