MISSOURI DELTA
WOMEN'S CARE CENTER

Dear New Obstetrics Patient,

Thank you for choosing Missouri Delta Women's Care Center!

To save time during your first appointment, feel free to print and fill out the following forms and bring with you to your appointment.

☐ Patient Information ☐ Patient Assessment ☐ Worksheet for First OB Visit
☐ Consent for Treatment ☐ Acknowledgement of Privacy Practices

Also, please remember to bring with you to the appointment:

- Your insurance cards and photo identification (preferably driver's license).
- Any prescription medicines you are taking (in the original packaging).
- Any over-the-counter supplements.

The above items are ***REQUIRED*** in order to be seen by the medical provider. Not bringing the above listed may result in your appointment being rescheduled.

We look forward to meeting you. If you have any questions, please let us know!

Fallan Mayabb, MD, FACOG
Jennifer Nickell, MD, FACOG
David Stroud, MD, FACOG
Jane Eaves, WHNP-BC
Sherry Welker, WHNP-BC

1013 N. Main
Sikeston MO 63801
(573) 472-7535
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MISSOURI DELTA PHYSICIAN SERVICES
SIKESTON, MISSOURI

PATIENT INFORMATION
(to be completed by patient)

Date: _____

Name: First _____ Middle _____ Last _____

Date of Birth _____ Age _____ Sex _____ Marital Status _____ Race _____ Religion _____

Social Security Number _____ Maiden/Other Name _____ Family Doctor _____

Patient Address _____

City/State/Zip _____ Home Phone _____ Cell Phone _____

Email Address _____

Patient Employer _____

Address: _____

City/State/Zip _____ Phone _____

Preferred Pharmacy _____

Next of Kin

Spouse/Father/Mother Name _____ D.O.B. _____

(Spouse or Parent if Patient is under 18 years of age)

S.S.N.# _____ Cell Phone Number _____

Address if different from above _____

Spouse/Parent Employer _____

Address _____

City/State/Zip _____ Phone _____

Closest Relative NOT Living With You

Name _____

Address _____

City/State/Zip _____ Phone _____

Relationship to Patient _____

Person to Notify (other than Next of Kin)

Name _____

Address _____

City/State/Zip _____ Phone _____

Relationship to Patient _____

MISSOURI DELTA PHYSICIAN SERVICES
SIKESTON MISSOURI
Patient Assessment

DATE: _____ NAME: _____ DOB: _____

Do you have an Advance Directive (i.e. Living Will, Power of Attorney, etc)? Yes No

If yes, which one and do we have a copy? _____

Please check any immunizations you've had:

Flu Vaccine □ **No** □ **Yes** If yes, when? _____ Where? □ at MDMC □ other facility

HPV Vaccine □ **No** □ **Yes** If yes, when? _____ Where? □ at MDMC □ other facility

Pneumonia Vaccine □ **No** □ **Yes** If yes, when? _____ Where? □ at MDMC □ other facility

TDAP Vaccine □ **No** □ **Yes** If yes, when? _____ Where? □ at MDMC □ other facility

□ Other: _____ Where? □ at MDMC □ other facility

Do you smoke? _____ **If yes, how long?** _____ **How many packs per day?** _____

Female
When was your last?
Mammogram? _____
Pap Smear? _____
Colonoscopy? _____

Male
When was your last?
PSA? _____
Colonoscopy? _____

If Diabetic:
When was your last?
Hgb A1C? _____ Foot Exam? _____ Eye Exam _____

Have you had any visits to the Emergency Room or Hospital stay since your last office visit?

If yes, When? _____ Why? _____

Do you see other physicians/providers besides your Primary Care Physician?

If yes, Name of Provider/Specialty _____

Reason? _____

Are you having any pain? Yes No Please circle the number that describes your pain.

