

DATE: _____

BridgeCare Specialists

Registration, Medical Consents, Policies

Name _____

Date of Birth _____

Permanent Michigan Address _____

Phone Number _____

I have the capability to do a telehealth (video conferencing) visit? _____ Y / N

Reasons for requesting BridgeCare services _____

I understand BridgeCare provides a temporary primary care service lasting up to 60 days. I understand if I have any medication or medical needs during the 60 days, I can call BridgeCare to help me. _____ Y / N

I know I must make an appointment with a long term primary care doctor before 60 days are completed. _____ Y / N

Primary Insurance Name _____

Will your care be billed to Auto Insurance? _____ Y / N IF YES, NUMBER: _____

Next scheduled doctor's appointment? _____

Do you have a primary care provider already? If so, please list their name. _____

Consent for Medical Treatment via Telehealth

BridgeCare Specialists

OVERVIEW

The primary purpose of BridgeCare's Discharge Clinic is to assist patients in their recovery after discharge from the hospital or rehabilitation center. Our services are primarily reserved for the following:

- A patient without a primary care physician
- A patient with a primary care physician but is unable to schedule a visit within 13 days of coming home.
- A patient specifically requesting BridgeCare discharge services. They must still not have a primary

care appointment within the first 14 days of coming home.

If a patient has a doctor willing to offer a visit within the first 14 days, authorize home care orders, refill medications, and manage their medical needs from the moment of discharge, the patient will likely not need BridgeCare's discharge services. A patient is exempt from BridgeCare's discharge services if they have a scheduled appointment with their primary care provider within the first 14 days.

VISIT REQUIREMENTS

A patient must have the following to become a patient of BridgeCare and to receive medical care/services

- Reliable video/audio
- Reliable internet connection

If these requirements cannot be met, there may attempt to find assistance from visiting home health staff if available. Patients must have a video visit to qualify for home health because a face-to-face visit is required by insurance. If that also fails, patients will be given the choice to complete a phone visit outside of insurance coverage.

If a patient's care needs extend beyond 8 weeks, they can request an extension of services. Extensions are at the discretion of the BridgeCare provider and cannot be guaranteed.

SERVICES

BridgeCare provides primary care and extensivist care for patients leaving the hospital. We continue many of the hospital treatments and manage these at home to allow patients to avoid being admitted to a short-term nursing home. BridgeCare refills medications completes and follows orders for labs/imaging and manages the overall needs of a patient to prevent avoidable admissions to the ER or hospital.

BridgeCare provides all medical services using telehealth (video conferencing). Patients do not need to leave their homes and will not be in the same room as the BridgeCare doctor during appointments.

Patients will need access to the internet (via a cell phone or computer) to complete their first onboarding visit. Follow-up visits will be completed via video/audio or by audio (phone).

Once a patient's 60-day treatment plan is completed, their care will be transferred to a doctor of their choosing. If a patient's care needs extend beyond 60 days, they can request an extension of services which will be determined case by case.

I agree:

- To evaluation and treatment by providers and other healthcare professionals at BridgeCare Specialists. This may include shared medical appointments, telemedicine, videotaping, and audio devices. These tools may be used to treat/diagnose or for procedures to be performed for medical, scientific, and/or personal safety.
- Once discussed and agreed upon, I understand the provider may change my care to benefit my life or health.

I understand that:

- I can ask questions.
- I am aware the practice of medicine and surgery is not an exact science. No promises or guarantees can be made about the results of my treatment, care, or exact prognosis.
- Students and staff may see me and look at my medical record for teaching or research purposes.
- BridgeCare Specialists will not tolerate discrimination against my provider, other healthcare professionals or staff because of race, color, gender, national origin, age, disability, sex or any other basis prohibited by federal, state or local law.
- Should my condition require referral to a specialist, I understand I will be asked my choice of a provider. I will have the opportunity to have BridgeCare Specialists contact the provider of my choice or if I do not have a preference, an independent provider can be recommended by BridgeCare Specialists.
- BridgeCare Specialists may release my medical information to:
 - Insurance companies, health plans, and administrators for payment of services I receive to
 - government agencies like Medicare and Medicaid or as required by law, my providers and others involved in my care now or in the future,
 - my employer, if the records are related to care or services paid for by my employer, or for other purposes that are allowed under law.
 - any person or entity responsible to paying all or part of my bill.

