MISSOURI DELTA
CHIROPRACTIC

Dear New Patient,

Thank you for choosing Missouri Delta Chiropractic!

To save time during your first appointment, please print and complete the attached New Patient paperwork.

Along with completed paperwork, please remember to bring the following:

- 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*** 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!

Missouri Delta Chiropractic Staff

MISSOURI DELTA CHIROPRACTIC

WELLPOINT PAIN CENTER
Kenneth C. Moy, D.O.
Heather Jackson, FNP-C

PATIENT INFORMATION

Date: _____

Name: First_____Middle_____Last_____

DOB _____ SSN_____ Sex _____ Marital Status _____ Race_____

Mailing Address_____

City _____ State _____ Zip _____

Physical Address (*if different from above*) _____

Home Phone Number _____ Mobile Phone Number _____

Email Address (*required for access to your Patent Portal*) _____

Primary Care Provider _____ Preferred Pharmacy _____

Circle one:

Employed Full-Time Employed Part-Time Unemployed Retired Disabled

Retired/Disabled Date: _____

Employer _____ Phone_____

Address _____

City_____ State_____ Zip_____

Emergency Contact- 1

Name_____ Relationship to patient _____

DOB_____ SSN _____ Phone_____

Address (if different from patient) _____

City_____ State_____ Zip_____

Emergency Contact- 2

Name_____ Relationship to patient _____

DOB_____ SSN _____ Phone_____

Address (if different from patient) _____

City _____ State _____ Zip _____

MISSOURI DELTA
CHIROPRACTIC

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following chiropractic manipulation. Complications could include but are not limited to fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare." The probability of adverse reaction due to ancillary procedures is also considered "rare."

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care*, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

_____	_____	_____
Printed Name	**Signature**	**Date**

WITNESS:

_____	_____	_____
Printed Name	**Signature**	**Date**

MISSOURI DELTA CHIROPRACTIC

NEW PATIENT
Adult History Form

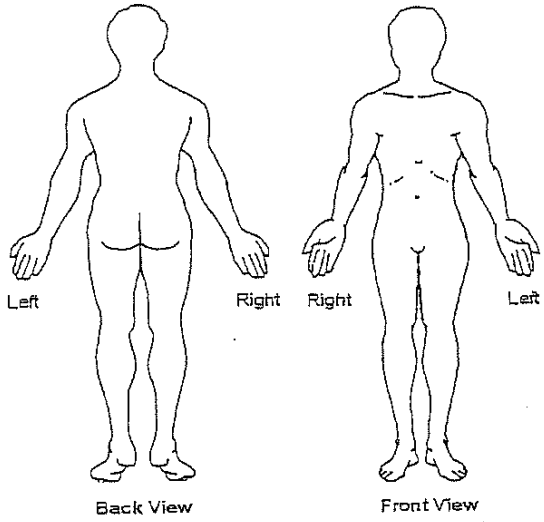
FIN#_____

Name	Age	Date
Regular Physician	DOB	❑ Male ❑ Female

Nurse use: Temp: O2 sat:	Ht:	Wt:	BMI:	Temp:
	BP:		HR:	RR:

Locate your pain on the figures below, using the symbols Given below:

Ache	Numbness	Pins/Needles	Burning	Stabbing	Other
△△△	═══	○○○	XXX	////	●●●



Reason for visit: _____

_____

Medications that need to be refilled: _____

_____

Have you had this problem before? ❑ Yes ❑No

If Yes, how long ago? _____

How often are you having symptoms?

❑ Constantly (100% of time) ❑ Frequently (75% of time) ❑ Intermittently (50% of time) ❑ Occasionally (25% of time(

When did your symptoms begin? _____

What caused your symptoms: ❑ Unknown ❑Injury

❑ Describe/Other: _____

_____

Are your symptoms related to a work injury or automobile accident? ❑ Yes ❑No

What makes your problem feel BETTER?

_____

What makes your problem feel WORSE?

_____

Have you seen any other providers relating to the problem recently?

❑ Yes ❑ No

Who? _____

Have you had any tests performed for this problem?

❑ Lab tests ❑ X-Ray ❑ CT Scan ❑ MRI ❑ Other

Location of previous test(s) _____

NP, PA, or Physician Signature: _____

How would you describe your pain?

❑ Ache/Dull	❑Pins/Needles	❑Stabbing
❑ Burning	❑Pulling	❑Stiff or tight
❑ Cramping	❑Sharp	❑Throbbing
❑ Numbness	❑Shooting	❑Tingling

❑ Other: _____

❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Possible

Have you had COVID vaccines? ❑YES ❑NO

PLEASE CONTINUE ON NEXT PAGE

Current Medical Conditions			Allergies (Drug and Environmental)

Prior Traumas (Broken bones, etc)	Prior Surgeries		Pregnancy History
			Total # Pregnancies:
			# of live births:
			# of preterm births:
Medications (Include vitamins and supplements)			# of C-sections:
			# of miscarriages:
			# of abortions:

Family Health History (Does anyone in your family have any health problems? How old are they?