Location: _____

0	1	2	3	4	5	6	7	8	9	10
None		mild		mod		severe		very severe		worse

Have you had any falls that have resulted in injury in the past year? _____

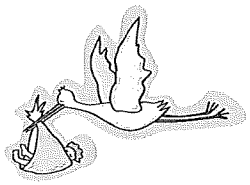
If yes, How Many? _____ Type of injury? _____

Do you have any of the following?

□ CAD (Coronary Artery Disease) □ Diabetes □ Hypertension

What level of education have you completed? _____

MISSOURI DELTA
WOMEN'S CARE CENTER



Patient Worksheet for First Obstetrical Visit

Name:_____DOB:_____Date:_____

Primary Care Provider:_____Preferred Pharmacy:_____

GYNECOLOGY HISTORY

Menstrual History:

First day oflast period:___/___/_____ Is this a sure date?____Yes____No

Were you on any birth control at the time of conception?____Yes____No

Sexual History:

Age at first Intercourse _____

Are your partner(s):___Male___Female___Both

Do you or your partner have more than one partner?____No____Yes____I Don't Know

Women's Health Maintenance (provide dates if known/applicable)

Last Pap: _____

History of abnormal Paps?____Yes___No
If yes, any of the following treatments:

Colposcopy _____

LEEP _____

Cryo (freezing) _____

Cone biopsy _____

OBSTETRICAL HISTORY

Total Pregnancies_____Term Deliveries_____Preterm Deliveries_____Miscarriages_____

Ectopics_____Abortions_____Living Children_____

Past Pregnancies:

	Date	Weeks	Weight	Gender	Type of Delivery	Anesthesia	Complications
Example:	5/4/2014	37	7 lb 8 oz	F	Vaginal	Epidural	Gestational Diabetes

MEDICAL HISTORY

Have you ever had the chicken pox or chicken pox vaccine?____Yes___No___I don't know

List all major medical problems ___None

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

SURGICAL HISTORY

List all surgical procedures and years/age at procedure ___None

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY

Tobacco use:___Never____Current:____Packs/Day____Former, Quit age: ____

Alcohol use:___No____Yes; average drinks/week: ____

Street drug use:___No____Yes; type used and last use: _____

Highest level of education:___Junior High___High School___College___Graduate School

Marital Status:___Single___Partnered/Married___Divorced___Other

Has your partner ever hit, kicked, threatened you or made you feel unsafe?___Yes___No

Do you have any religious preferences that could impact your care?___Yes___No

If yes, please explain: _____

Do you own a cat?___Yes___No If yes, who changes the litter box?

GENETIC HISTORY

You identify as the following ethnicity (please circle)

Asian African-American Caucasian French-Canadian Jewish Hispanic Mediterranean Other

The father of the baby is of the following ethnicity (please circle)

Asian African-American Caucasian French-Canadian Jewish Hispanic Mediterranean Other

Have you, the baby's father, or anyone in either family ever had any of the following disorders:

Thalassemia	
Neural Tube Defect, Spina Bifida, Anencephaly	
Congenital Heart Defect	
Down Syndrome	
Tay-Sachs	
Canavan Disease	
Sickle Cell Disease or Trait	

Hemophilia or Bleeding Disorder	
Muscular Dystrophy	
Cystic Fibrosis	
Huntington's Disease	
Mental Retardation	
Other Genetic or Chromosomal Disorder	
Metabolic Disorder (Type 1 Diabetes, PKU)	

Any history of any of the following?

Condition	Which Relative?	Age at Diagnosis? (for Cancers)
Hypertension		
Diabetes		
Heart Disease		
Stroke		
Breast Cancer		
Ovarian Cancer		
Uterine Cancer		
Colon Cancer		

CURRENT MEDICATIONS ____None

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES ____None

Medication:_____ Reaction:_____
Medication:_____ Reaction:_____
Medication:_____ Reaction:_____
Medication:_____ Reaction:_____