NOTICE OF NONDISCRIMINATION

BridgeCare Specialists complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex. BridgeCare Specialists does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, or any other basis prohibited by law.

PRIVACY NOTICE

I agree to allow BridgeCare Specialists to take my picture and save it to my electronic medical record. I

understand that BridgeCare Specialists will use this picture for identification purposes and to indicate a face-to-face appointment has taken place as required by insurance for billing.

I understand BridgeCare Specialists will keep my medical information according to state law, federal law, and policy. I also understand that my medical information may be stored electronically and may be sent to or received from other healthcare providers and/or payers electronically. This includes my diagnosis (what is wrong with me), treatments (what is being done to make me better), and medicine or prescription information. This will also include any details about my mental health, infectious diseases (like HIV), and other problems like drug or alcohol use disorder.

I authorize my protected health information (PHI) to be sent to a patient portal account I can account. This patient portal is a secure internet portal that allows me to see, receive, and manage information about my health.

In some cases, BridgeCare Specialists is required by law to report medical information to an agency like the health department. This may include information about HIV, TB, and other diseases.

If I am transferred to another facility, BridgeCare Specialists' providers/resident providers may access my medical records to follow up on my care and/or use the information for medical research.

I have rights and responsibilities when I receive services. I understand I have access to a copy of the Notice of Privacy Practices and have had an opportunity to ask questions about the information in the Notice. I have read this form and I understand it. All my questions have been answered.

I have read BRIDGECARE SPECIALISTS's Consent to Treat and by signing below, I indicate that I understand and agree to comply with the policy. I understand that failure to comply will result in the interruption of my treatment until my account is in good standing.

FINANCIAL

As a potential patient of BridgeCare, I understand that paying my bill is a part of my treatment process and it is important that I understand the following:

- Equal Pricing for Services:

The fee for any medical service provided to me is based on a standard rate, regardless of the payment method or source. This means that the amount billed to me directly, if I am self-paying, is the same as the amount billed to any insurance company or third-party payer on my behalf. BridgeCare believes in transparent billing. You may request a current fee list before your first billable visit.

- Understanding Financial Responsibility:

I understand that I am responsible for payment in full for services provided, whether through insurance or out-of-pocket. In cases where my insurance company does not cover the full amount or denies the claim, I acknowledge my responsibility to cover the remaining balance.

- Payment Expectations:

Payments for services are expected at the receipt of a bill unless other arrangements have been made in advance. If I am unable to make timely payments, I understand that I may be subject to additional fees or charges.

- o Co-pays must be paid at the time of my visit. BRIDGECARE SPECIALISTS accept payment in the form of mailed checks and/or credit cards. Deductibles and co-pays are the responsibility of the patient and must be paid. I understand that payment arrangements can be made based on financial need.
- o If my insurance requires a referral from my primary care physician, it is my responsibility to obtain this referral.
- o Medicare requires a 20% co-pay at the time of the visit unless the patient holds secondary insurance.
- o If the patient's insurance company fails to pay the medical bill within 90 days due to reports of inaccurate information or non-covered service, the bill will be transferred to the patient.
- o If I do not have insurance, BRIDGECARE SPECIALISTS has payment options available upon request.
- o If payments have not been received as per the payment schedule agreement or if the account is in outstanding payments for 90 days, patient account information will be turned over to a collection agency, unless prior arrangements have been made. The patient shall be responsible for all costs of collection.
- o If a patient fails and/or refuses to make all payments due to BRIDGECARE SPECIALISTS, treatment may be interrupted or placed on hold until the balance is paid in full.

By signing below, I understand and acknowledge that I have received the above information and that any questions have been answered to my satisfaction. By signing I also indicate that I understand and agree to comply with the policy.

CONTROLLED SUBSTANCE POLICY

BridgeCare Specialists adhere to a practice policy that improves the quality of functioning while minimizing the risk for misuse, abuse, and dependency of any medication that is considered a controlled substance. This policy is in place to protect the safety of our patients and the community. All controlled medication will be prescribed only at levels that are considered safe and will be monitored closely throughout the course of treatment. Any patient who is on higher doses of a controlled medication than our practice policy allows will be given a tapering plan by their provider that will safely decrease the dose to an acceptable level. All patients who are being considered for the administration of a controlled substance or are currently being prescribed a controlled substance must agree to BRIDGECARE SPECIALISTS controlled substance policy.

