

New Patient Registration Information



Patient Demographics

Name: _____

SSN: _____

Preferred Name: _____

Employer: _____

Date of Birth: _____

Preferred Language: _____

Birth Sex (Circle One): Male / Female

Marital Status: _____

Address: _____

Gender Identity: _____

City: _____

Sexual Orientation: _____

State: _____ ZIP: _____

Phone Number: _____

Name: _____

Email: _____

Phone Number: _____

Grant Records Access: Yes No

Race

- White or Caucasian
- Black or African American
- Other: _____

PCP: _____

Establishing Care Other, Enter below

Ethnicity

- Hispanic or Latin@
- Not Hispanic or Latin@
- Other: _____

Reason for Visit: _____

Discomfort Level:

- | | | |
|---|---|--|
| <input type="checkbox"/> 
None | <input type="checkbox"/> 
Mild | <input type="checkbox"/> 
Moderate |
| <input type="checkbox"/> 
Severe | <input type="checkbox"/> 
Very Severe | <input type="checkbox"/> 
Worst Possible |



PATIENT CONSENT & AUTHORIZATION STATEMENT

1 I, _____, hereby grant permission for any and all medical attention to be administered to me in the event of accident, injury, sickness, etc. I understand that I have the right to refuse any such treatment. I also assume the responsibility for the payment of any such treatment, and give Solvera Health permission to submit claims to insurances on my behalf.

This release is effective for the period of one year from the date given below.

Solvera Health is specifically authorized to release all health care information pertaining to diagnosis, testing or treatment.

2 _____
PATIENT SIGNATURE

DATE

PARENT / LEGAL GUARDIAN SIGNATURE

RELATIONSHIP TO
PATIENT

Medical Record Disclosure Agreement



Solvera Health values your privacy. Thus, our policy follows the legal aspects of patient confidentiality. In order to discuss medical billing and treatment with anyone besides yourself either in the office or by telephone, we require your written consent.

Please mark the area(s) of your information that you wish to grant access to:

Billing Information: Yes No _____
Patient Initials

Medical Information: Yes No _____
Patient Initials

Discuss with me only: _____
Patient Initials

Mark this box if you wish for your information to not be shared with anyone but yourself either in the office or by telephone.

PARTIES ALLOWED ACCESS

Please print the contact information of those with whom you wish to grant access to your information.

1 Full Name: _____ Phone Number: _____
Address: _____ Relationship to Patient: _____
City: _____ State: _____ ZIP: _____

2 Full Name: _____ Phone Number: _____
Address: _____ Relationship to Patient: _____
City: _____ State: _____ ZIP: _____

3 Full Name: _____ Phone Number: _____
Address: _____ Relationship to Patient: _____
City: _____ State: _____ ZIP: _____

4 Full Name: _____ Phone Number: _____
Address: _____ Relationship to Patient: _____
City: _____ State: _____ ZIP: _____

I authorize Solvera Health to discuss my information with the above named person(s). It is my responsibility to inform Solvera Health of any changes to this medical records disclosure agreement.

5 _____
Patient Name Date of Birth

Patient or Partner in Health SIGNATURE DATE

SOLVERA HEALTH STAFF

REVIEWED BY _____ DATE APPROVED _____

Medical Record Release Authorization



PATIENT CONSENT & AUTHORIZATION STATEMENT

Facility Name: _____

This medical records release authorizes Solvera Health to obtain a complete set of my medical records from any physician, pharmacy, medical group, hospital, diagnostic laboratory, imaging center, or mental health treatment facility.

This consent and authorization shall be active for a period of one year from the date given below.

The signee understands that their express consent is required to release any health care information relating to testing, diagnosis, and / or treatment for HIV, sexually transmitted disease, psychiatric disorders, mental health, or drug and alcohol use.

PATIENT INFORMATION

Patient Name

Date of Birth

Sex F M

PROVIDER INFORMATION

Provider Name

Specialty

PATIENT SIGNATURE

DATE

PARENT / LEGAL GUARDIAN SIGNATURE

RELATIONSHIP TO
PATIENT

SOLVERA HEALTH STAFF

REVIEWED BY _____ DATE APPROVED _____



This notice of Privacy has been created by the Provider to inform you of how we may use your protected health information for treatment, payment and health care operations purposes and as otherwise permitted by law. Protected health information is information about you which can be used to identify you and which relates to your physical or mental condition, our provision of health care services to you, or the payment for health care services we provide to you. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with regard to accessing, amending, and controlling the use of your protected health information

We will abide by the terms of the Notice of Privacy Practices currently in effect. However, we reserve the right to change the terms of this Notice of Privacy Practices at any time as it applies to all protected health information in our custody without providing any notice of such change. Upon the occurrence of any revision of the terms of the Notice of Privacy Practices currently in effect, you may obtain a revised copy of this Notice of Privacy Practices from our registration personnel at our office located at 3525 University, Peoria, Illinois 61604 at your request.