Review of Systems

Please **CIRCLE** any symptoms below that you ***currently*** have

General
Fatigue
Fever
Chills
Night Sweats
Weight Loss
Weight Gain
Poor Appetite

Heart
Dizziness
Palpitations
Swelling of legs/ankles
Chest Pain

Lungs
Cough
Shortness of breath

Digestion
Nausea
Vomiting
Change in Bowels (frequency, size or shape)
Black stools
Blood in stools
Diarrhea
Constipation
Abdominal Pain

Bladder
Urinary frequency
Painful urination
Sudden urge to urinate
Blood in urine
Loss of urine with cough or sneeze
Slow stream
Incomplete emptying

Joints/Muscles
Sti□ Joints
Neck pain
Back pain
Joint swelling/redness

Skin
Rash
New or changing mole

Breast
Lump
Pain
Nipple discharge

Neurologic
New headaches
Seizures

Endocrine
Excessive urination
Excessive thirst
Heat intolerance
Cold intolerance

Hematologic
Easy bruising
Excessive bleeding from nose/gums/cuts

Mood
Anxiety
Mood swings
Insomnia
Depression

Over the past 2 weeks, how often have you been bothered by the following problems:

1. Little interest or pleasure in doing things
   1. Not at all
   2. Several days
   3. More than half of days
   4. Nearly every day
2. Feeling down, depressed or hopeless
   1. Not at all
   2. Several days
   3. More than half of days
   4. Nearly every day

_____

Patient Signature Date

Missouri Delta Physician Services

MISSOURI DELTA PHYSICIAN SERVICES

SIKESTON, MISSOURI

CONSENT FOR TREATMENT

CONSENT FOR TREATMENT: I/we hereby consent to treatment and routine medical and nursing procedures. I/we understand this may include, but is not limited to laboratory tests or other diagnostic procedures, local anesthesia, intravenous fluids and other modes of medication as may be specifically ordered by a physician/nurse practitioner/physician assistant or customarily provided under medical supervision.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION FOR PAYMENT AND HOSPITAL OPERATIONS: I/we authorize Missouri Delta Medical Center, Missouri Delta Radiology Group, Inc. and any other physician/nurse practitioner/physician assistant to release information and/or copies of the patient's medical records to the Medical Center, physicians or insurance companies to which I/we have assigned benefits for the care and treatment rendered and if requested to the referring provider or any other health care facility responsible for care and the release of any pertinent patient information to authorized organizations to comply with state and federal regulations.

AUTHORIZATION FOR PAYMENT OF BENEFITS: I/we hereby authorize, request and assign payment directly to Missouri Delta Medical Center, Missouri Delta Radiology Group, Inc and any other treating physicians repetitively, of any hospital, Medicare, Medicaid or other medical insurance benefits payable to me/us for services rendered by the respective health care providers named. I/we understand that I/we am/are financially responsible to the health care provider for charges not covered by this authorization.

GUARANTEE OF PAYMENT: By signing this authorization, I/we hereby agree that all charges connected with this treatment not covered by insurance or other third-party coverage are due and payable at the time of service. Missouri Delta Medical Center has the right to demand payment in full from me/us at any time prior to full payment from any insurance or third-party carrier, unless Missouri Delta Medical Center and my/our insurance company or third-party carrier have agreed that I/we will not be billed. I/we, jointly and severally, guarantee full payment to the Missouri Delta Medical Center for all services rendered to the patient. I/we further agree that if the account becomes delinquent, interest on the amount due will accrue at the maximum amount by law, and if the delinquent account is referred to a collection agency or attorney, I/we shall pay all reasonable collection expenses, court costs, and a reasonable attorney's fee.

BILL OF RIGHTS: I acknowledge having received a copy of the patient's bill of rights and grievance process. **Initials** _____

DATE/TIME: _____

PATIENT NAME (PRINT) _____

PATIENT/RESPONSIBLE PARTY SIGNATURE _____

RELATIONSHIP TO PATIENT _____

OFFICE USE ONLY

WITNESS _____ **DATE/TIME:** _____

MISSOURI DELTA
MEDICAL CENTER

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notices applies to Missouri Delta Medical Center and its affiliates.