Patients on controlled medication treatment are required to sign the following agreement indicating that they have been made aware of and understand the following conditions.

1. Patients are required to disclose if they are prescribed any new medication by other providers while being treated with a controlled medication.
2. Patients are expected to comply with all recommendations made by the provider that are expected to improve treatment outcomes associated with prescribing a controlled medication.
3. BridgeCare cannot provide any early refill request for controlled medication or for any replacement of lost or stolen controlled medication. In addition, any reports of lost or stolen medication will require a police report to be obtained. It is the patient's responsibility to keep their medication in a safe and protected location.
4. Patients are required to obtain the prescription only at a pre-agreed pharmacy location.
5. Patients can expect to be asked to submit to a urine or blood test if they take a controlled substance medication for longer than two weeks. Testing positive for any illicit drugs or any medication that is not being prescribed, or indication that the controlled medication is not being taken as prescribed is a violation of this agreement and may result in the discontinuation of the medication and/or discharge from the practice.
6. Patients must maintain all scheduled appointments and, if unable to attend the scheduled appointment. Controlled medications are not typically prescribed for more than seven days without the patient following up with the provider for another refill. Repeatedly missing appointments will be considered a violation of this agreement as it makes it difficult to safely manage the controlled medication.
7. Patients are required to disclose if they are prescribed any new medication by other providers while being treated with a controlled medication.
8. Any concerns that the controlled medication is being diverted will result in discontinuation of the controlled medication and/or discharge from the practice.
9. Refills for controlled medication will be made only during regular office hours. There will be no refills after office hours, on weekends, or during holidays. A minimum of 48 hours notice is required for controlled medication refills to ensure sufficient time to review the request.
10. All sedatives and benzodiazepines are to be prescribed in a quantity of not more than 15 tablets per month.

FORM COMPLETION POLICY

BridgeCare Specialists receives many requests for the completion of paperwork that require increased time and resources more than what is normally needed to complete the medical record. Since all forms require a legal signature, the provider is personally responsible for the accuracy of the information provided. As a result, the completion of forms requires careful consideration and a considerable amount of time. Therefore, it is our office policy for the completion of all requested forms to be done during an office visit.

If an office visit cannot be accommodated to complete a form, BridgeCare charges \$50 for the completion of each form or request.

The following forms will be assessed a fee for completion as indicated above:

- FMLA
- Employment short-term/long-term disability Workers' compensation
- Letter of condition School forms
- Miscellaneous patient requests

Instructions for completion of paperwork:

1. Requested forms must be submitted well in advance of when they are needed to allow for adequate time to review the medical record. All form requests must be addressed to the provider directly.
2. Patients must complete all the information on the forms prior to giving them to the office.
3. Payment is required prior to the completion of all forms not completed during an office visit. We will complete the form and fax it to the designated recipient (or return it to you if you prefer) within 5-7

business days of receipt of payment.

4. Completing certain forms may require updating your medical information. In such cases, you will be requested to make an appointment prior to the completion of such forms.

PROTECTED TEXT/EMAIL COMMUNICATION AGREEMENT

BridgeCare Specialists, as a virtual company, communicate with me regarding my Protected Health Information and/or Personally Identifiable Information (Confidential Information) using text messaging and/or email.

I understand:

- BRIDGECARE SPECIALISTS is not responsible for the security of my text messages and/or email
- Text messages and/or emails can be intercepted, spied upon, and otherwise accessed without my consent. BRIDGECARE SPECIALISTS can provide no protections to any communications transmitted to me.
- It is my responsibility to inform BRIDGECARE SPECIALISTS of changes to my text message number and/or email address. BRIDGECARE SPECIALISTS is not responsible for any disclosures that occur because I don't tell BRIDGECARE SPECIALISTS about these changes.
- I may have limitations to my texting or data plan through my provider and any overage charges are not the responsibility of BRIDGECARE SPECIALISTS.
- I may opt out of text messaging and/or email communication at any time in writing. I understand the above statements and with my signature opt into text messaging communication. This consent shall remain in effect until revoked in writing.