The Privacy Contact for the Provider is Patrick J. Caplis. Please direct all questions and requests to the Privacy Contact in writing at the Peoria, IL address listed in the preceding paragraph.

I. Treatment, Payment, and Health Care Operations

Your protected health information may be used and disclosed by us and other health care providers outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. We may use and disclose your protected health information in order for us to obtain payment for the health care services and goods which we provide to you. We may also use and disclose your protected health information in order to conduct the business of the Provider.

Following are examples of the types and uses and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures we may make.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with another

health care provider. For example, we could disclose your protected health information, as necessary, to a hospital that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred so that the physician has the necessary information to diagnose you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who becomes involved in your care by providing assistance with your health care diagnosis or treatment.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you or medical necessity, and undertaking utilization review activities. We will disclose to your health insurance company information about the goods and services rendered to you in order to obtain payment from your insurance company.

We may also disclose your protected health information to another entity so that it may seek payment.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support our business activities. These activities include, but are not limited to, quality assessment activities, employment review activities, face-to-face marketing activities, and conducting or arranging for other business activities.

For example, we may share your protected health information with other physicians in the practice for quality assurance or peer review purposes. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your physician is ready to see you.

We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information, as necessary, to contact you to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

We will share your protected health information with third party business associates that perform various activities (e.g. billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may disclose your protected health information to another entity for: health care fraud and abuse detection or compliance, conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contracting of health care providers and patients with information about treatment alternatives, and related functions that do not include treatment, reviewing the competence of health care professionals, conducting training programs, accreditation, certification, licensing, credentialing or other similar activities. Disclosures described in the preceding sentence will only be made if the other entity has or had a relationship with you.

We may disclose your protected health information to an organized health care arrangement in which we participate for any health care operation activities of said organized health care arrangement. An example of an organized health care arrangement is a hospital and its medical staff.

II. Uses and Disclosures of Protected Health Information

Based upon our Written Authorization

Other uses and disclosures of your protected health information for purposes other than treatment, payment and health care operations will be made only with your written authorization, unless otherwise permitted or required by law as described below. For example, if you wish to have a life insurance company have access to your protected health information which is in our files, you will need to sign a written authorization permitting us to disclose such information. You may revoke an authorization at any time in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.

III. Uses and Disclosures for Which You Have the Opportunity to Agree or Object

We may use or disclose your protected health information in the circumstances described in this Section III, without seeking an authorization,

provided we first give you an opportunity to object to such use or disclosure. If you are present, we may either obtain your agreement to use or disclose your protected health information as described below, or we may provide you with an opportunity to object and accept your failure to object as your agreement, or we may reasonably infer from the circumstances that you do not object. If you are not present or are unable to agree or object to such use or disclosure of your protected health information, we may use our professional judgment to determine whether the use or disclosure of your protected health information is in your best interest. All communications described in this Section III may be done orally.

Individuals Involved in your Care. Unless you object, we may disclose your protected health information to your family member, other relative or close personal friend or any other individual identified by you as being a person who is directly involved with your care or payment relating to your care or treatment.

Disaster Relief. Unless you object, we may use or disclose your protected health information to a public or private entity authorized to assist in disaster relief efforts for the purpose of coordinating with such entities the notification of your family or other persons involved in your care.

Notification of Family or Friends. Unless you object, we may use or disclose protected health information to notify or assist in the notification of a family member, a personal representative, or other person responsible for your care of your location and general condition.

IV. Uses and Disclosures of Protected Health Information Which Do Not Require Your Authorization or Opportunity to Object

We are permitted to make the following uses and disclosures of your protected health information without having to obtain your authorization, or give you an opportunity to object:

Uses and Disclosures Required by Law.

We may use or disclose your protected health information when the use or disclosure is required by law, as long as the use or disclosure meets all applicable requirement by of such law.

Uses and Disclosures for Public Health

Activities. Governmental Activities.

We may disclose your protected health information to a public health authority, including but not limited to: the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions; or at the direction of a public health authority, to an official of a foreign govern-

ment agency that is acting in collaboration with a public health authority; the reporting of child abuse or neglect; reporting to the Food and Drug Administration adverse events, product defects or problems, any biological deviations, to track products, to enable product recalls, repairs or replacements, or to conduct post marketing surveillance, reporting a person who may have been exposed to a communicable disease or otherwise be at risk for contracting or spreading a disease or condition as authorized by law.

Employers. We may disclose your protected health information to you for medical necessity, and undertaking utilization review activities. We will disclose to your health insurance company information about the goods and services rendered to you in order to obtain payment from your insurance company.

We may also disclose your protected health information to another entity so that it may seek payment.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support our business activities. These activities include, but are not limited to, quality assessment activities, employment review activities, face-to-face marketing activities, and conducting or arranging for other business activities.