PROTECTION OF PROTECTED HEALTH INFORMATION (PHI)

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Missouri Delta Medical Center is required by law to keep protected health information (PHI) private. PHI is any health information that identifies you, including information such as your name, address, telephone number and any information created by your healthcare providers for treatment, billing or payment. Missouri Delta Medical Center is committed to the protection of your PHI and will make reasonable efforts to keep your PHI confidential as required by law. Missouri Delta Medical Center is also required to provide you with this notice of our privacy practices. We take this commitment seriously and will work with you to comply with your right to receive certain information under HIPAA.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

This notice applies to all of the records of your care at Missouri Delta Medical Center and will tell you about the ways in which we may use and disclose your medical information. This notice will also describe your rights and certain obligations Missouri Delta Medical Center has regarding the use and disclosure of medical information.

STANDARD USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

Missouri Delta Medical Center and physicians with staff privileges may use your medical information to provide you with medical treatment and services, to receive payment for those services and in daily health care operation in the following ways without your permission:

Treatment: Missouri Delta Medical Center may disclose your medical information to those involved in your treatment on an as-needed basis. For Example: Information taken by a nurse, physician or other member of your health care team will be documented in your record and used to decide the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.
We will also provide your physician or a following health care provider with copies of various reports that should help him or her in treating you once you are discharged from this hospital.

Payment: Missouri Delta may be required to use or disclose your medical information for payment or billing purposes. For Example: A bill may be sent to you or a third-party payer such as Medicare, Medicaid, your insurance company, workman s compensation, etc. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

Health Care Operations: Missouri Delta Medical Center may also use and disclose your medical information in our everyday health care operations. For Example: Members of the Medical Staff, the Risk or Quality Management Director, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like

it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide. Also, the state, JCAHO, and auditors may see your information in the course of a survey for accreditation, licensure or audit of financial records.

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include services in the radiology and laboratory departments. When these services are contracted, we may release your health information to our business associate so that they can perform the job we ve asked them to do and bill you or your third-party payer for services provided. To protect your health information, however, we require the business associate to appropriately safeguard your information.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION THAT DO NOT REQUIRE YOUR CONSENT:

Missouri Delta may also share your medical information without your permission for the following reasons:

Public Health activities: To prevent or control disease, report birth or death, and for the purpose of public health investigations, interventions and other related matters.

Government Authorities: Reporting medical information as required by law about persons who may be victims of abuse, neglect or other crime.

Oversight Activities: Reporting information to agencies that oversee insurance health benefit programs for the purpose of audits, investigations, inspections or other activities.

Workman s Compensation: Disclosing information necessary to comply with Worker s Compensation laws or purposes.

Administrative Proceedings: Releasing information in response to a court order or subpoena in a judicial or administrative proceeding.

Law enforcement: Cooperating with law enforcement officials for law enforcement purposes in the following situations: when required by law; for identification and location purposes; if you are suspected to be a victim of a crime; to report suspicion of death by criminal conduct; to report suspicion of criminal conduct occurring on the grounds of our facility; and in the case of an emergency.

Coroner, Medical Examiner, Funeral Director: Releasing information to a coroner, medical examiner or funeral director in the event of your death.

Organ and Tissue Donation: Consistent with applicable law, we will release health information to organ procurement organizations or other entities involved in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

Prevention of an Immediate Health and Safety Threat: To prevent an immediate threat to the health or safety of the public limited health information may be disclosed if necessary.

Research: Disclosing information related to a research project when a waiver of authorization has been approved by the Investigational Research Body (IRB).

Special Government Circumstances: Involving military or veterans activities; national security and intelligence activities; protective services for the President; medical suitability determinations; law enforcement custodial situations; and government programs providing public benefits

Military Command Authorities: If you are a member of the armed forces (or if foreign military personnel, to appropriate foreign military authorities.)