TERMINATION POLICY

It is the policy of BRIDGECARE SPECIALISTS, its practices, and physicians/providers to maintain a therapeutic and trusting relationship with all patients. When such a relationship has not been formed or the relationship with a patient is no longer proceeding in an effective manner, the attending provider may terminate his/her relationship with the patient which would include ALL members of the patient's family and it would also include being seen by any other provider in this practice. Any such termination shall be carried out within the bounds of applicable state and federal laws, rules, regulations, and professional guidelines such as the American Medical Association guidelines. If efforts to rehabilitate the relationship are not appropriate or unsuccessful, the criteria for terminating a provider-patient relationship require careful documentation in the patient's record. Although the following list is not exhaustive, it is generally appropriate to end a relationship under the following circumstances:

- Treatment nonadherence: The patient does not or will not follow the treatment plan or the terms of a pain management contract or discontinues medication or therapy regimens prior to completion.
- Follow-up noncompliance: The patient repeatedly cancels follow-up visits or fails to keep scheduled appointments with providers or consultants.
- Office policy nonadherence: The patient fails to observe office policies, such as those implemented for prescription refills or appointment cancellations or refuses to adhere to mandated infection-control precautions.
- Verbal abuse or violence: The patient, a family member, or a third-party caregiver is rude, uses disparaging or demeaning language, or sexually harasses office personnel or other patients, visitors, or vendors; exhibits violent or irrational behavior; makes threats of physical harm; or uses anger to jeopardize the safety and well-being of anyone present in the office.
- Nonpayment: The patient owes a backlog of bills and has declined to work with the office to establish a payment plan or has discontinued making payments that had been agreed on previously.
- Inappropriate or criminal conduct: The patient exhibits inappropriate sexual behavior toward providers or staff or participates in drug diversion, theft, or other criminal conduct involving the practice.

I have read BRIDGECARE SPECIALISTS's consents and policies. By signing below, I indicate that I understand and agree to comply with the consents and policies. All my questions have been answered to my satisfaction. I understand that failure to comply will result in the interruption of my treatment until my account is in good standing. I understand that violation of the practice's consents and policies can result in discontinuation of the controlled medication and/or potential discharge from the practice.

Patient Name

Patient Date of Birth

Patient Authorized Signature

Release of Information

AUTHORIZATION TO DISCLOSE/RECEIVE HEALTHCARE INFORMATION

I hereby authorize disclosure of information in the medical record of the patient identified above which includes information that may be stored in a paper and /or another electronic format. Such records may contain information on demographics; financial/insurance information; general medical care; alcohol and drug abuse treatment; psychiatric treatment; behavioral or mental health treatment; HIV or AIDS: AIDS-related treatment; sexually transmitted diseases or infections venereal disease; tuberculosis; hepatitis. Disclosure shall be limited to the listed entities and to the information obtained during treatment.

I hereby authorize BridgeCare Specialists to obtain information from external care providers for care coordination, including hospitals, PCP, therapists, home health, specialists & other care providers.

The following information is specifically requested:

- **Discharge Summary & Progress Notes (signed by a medical provider)**
- **Patient Registration Information**
- **Laboratory/Imaging Results**

The Purpose for Disclosure: **Medical Care, Care Planning, Insurance Verification, Coordination of Care, Referral Purposes**

The dates of service being requested: **Time frame of most recent inpatient care episode (Admission to discharge)**

Disclosure Format: **Fax or Email or Secure online portal**

Authorization is valid only if received within 90 days of being signed and will expire within one year from the date of signature or if services are terminated prior to the one year of if otherwise specified:

Unless otherwise specified in writing:

I may revoke this authorization at any time by submitting a written request or through verbal indication.

Revocation will not apply to information disclosed prior to receiving notification of revocation.

I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy laws.

I have carefully read and understood this authorization and have had any questions answered to my satisfaction. By signing below, I do hereby expressly and voluntarily authorize the disclosure of the above information regarding my health to BridgeCare Specialists.

By signing below, I understand and acknowledge that I have received the above information and that any questions have been answered to my satisfaction. By signing I also indicate that I agree for BridgeCare to receive and disclose health information to best serve my medical needs.

Name

Date

Signature

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

YOUR RIGHTS

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- ONLY if you pay for a service or health care item out-of-pocket, in full, at the time of service, can we comply with your request NOT to share that information for the purpose of payment or our operations with your health insurer. (i.e. - comply with your request not to file your claims to your insurance company). Otherwise, we will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- If you believe your rights have been violated, start by contacting us. You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share.