For example, we may share your protected health information with other physicians in the practice for quality assurance or peer review purposes. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your physician is ready to see you.

We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information, as necessary, to contact you to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

We will share your protected health information with third party business associates that perform various activities (e.g. billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may disclose your protected health information to another entity for: health care fraud and abuse detection or compliance, conducting quality

assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contracting of health care providers and patients with information about treatment alternatives, and related functions that do not include treatment, reviewing the competence of health care professionals, conducting training programs, accreditation, certification, licensing, credentialing or other similar activities. Disclosures described in the preceding sentence will only be made if the other entity has or had a relationship with you.

We may disclose your protected health information to an organized health care arrangement in which we participate for any health care operation activities of said organized health care arrangement. An example of an organized health care arrangement is a hospital and its medical staff.

II. Uses and Disclosures of Protected Health Information

Based upon our Written Authorization

Other uses and disclosures of your protected health information for purposes other than treatment, payment and health care operations will be made only with your written authorization, unless otherwise permitted or required by law as described below. For example, if you wish to have a life insurance company have access to your protected health information which is in our files, you will need to sign a written authorization permitting us to disclose such information. You may revoke an authorization at any time in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.

III. Uses and Disclosures for Which You Have the Opportunity to Agree or Object

We may use or disclose your protected health information in the circumstances described in this Section III, without seeking an authorization, provided we first give you an opportunity to object to such use or disclosure. If you are present, we may either obtain your agreement to use or disclose your protected health information as described below, or we may provide you with an opportunity to object and accept your failure to object as your agreement, or we may reasonably infer from the circumstances that you do not object. If you are not present or are unable to agree or object to such use or disclosure of your protected health information, we may use our professional judgment to determine whether the use or disclosure of your protected health information is in your best interest. All communications described in this Section III may be done orally.

Individuals Involved in your Care. Unless you object, we may disclose your protected health information to your family member, other relative or close personal friend or any other individual identified by you as being a person who is directly involved with your care or payment relating to your care or treatment.

Disaster Relief. Unless you object, we may use or disclose your protected health information to a public or private entity authorized to assist in disaster relief efforts for the purpose of coordinating with such entities the notification of your family or other persons involved in your care.

Notification of Family or Friends. Unless you object, we may use or disclose protected health information to notify or assist in the notification of a family member, a personal representative, or other person responsible for your care of your location and general condition.

IV. Uses and Disclosures of Protected Health Information

Which Do Not Require Your Authorization or Opportunity to Object

We are permitted to make the following uses and disclosures of your protected health information without having to obtain your authorization, or give you an opportunity to object:

Uses and Disclosures Required by Law.

We may use or disclose your protected health information when the use or disclosure is required by law, as long as the use or disclosure meets all applicable requirement by of such law.

Uses and Disclosures for Public Health Activities.

Governmental Activities. We may disclose your protected health information to a public health authority, including but not limited to: the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions; or at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority; the reporting of child abuse or neglect; reporting to the Food and Drug Administration adverse events, product defects or problems, any biological deviations, to track products, to enable product recalls, repairs or replacements, or to conduct post marketing surveillance, reporting a person who may have been exposed to a communicable disease or otherwise be at risk for contracting or spreading a disease or condition as authorized by law.

Employers. We may disclose your protected health information to an employer if you are a member of the employer's workforce and we have been

requested by the employer to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. This only applies if the employer needs such findings to comply with the requirements of federal or state law regarding recording of illness or injury or to carry out responsibilities for workplace medical surveillance. In such an instance, we will provide you with written notice at the time we provide you health care that your protected health information relating to medical surveillance or the workplace and work-related injuries will be disclosed to the employer.

Uses and Disclosures about Victims of Abuse, Neglect, or Domestic Violence.

We may disclose your protected health information, to a government authority if we reasonably believe that you are a victim of abuse, neglect or domestic violence. Such disclosure is only allowed if it is required by law or if it is expressly authorized by law and certain other requirements are met.

Uses and Disclosures for Oversight Activities.

We may disclose your protected health information to health oversight agencies (e.g., the U.S. Department of Health and Human Services) for oversight activities authorized by law, including the following: audits, civil, administrative, or criminal investigations; inspections, licensure or disciplinary actions; audits, civil, administrative, or criminal proceedings or actions; or other appropriate oversight activities.

Disclosures for Judicial Proceedings.

We may disclose your protected health information in a judicial or administrative proceeding if the request for such protected health information is made through or pursuant to: (A) an order from a court or administrative tribunal or (B) in response to a subpoena or discovery request from a party to the proceeding if certain assurances have been provided to us.

Disclosures for Law Enforcement Purposes.

Under certain circumstances, we may disclose your protected health information to law enforcement officials.