Prison Inmates: Information can be released to the correctional facility in which the inmate resides for the following purposes: 1) for the correctional facility to provide the inmate with healthcare; 2) to protect the health and safety of the inmate or the health and safety of others; or 3) for the safety and security of the correctional facility.

Food & Drug Administration (FDA): To report adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

MISSOURI DELTA MEDICAL CENTER MAY ALSO SHARE THE FOLLOWING INFORMATION WITH YOU ABOUT PRODUCTS/SERVICES THAT ARE RELATED TO YOUR TREATMENT WITHOUT AN AUTHORIZATION

- Products/services that pertain to care coordination or case management
- Recommendation of alternative treatments, therapies, health care providers or settings of care.
- Small promotional items.
- Face–to–face communications.
- Prescription refill reminders

USES AND DISCLOSURES THAT REQUIRE YOUR CONSENT

Your consent is required for the following uses and disclosures and will be made only with written authorization from you:

Marketing: We must have your written permission before we can accept payment for the use and disclosure of your PHI for marketing purposes.

Sale of PHI: We cannot sell your PHI without your written permission, except we may be paid our costs (i.e. labor, supplies, postage) to provide PHI to public health/other purposes permitted by HIPAA.

Immunizations: We will comply with requests received for proof of immunizations from schools as required by Missouri law to have such proof prior to admitting the individual. Verbal authorization is required.

PLANNED USES OR DISCLOSURES TO WHICH YOU MAY OBJECT

Unless you object in writing to the Privacy Officer at Missouri Delta Medical Center, MDMC will also use or disclose your health information for purposes described in this section. Refer to the Contacting Missouri Delta Medical Center section at the end of this notice.

Hospital Directory: Unless you notify us that you object, we will use your name, location in the facility, and general condition for directory purposes. This information may be released to people only who ask for you by name.
Your religious affiliation may be provided to members of the clergy.

Notification: In an emergency, Health Care Professionals, using their best judgment, may release to a family member, relative, friend or any other person you identify, health information necessary for their involvement in your care or payment related to your care.

Disaster Relief: We may use or release health information to a public or private party authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating the uses orreleases described in **Notification** above. Privacy requirements apply to the extent that we may use professional judgment to determine they do not interfere with the ability to respond to the emergency circumstances.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Health Information Exchange (HIE): We may make your protected health information available electronically through a secure health information exchange service to facilitate the exchange of your health information between and among other healthcare providers or other health care entities for your treatment, payment or other healthcare operations purposes. This means we may share information we obtain or create about you with outside entities (such as hospitals, physician offices, pharmacies or insurance companies) or we may receive information they create or obtain about you (such as medication history, medical history or other information) so each of us can provide better treatment and coordination of your healthcare services. You have the right to opt-out of participation in the Health Information Exchange.

Fundraising: If Missouri Delta Medical Center sends fundraising communications to you, you have the right to opt out of such fundraising communications.

YOUR RIGHTS: You have the right to:

- Request a Restriction: You may request a restriction on the protected health information that Missouri Delta Medical Center uses or discloses about you for payment, treatment or health care operations using the Contacting Missouri Delta Medical Center section of this notice. You have the right to request a limit on disclosures of your PHI to family members or friends who are involved in your care or the payment for your care. Missouri Delta may disclose information about you that is directly relevant to any member of your family, or to a designated caregiver of yours, if that person is involved with your care or the payment for your care. Missouri Delta may also use or disclose your health information to notify, identify or locate a family member, or other person responsible for your care, of your location, condition or death. If you pay in full for a health care item or service out-of-pocket and request that Missouri Delta Medical Center not disclose PHI about that health care item/service to your health plan, Missouri Delta Medical Center will not disclose PHI about that service to the health plan unless we are required to do so by law. It is your responsibility to alert Missouri Delta Medical Center if this is your intention before the health care item or service is performed so that written authorization can be obtained and full payment can be collected at that time.
- Request Confidential Communication: You may request to receive your PHI by alternative means or at an alternative location if you reasonably believe that other disclosure could pose a danger to you. For Example: You may only want to have PHI sent by mail or to an address other than your home. While we are not required to agree to all requests, Missouri Delta Medical Center will accommodate all reasonable requests for confidential communications. For more information about exercising these rights, contact the Privacy Officer using the Contacting Missouri Delta Medical Center section at the end of this notice.
- Request Access: You have the right to inspect and have a copy of your PHI in paper or electronic format. You must submit your request in writing.
- Request an Amendment: You have the right to request an amendment of your PHI held by Missouri Delta Medical Center if you believe that information is incorrect or incomplete. Your request must be in writing and sent to the Privacy Officer using the Contacting Missouri Delta Medical Center section of this notice and must give a reason(s) in support of the proposed amendment.