- If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
- In these cases, you have both the right and choice to tell us to:
 - o Share information with your family, close friends, or others involved in your care
 - o Share information in a disaster relief situation
 - o Contact you for fundraising efforts

If you are not able to tell us your preference, for example, if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

Help with public health and safety issues

- We can share health information about you for certain situations such as preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; and, preventing or reducing a serious threat to anyone’s health or safety.

How else can we use or share your health information?

- We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research.

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you for workers' compensation claims, for law enforcement purposes, or with a law enforcement official. We can also use or share health information about you with health oversight agencies for activities authorized by law for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Patient Rights and Responsibilities

You have the right to:

- Be treated in a dignified and respectful manner and receive reasonable responses to reasonable requests for service.
- To effective communication that provides information in a manner you understand, in your preferred language with provisions of interpreting or translation services, at no cost, and in a manner that meets your needs in the event of vision, speech, hearing, or cognitive impairments. Information should be provided in easy-to-understand terms that will allow you to formulate informed consent.
- Respect for your cultural and personal values, beliefs, and preferences.
- Personal privacy, the privacy of your health information and to receive a notice of the facility's privacy practices.
- Pain management.
- Accommodation for your religious and other spiritual services.
- To access, request an amendment to, and obtain information on disclosures of your health information in accordance with law and regulation within a reasonable time frame.
- To have a family member, friend, or other support individual be present with you during the course of your stay, unless that person's presence infringes on other's rights, or safety or is medically contraindicated.
- Care or services provided without discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.
- Participate in decisions about your care, including developing your treatment plan, discharge planning, and having your family and personal physician promptly notified of your admission.
- Select providers of goods and services to be received after discharge.
- Refuse care, treatment, or services in accordance with law and regulation and conclude the visit against the advice of the physician.
- Have a surrogate decision-maker participate in care, treatment, and services decisions when you are unable to make your own decisions.
- Receive information about the outcomes of your care, treatment, and services, including unanticipated outcomes.
- Give or withhold informed consent when making decisions about your care, treatment, and services.
- Receive information about benefits, risks, and side effects of proposed care, treatment, and services; the likelihood of achieving your goals and any potential problems that might occur during recuperation from proposed care, treatment, and service and any reasonable alternatives to the care, treatment, and services proposed.
- Give or withhold informed consent to recordings, filming, or obtaining images of you for any purpose other than your care.
- Participate in or refuse to participate in research, investigation, or clinical trials without jeopardizing your access to care and services unrelated to the research.
- Know the names of the practitioners who have primary responsibility for your care, treatment, or services and the names of other practitioners providing your care.
- Formulate advance directives concerning care to be received at end-of-life and have those advance directives honored to the extent of the facility's ability to do so in accordance with law and regulation. You also have the right to review or revise any advance directives.
- Be free from neglect, exploitation; and verbal, mental, physical, and sexual abuse.

- An environment that is safe, preserves dignity, and contributes to a positive self-image.
- Be free from any forms of restraint or seclusion used as a means of convenience, discipline, coercion or retaliation; and to have the least restrictive method of restraint or seclusion used only when necessary to ensure patient safety.
- Access protective and advocacy services and receive a list of such groups upon your request.
- Receive the visitors whom you designate, including but not limited to a spouse, a domestic partner (including same-sex domestic partner), another family member, or a friend. You may deny or withdraw your consent to receive any visitor at any time. To the extent this facility places limitations or restrictions on visitation; you have the right to set any preference of order or priority for your visitors to satisfy those limitations or restrictions.
- Examine and receive an explanation of the bill for services, regardless of the source of payment.

You have the responsibility to:

- Provide accurate and complete information concerning your present medical condition, past illnesses or hospitalization and any other matters concerning your health.
- Tell your caregivers if you do not completely understand your plan of care.
- Follow the caregivers' instructions.
- Follow all medical center policies and procedures while being considerate of the rights of other patients, medical center employees, and medical center properties.
- You also have the right to:

Lodge a concern with the state, whether you have used the hospital's grievance process or not. If you have concerns regarding the quality of your care, or coverage decisions or want to appeal a premature discharge, contact the State Quality Improvement Organization (QIO).

By signing below, I confirm I have received a copy of the Notice of Privacy Practices and Patient Rights and Responsibilities. I confirm I understand these forms and have no further questions.

Signature