Inova™

3RIGHTS

Patients' Rights and Responsibilities:

The following list of rights and responsibilities does not presume to be all-inclusive, but is intended to show our concern for you and to emphasize the need for observance of these rights and responsibilities.

As a patient, you have the right to . . .

- Considerate and respectful care provided in a safe environment, free from all forms of abuse, harassment or discrimination.
- Participate in the development and implementation of your plan of care and actively participate in decisions regarding your medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment.
- Upon your request, have a family member, chosen representative and/or your own physician notified promptly of your admission to the facility.
- Receive visitors designated by the patient, including the right to withdraw or deny such consent at any time.
- Not undergo any procedure unless you or your legally authorized representative gives voluntary, competent and understanding consent.
- Be well informed about your illness, possible treatments, and likely outcomes of care (including unanticipated outcomes) and to discuss this information with your doctor. You have the right to designate someone to receive this information on your behalf.
- Have a designated representative present for any updates provided regarding your routine course of care. In an emergency, when you lack decision-making capacity and the need for treatment is urgent, the information is made available to another person on your behalf. We will communicate to your designated representative any significant changes in your status, such as transfer to a higher level of care or need for unplanned emergency procedures as soon as clinical care allows.
- Have an advance directive (such as health care proxy, organ donation or living will) and the expectation that Inova will honor the intent of the directive to the extent permitted by law and facility policy.
- Confidentiality of your treatment records, unless you have given permission to release information or if reporting is permitted or required by law.
- Leave the facility even against the advice of your physician.
- Know the name of the physician, clinical psychologist, or other practitioner who has primary responsibility for coordinating your care, treatment, or services.
- Be told of alternatives when facility care is no longer appropriate.
- Be informed by your physician of the continuing healthcare requirements following your visit to or discharge from the facility.
- Access to interpreter services free of charge.
- The privacy of your medical information. Disclosures regarding you, your rights and our obligations regarding the use and disclosure of your medical information are made in accordance with our Notice of Privacy Practices.
- Have a designated support person if you have a diagnosed disability and need ongoing support and assistance for that disability.
- If you have a complaint or wish to file a grievance, call Patient Relations at 703-205-2175. If you believe that Inova has failed to provide these services or discriminated on the basis of race, color, national origin, age, religion, culture, sex, gender, gender identity or expression, sexual orientation, marital status, disability, military status, pregnancy or childbirth, or related medical conditions, you can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Patient Relations staff or manager is available to help you.

  If you have a complaint or wish to file a grievance you may also contact the Virginia Department of Health, Office of Licensure and Certification, 9960 Mayland Drive, Suite 401, Richmond, VA 23233, or call 800-955-1819. Additionally, you may contact the Office of Quality Monitoring, The Joint Commission, One Renaissance Blvd., Oakbrook Terrace, IL 60181, or at www.jointcommission.org using the "Action Center" on the home page of the web site.

As a patient, you are responsible for:

- Providing complete and accurate information about your health, including past illnesses, facility stays, use of medications, and other matters relating to your health.

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Inova

Patient Rights and Responsibilities

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH

☐ Outpatient Location: _____

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As a patient, you are responsible for: (continued)

- Asking questions when you do not understand what you have been told about your care or what you are expected to do.
- Following the care, service or treatment plan developed for you.
- Understanding that patients may not photograph, videotape, record or film any person or practice on Inova property without prior permission from Inova. This applies to your visitors as well.
- Recognizing that all medications you will take while in the facility will be prescribed by your facility licensed practitioner, dispensed by the facility Pharmacy and administered by a nurse or therapist.
    - Patients may not take their own medications, unless allowed by facility protocol.
    - Patients may not keep medications at their bedside.
- Telling your doctor if you believe you cannot follow through with your treatment plan and understanding the possible results if you decide not to follow the recommended treatment plan.
- Providing the facility with accurate contact and billing information.
- Having detailed knowledge of your health insurance coverage including deductibles, co-pays, and network coverage, including any patient financial responsibilities.
- Recognizing that the facility cannot accept responsibility for any personal property.
- Being respectful of staff, patients and facility property and following facility rules and regulations. This applies to your visitors as well.
- Abiding by all safety expectations. Inova has zero-tolerance for:
    - Biased, racist, or discriminatory language or behavior from patients and visitors.
    - Destructive or disrespectful patients and visitors.
    - Contraband or weapons of any kind being brought in by patients or visitors. This includes but is not limited to illegal substances, drug paraphernalia, controlled substances, firearms, knives, sharps such as shivs, razors or box-cutters, tasers, or other instruments intended to cause harm.

Notice of Deemed Consent for Infectious Disease Testing:

Virginia Code Section 32.1-45.1 provides that when either a person providing health care or a patient is directly exposed to the bodily fluids of the other in a way that may transmit human immunodeficiency virus (HIV) or Hepatitis B or C virus, such other person is deemed to have consented to testing for those viruses and to release of the test results to the person so exposed, and actual consent is not required.

Consent for Treatment:

- I hereby authorize medical treatment by the physician, the clinical staff and technical employees assigned to my care or the care of my minor child or the patient named below.
- I authorize my treating providers to order any ancillary services, such as laboratory or radiology tests, or any other services or treatments deemed necessary for my care and safety. Laboratory tests may include testing for HIV and I understand that I have the right to decline testing for HIV.
- I understand that Inova utilizes an electronic medical record system.
- I authorize the release of my prescription history to my Inova physician from any pharmacy or drug monitoring agency.
- I understand that certain critical patient procedures and care may be digitally recorded for internal quality improvement purposes.
- By signing below, I acknowledge and accept the patient rights and responsibilities outlined above and consent to treatment.

Patient/Guardian/etc. (signature)	**Patient/Guardian/etc.** (print name)	Date	Time

Relationship to Patient (if not signed by patient)

Witness (signature)	**Witness** (print name)	Date	Time

Interpreter Information (To be completed by Inova staff, if applicable): ☐ **No Interpreter Required**

☐In person ☐Telephonic ☐Video Interpreter name/ID number (if applicable) _____

☐Patient/Designated Decision Maker was offered and refused interpreter ☐Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

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