  In certain cases, Missouri Delta Medical Center may deny your request for an amendment. For Example: Missouri Delta may deny your request if the information you want to amend is accurate and complete or was not created by Missouri Delta.

  If Missouri Delta denies your request, you have the right to file a statement of disagreement. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

- Request an Accounting of Disclosures: You have the right to request an accounting of certain disclosures Missouri Delta Medical has made of your PHI. You may request an accounting using the Contacting Missouri Delta Medical Center section of this notice. You can request an accounting of disclosures made up to six years prior to the date of your request.

MISSOURI DELTA
MEDICAL CENTER

NOTICE OF PRIVACY PRACTICES

- To be Notified of a Breach: You have the right to be notified in the event that Missouri Delta Medical Center (or their Business Associate) discovers a breach (unauthorized or inadvertent) release of PHI.
- Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice, even if you have agreed to accept this Notice electronically.

Changes to this Notice: Missouri Delta Medical Center has the right to change this notice. Changes may be effective for any current health information about you and any information that may be obtained in the future. Changes to this notice will also be effective for all health information Missouri Delta maintains about you. The most recent copy of this notice will be available anywhere you register for services. You can also contact the Missouri Delta Privacy Office to obtain the most recent copy of this notice.

To Report a Privacy Concern: Missouri Delta Medical Center takes the privacy and security of your protected health information very seriously. If you believe that your privacy rights have been violated, please contact Missouri Delta Privacy Officer so we may investigate and try to correct the problem. You also have the right to file a complaint with the Department of Health and Human Services. Missouri Delta Medical Center will not treat you differently or prevent you from receiving care if you decide to report a complaint.

Contacting Missouri Delta Medical Center: Missouri Delta Privacy Officer can be reached by phone, email or mail.

Phone: 573-472-7628 or 573-472-7630

Email: privacyofficer@missouridelta.com <mailto:privacyofficer@missouridelta.com>

Mailing Address:
Missouri Delta Medical Center Privacy Officer
1008 N. Main St.
Sikeston, Missouri 63801

You can request a paper copy of this notice by contacting Missouri Delta s Privacy Officer or from the area where you received your services.

EFFECTIVE: 4/14/2003

REVISED: APRIL 2013, MARCH 2015

MISSOURI DELTA
MEDICAL CENTER

PATIENT BILL OF RIGHTS

Quality patient care is the primary concern of Missouri Delta Medical Center s personnel and its Medical Staff. It is our goal to provide you with the most personalized care possible to facilitate a pleasant and comfortable experience.

Our patients can expect and are entitled to quality health care. To help meet your expectations, Missouri Delta Medical Center extends a list of hospital responsibilities, which describes the philosophy and practice of our hospital and upholds the tradition of concern for patients. It is our belief that observance of and adherence to these responsibilities will contribute to effective patient care and greater satisfaction to you, your physician and the hospital.

Missouri Delta Medical Center is a private, not for profit institution.

Information:

1. You have the right to have information regarding your rights, responsibilities, and care presented to you by an interpreter, in Braille or print that is appropriate to your needs, or by other means as necessary.