Mother	Sisters
Father	Brothers
Paternal Grandparents	Daughters
Maternal Grandparents	Sons

Social History	Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed	Children? ❑ Yes ❑ No
Education Level (last grade completed:		Current Employment?
Do you drink alcohol? ❑ Yes ❑ No	If yes, how much per week?	
Do you smoke? ❑ Yes ❑ No	If yes, how much per day?	How may years?
Do you use street drugs? ❑ Yes ❑ No	If yes, what do you use?	
Do you drink caffeine? ❑ Yes ❑ No	If yes, how much per day?	

Mark any symptoms you have experienced in the past 2 weeks:

❑ NONE

Musculoskeletal
❑ Back pain
❑ Morning stiffness
❑ Muscle weakness
❑ Neck pain
❑ Joint pain
❑ Joint swelling

Skin
❑ Itching
❑Rash

Heme
❑ Easy bleeding
❑ Easy bruising tendency

Psychiatric
❑ Anxiety
❑ Depression
❑ Insomnia

Neurology
❑ Dizziness
❑ Difficulty walking
❑ Headache
❑ Arm/Leg weakness
❑ Memory lapses/loss
❑ Numbness
❑ Tingling
❑ Tremors

General
❑ Chills
❑ Fatigue
❑ Fever
❑ Night sweats
❑ Weight gain
❑ Weight loss

Heart
❑ Chest pain
❑ Swelling in ankles
❑ Palpitations

Lungs
❑ Chronic cough
❑ New cough
❑ Difficulty breathing
❑Wheezing

Ears/Eyes, Nose, Throat
❑ Earache
❑ Nasal drainage
❑ Hearing loss
❑ Eye pain
❑ Sinus pain/pressure
❑ Sore throat
❑ Vision problems

Immunological
❑ Contact allergies
❑ Food allergies
❑ Swollen lymph nodes
❑ Seasonal allergies

Stomach/Bowels
❑ Abdominal pain
❑ Loss of appetite
❑ Blood in stools
❑ Bloating
❑ Constipation
❑ Diarrhea
❑ Heartburn
❑ Nausea
❑ Vomiting

Kidneys/Bladder
❑ Painful urination
❑ Frequency urination
❑ Urinary incontinence

Metabolic
❑ Excessive sweating
❑ Excessive thirst

Other Issues: _____

Patient's Name:	NP, PA, or Physician's Signature:	Date:

FIN#: _____

PLEASE CONTINUE ON NEXT PAGE

NUTRITION

Any special diet: ❑ Yes ❑ No If yes, please explain: _____

_____

Is weight a concern physically or emotionally? ❑ Yes ❑ No

My dietary intake consists mainly of (mark all that apply):

❑ Fruits	❑ Vegetables	❑Whole Grains	❑ High Fiber	❑ Low Fiber
❑High Salt	❑Low Salt	❑High Sugar	❑Low Sugar	❑Low Carbohydrates
❑High Fat	❑Low Saturated Fats	❑High Protein	❑Low Calorie	

How many 8 ounce glasses of water do you drink a day? _____

HEALTH REVIEW

On average, how many hours of sleep do you get a night? _____

Rate the quality of your sleep on scale of 1-10:

❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑

No/ | | | | | | | | | | | Fully
Poor 0 1 2 3 4 5 6 7 8 9 10 Restored

How many days a week do you exercise? _____ 30 or more minutes? ❑Yes ❑No

Rate the intensity of your exercise on scale of 1-10:

❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑

No | | | | | | | | | | | High
Exercise 0 1 2 3 4 5 6 7 8 9 10 Intensity

Rate your physical stress level on scale of 1-10:

❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑

No | | | | | | | | | | | Very
Stress 0 1 2 3 4 5 6 7 8 9 10 Stressed

Rate your emotional/mental stress level on scale of 1-10:

❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑

No | | | | | | | | | | | Very
Stress 0 1 2 3 4 5 6 7 8 9 10 Stressed

List major stressors: _____

_____

List health goals: _____

_____

MISSOURI DELTA
PHYSICIAN SERVICES

ACKNOWLEDGMENT: 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: _____

Patient's DOB: _____

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

MISSOURI DELTA
MEDICAL CENTER

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

Effective 4−14−2003

Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third−party payer can verify that services billed were actually provided
- tool in educating health professionals
- source of facts for medical research
- source of information for public health officials in charge of improving the health of the nation
- source of data for hospital planning and marketing
- tool to evaluate and continually work to improve the care we provide and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- make sure it is accurate
- better understand who, what, when, where, and why others may see your health information
- make more informed decisions when authorizing release of information to others

Your Health Information Rights

Although your health record is the physical property of the hospital or the healthcare provider who gathered it, the information belongs to you. You have the right to:

- provide a password for friends or family to use to receive information while you are a patient
- request a restriction on certain uses and releases of your information
  We reserve the right to determine if this is reasonable. We must notify you if we are unable to agree to a requested restriction.
- obtain a paper copy of the notice of information practices upon request (this information sheet)
- inspect and receive a copy of your health record in paper or electronic form
- request an amendment to your health record
  We reserve the right to determine if this is reasonable. If the request is granted, the original information will be kept in the chart and the amendment added.
- obtain an accounting of releases of your health information except for purposes of treatment, payment, hospital operations, and releases you have authorized. Disclosures that are reported as *required* (i.e. all births, deaths, tumors, communicable diseases, infections, newborn hearing screen, suspected abuse or neglect, Mid America Transplant for all deaths, or to the coroner will not be listed on the Disclosure Log.
- receive confidential communications of protected health information
- request communications of your health information by alternative means or at alternative locations
- cancel your authorization to use or release health information except to the extent that action has already been taken
- restrict disclosure to a health plan concerning treatment for which the individual has paid out of pocket in full

MISSOURI DELTA
MEDICAL CENTER

SUMMARY OF NOTICE OF PRIVACY PRACTICES

We have summarized the attached Notice of Privacy Practices on this first page. For a complete description of your rights and responsibilities, please review the entire notice.

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

In regard to your health information, you have the right to:

- Request a restriction on certain uses and releases of your health information
- Obtain a copy of this Notice
- Inspect and receive a copy of your health information
- Request that we amend your health information
- Know how we have used or disclosed your health information
- Receive confidential communication about your health information
- Request communication about your health information in alternative ways
- Cancel your authorization to release information

It is our responsibility to:

- Protect the privacy of your health information
- Provide you with this Notice of our Privacy Practices
- Abide by the terms of this Notice
- Accommodate reasonable requests.

We may make changes in our privacy practices based on laws and regulations. If we do change them, we will change this Notice and post the changes in our hospital and on our website.

If you have any questions and/or would like additional information, please contact the Privacy Officer at (573) 472−7595 or (573) 472−6021.

MISSOURI DELTA
MEDICAL CENTER

OUR RESPONSIBILITIES

This organization is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of the notice currently in effect
- accommodate reasonable requests you may have to communicate health information by alternative means, at alternative locations, or to alternative persons.
- determine the probability that a breach of unsecured information has been compromised
- notify you of a breach of unsecured information that has been compromised
- prohibit sale of information without your consent

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain.

We will not use or disclose your health information without your authorization, except as described in this notice.

Examples of release of information for Treatment, Payment and Health Operations

We will use your health information for treatment.

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 re discharged from this hospital.

We will use your health information for payment.

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.

We will use your health information for 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.

Other Possible Uses and Releases of Health Information (These examples are not all inclusive.)

Health Information Exchange: 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.

***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.

MISSOURI DELTA
MEDICAL CENTER

OUR RESPONSIBILITIES

***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.

Also, we may contact you to provide appointment reminders

Funeral directors: We may release health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: 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.

***Food and Drug Administration (FDA)*:** We may release to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may release health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we will release your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may release to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law enforcement: We may release health information for law enforcement purposes as required by law or in response to a valid subpoena or court order.

Disaster relief purposes*:* 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 or releases 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.

Situations that require your authorization:

Communication: with other persons such as family members, friends, and clergy, except in emergencies as described above.

Marketing: to receive information about treatment alternatives or other health−related benefits and services that may be of interest to you.

Fund raising: to contact you as part of a fund−raising effort.

For More Information or to Report a Problem:
If you have questions and would like additional information, you may contact the Privacy Officer. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer or with the secretary of Health and Human Services. There will be no retaliation for filing a complaint.

MISSOURI DELTA
FOCUSED ON THE FUTURE OF HEALTHCARE

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 altematives 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 be informed of hospital visiting hours.

8. 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.

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

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

Respect and Dignity:

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

12 . 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.

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

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

15. You have the right to every consideration of your privacy conceming 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:

16. 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.

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

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

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

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

21. 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.

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

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

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

MISSOURI DELTA
FOCUSED ON THE FUTURE OF HEALTHCARE

PATIENT BILL OF RIGHTS

Decision Making and Care:

25. 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.

26. 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.

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

28. 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.

29. 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.

30.Youor your designee, have the right to participate in the consideration of ethical issues that arise in your care.

31. The dying patient has the right to care, which protects his/her comfort and dignity.
32. You have the right to receive, to the extent possible, effective pain management.

33. 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.

34. 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:
35. 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.

36. 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:
37. 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.

You 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 Quality Monitoring, The Joint Commission,
One Renaissance Boulevard, Oakbrook Terrace, IL 60181, (email complaint@jointcommission.org

For Sleep Lab Patients to file a complaint with an accredited organization with ACHC, please contact ACHC's complaint Department at 919-785-1214 and/or by calling Medicare at 1-800-Medicare.

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

Patient Responsibilities

1. Provide accurate and complete information about present complaints. past illnesses, hospitalization, medications. 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 responsible practitioner's orders, 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 responsible 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
FOCUSED ON THE FUTURE OF HEALTHCARE

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 Veteran, P.O Box 570, Jefferson City, MO 65102. The phone number is (573-751-6303). You may also contact the Joint Commission on Accreditation of Healthcare Organizations (630-792-5000).

For Sleep Lab Patients to file a complaint with an accredited organization with ACHC, please contact ACHC's Complaint Department at 919-785-1214 and/or by calling Medicare at 1-800-Medicare.

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.