2. You have the right to obtain from your physician complete current information concerning your diagnosis, treatment and prognosis in terms you can understand. When it is not medically advisable to give such information to you, the information should be made available to an appropriate person in your behalf. You have the right to know, by name, the physician responsible for coordinating your care.

3. You have the right to receive from your physician the information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include, but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved and the probable duration of incapacitation. Where medically significant alternatives for care of treatment exist, or when you request information concerning medical alternatives, you have the right to know the name of the person responsible for the procedures and/or treatment.

4. You have the right to examine and receive an explanation of your bill regardless of source of payment.

5. You have the right to be given notice of the rights afforded to you by the provider agreement, including a notice of non–coverage.

6. You have the right to know what hospital rules and regulations apply to your conduct as a patient.

7. You have the right to obtain information as to any relationship of this hospital to other health care and educational institutions insofar as your care is concerned and the likelihood that you might be referred to a health provider as a result of that relationship.

8. You have the right to obtain information as to the existence of any professional relationships among individuals, by names, who are treating you.

9. Healthcare workers who advocate on a patient s behalf will not be penalized.

Respect and Dignity:

10. You have the right to considerate and respectful care that supports your personal value and belief system.

11. You have the right to be free from discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, & gender identity or expression or other.

12. You have the right to safety from all forms of abuse, neglect, or harassment.

13. You have a right to obtain a paper copy of Missouri Delta Medical Center's notice of information practices upon request.

14. You have the right to every consideration of your privacy concerning your own medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. Those not directly involved in your care must have your permission to be present.

Privacy and Medical Records:

15. You have the right to expect that all communications and records pertaining to your care should be treated as confidential. This includes communications from the hospital to you.

16. You have the right to request communications of your health information by alternative means or at alternative locations.

17. You have the right to obtain an accounting of disclosures of your health information.

18. You have a right to request a restriction on certain uses and disclosures of your information.

19. You have the right to revoke your authorization to use or disclose health information except to the extent that action has already been taken.

20. You have the right to inspect and obtain a copy of your records upon your request/authorization in a timely manner. A Medical Records Release Form will be required. If all information is not available at the time of the request, you will be advised that the record is incomplete. You may request the complete record when all reports and documentation is available.

21. You have the right to request an amendment to your health record.

22. You have the right to be free of all forms of restraint and/or seclusion unless it is deemed clinically necessary by your physician.

23. You have the right to express your personal spiritual and cultural beliefs as long as they do not interfere with the well being of other patients or the planned course of your medical therapy.

MISSOURI DELTA
MEDICAL CENTER

PATIENT BILL OF RIGHTS

Decision Making and Care:

24. You have the right and are encouraged to participate in planning your care. You and your family have the right to receive education regarding safe and effective use of prescribed medication, including potential food and drug interaction, and medical equipment.

25. You have the right to formulate advance directives and appoint a surrogate to make treatment decisions in your behalf, to the extent permitted by law, if you should become incapable of making these decisions.

26. You have the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of your action.

27. You have the right to expect that, within its capacity, a hospital must make reasonable responses to your request for services. The hospital must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically permissible, you may be transferred to another facility only after you have received complete information and explanation concerning the needs for and alternatives to such a transfer. The institution to which you are to be transferred must have accepted you prior to transfer.

28. The hospital involves the patient in making decisions about his or her care, treatment, and services, including the right to have his or her family and physician promptly notified of his or her admission to the hospital.

29. You, or your designee, have the right to participate in the consideration of ethical issues that arise in your care.

30. The dying patient has the right to care, which protects his/her comfort and dignity.

31. You have the right to receive, to the extent possible, effective pain management.

32. You have the right to be advised if the hospital proposes to engage in or perform human experimentation affecting your care or treatment. You have the right to refuse to participate in such research projects.

33. When your neonate, child, or adolescent is a patient at Missouri Delta Medical Center, you have the right to become involved in the assessment, treatment, and continuing care of the patient. You and your family also have the right to be assisted by the Hospital in coping with illnesses that are particularly traumatic because of their duration, severity or because of the untoward effect on the patient s physical or psychological development.

Discharge Planning:

34. You have the right to expect assistance and discharge planning, which optimize the continuity and quality patient care following discharge, and how you can obtain further treatment, if you need it.

35. You have the right to expect reasonable continuity of care and to know in advance what appointment times and physicians are available and where. You have the right to expect that the hospital will provide a mechanism whereby you are informed by your physician, or his delegate, of your continuing health care requirements following discharge

Grievance:

36. If you feel your rights have not been honored, you have the right to file a complaint. If your complaint cannot be resolved immediately, or to your satisfaction, the Patient Representative or House Supervisor is available to assist you in filing a formal, written grievance to the Hospital s Patient Grievance Committee who will respond to your complaint in writing. You may also file a grievance directly with the Missouri Department of Health or the State peer review organization listed in the Patient Handbook.

Your may file a grievance directly with the Missouri Department of Health Facility Regulations, 912 Wildwood Drive, P.O. Box 570, Jefferson City, MO 65102, (ph 1-800-392-0210).

Peer Review: Primaris, 200 N. Keene St., Columbia, MO 65201 (ph 1-800-347-1016) Office of QualityMonitoring, The Joint Commision, One Renaissance Boulevard, Oakbrook Terrace, IL 60181, (email - complaint@jointcommission.org)

For More Information you may call the Patient Representative at (573) 472-7592 or 1-800-678-3577

Patient Responsibilites

1. Provide accurate and complete informaiton about present complaints, past illnesses, hospitalization, mediations, and other related health matter.

2. Report unexpected condition changes to the responsible practitioner.

3. Follow the treatment plan recommended by the practitioner. This may include following the instructions of nurses and allied health personnel as they carry out the coordinated plan of care, implement the repsonible practitioner's orderes, and as they enforce the applicable hospital rules and regulations.

4. Express concerns you have about your ability to follow the proposed course of treatment.

5. Keep appointments and, when unable to do so, notify the reponsible practitioner or the hospital

6. Assure that the financial obligations for health care are fulfilled as promptly as possible.

7. Follow hospital rules and regulations affecting patient care and conduct.

8. Be considerate of the rights of other patients and hospital personnel by assisting in the control of noise, smoking, and the number of visitors.

9. Be respectful of the property of other persons and of the hospital.

10. Ask questions when you do not understand what you have been told about care or what you are expected to do.

11. Accept the consequences of not following instructions.

MISSOURI DELTA
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IF YOU HAVE A COMPLAINT OR GRIEVANCE

As a patient, you can expect and are entitled to effective and satisfactory health care.

If you believe your patient rights have been violated, immediately contact the manager of the Area or ask that the Patient Representative be notified. They will address the problem and work to arrive at a solution.

If the problem persists or if, in your opinion, there is no satisfactory resolution, you have the right to file a formal written grievance with the Patient Representative (472-7592). You may also file a grievance directly with the Missouri Department of Health and Senior Services, 323 Vetern, P.O Box 570, Jefferson City, MO 65102. The phone number is (573-751-6303). You may also contact the Joint Commision on Accreditation of Healthcare Organizations (630-792-5000).

Missouri Delta Medical Center has a continuing commitment to provide you with the most personalized care possible in order to facilitate a pleasant and comfortable hospital experience.

MISSOURI DELTA MEDICAL CENTER

SIKESTON MISSOURI

ACKNOWLEGMENT: RECEIPT OF PRIVACY PRACTICES NOTICE

I acknowledge that I have been provided with Missouri Delta Medical Center's Notice of Privacy Practices.

Patient or legal representative: _____

Date:_____

□ Patient was unable /unwilling to sign acknowledgment.

Reason: _____

Staff initials: _____

Date: _____

Time: _____

Below is a list of people that may receive full disclosure of my medical information:

_____

_____

_____

Copy of Notice was included in patient's Admission Information Packet