Uses and Disclosures Concerning Decedents.

We may disclose protected health information to coroners and medical examiners for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. We may also disclose protected health information to funeral directors to carry out their duties in accordance with applicable laws.

Uses and Disclosures for Cadaveric Organ, Eye or Tissue Donation Purposes. We may disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye, or tissue donation or transplantation.

Uses and Disclosures for Research

Purposes. We may use or disclose your protected health information for research purposes, provided, the research has been approved by appropriate oversight entities and sufficient privacy protections have been implemented.

Uses and Disclosures to Avert a Serious Threat to Health or Safety.

We may disclose your protected health information if we believe the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and the disclosure is made to a person(s) able to prevent or lessen the threat including the target of the threat; or the disclosure is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activities. If you are a member of the Armed Forces we may use and disclose your protected health information for activities deemed necessary by appropriate military command authorities.

National Security and Intelligence Activities.

We may disclose your protected health information to authorized federal officials for the conduct of lawful intelligence, counter intelligence and other national security activities authorized by the National Security Act or for the provision of protective services to the President.

Correctional Activities. We may disclose protected health information of persons in custody of correctional authorities under certain circumstances if requested those authorities.

Workers' Compensation. We may disclose your protected health information as authorized to comply with workers compensation laws.

V. Emergencies.

We may use or disclose your protected health information without your authorization or acknowledgement of receipt of this notice in order to treat you or assist with coordinating your treatment in an emergency situation. As soon as reasonably practicable after treatment has been provided to you, we will seek your acknowledgement of receipt of this notice of privacy practices.

VI. Your Rights.

With regard to your protected health information, you have the following rights:

The Right to Request Restriction of Uses and Disclosures. You have the right to request that we restrict the uses or disclosures of your protected health information to carry out treatment, payment or health care operations to family members, other relatives or persons directly involved in your care or payment. We are not required to agree to any such restrictions, but if we do, we must comply with such restrictions, other than in an emergency or certain other circumstances permitted or required by law.

The Right to Confidential Communications. You have the right to request that we provide you with an alternative means of communication in the event you tell us that our customary methods of communication may not preserve the confidentiality of your information. You may request that we send such communications to you to alternative locations. This request must be made by you, in writing, to our Privacy Contact. The request must specify how or where you wish to be contacted. We will attempt to accommodate all reasonable requests. The Right to Access Protected Health Information. You have a right to access to inspect and copy your protected health information. Under certain circumstances, we may deny your request for access to inspect and copy your protected health information. Depending on the circumstances, our denial of your request for access may be reviewed by a licensed health care professional who was not involved in the original decision to deny your request to review your information.

To request access to your protected health information in our custody, you must submit your request in writing to our Privacy Contact. If you request a copy of your information, we may charge a fee for the cost of copying, postage or other items or services involved with your request. You may not remove our records from the premises. The Right to Amend Protected Health Information. You have the right to request that we amend your protected health information in our custody. We may deny your request to amend your protected health information if a) we did not create the information unless the individual or the entity that created the information is no longer available to make the request amendment, b) the information is not maintained by or in our custody, c) you do not have the right to access such information, or d) we have determined that such information is accurate and complete.

You must submit your request for an amendment to your protected health information in writing to our Privacy Contact and explain the basis for your request.

The Right to an Accounting of Disclosures of Protected Health Information. You have the right to an accounting of how we have disclosed your protected health information we have made in the six-year period prior to the date of your request for accounting.

We are not required to account for uses and disclosures of your protected health information by us:

1. To carry out treatment, payment or health care operations performed by us or our business associates;
2. To other healthcare providers to provide treatment to you;
3. To other covered entities or health care providers for payment activities of said persons;
4. To other covered entities which have had a treatment relationship with you for certain health care operation purposes of said entities;
5. To you pursuant to your rights to access your protected health information;
6. Made pursuant to an authorization signed by you;
7. To friends and family involved in your care and treatment or payment for your care and treatment, or for certain notification purposes;
8. For national security or intelligence purposes;
9. To correctional authorities with respect to persons in custody;
10. That occurred prior to April 13, 2003;
11. For facility directory purposes, if applicable; or
12. Incident to use or disclose or otherwise permitted or required by law. Your request for an accounting must be made in writing to our Privacy Contact at the 3525 N. University, Peoria, Illinois 61604 address. Your first request in any twelve (12) month period will be provided to you at no charge, however, additional requests will be charged to you based on our cost of conducting the accounting. We will inform you of the fee for the additional accountings prior to our conducting the accounting so that you may consider whether to modify or withdraw your request before you incur any fees.

Right to Receive Paper Notice. If you have agreed to receive this notice electronically, you have the right to receive a paper copy of this notice at our Peoria, IL office address.

VII. Complaints.

If you believe that your privacy rights have been violated or that we have not complied with this Notice for Privacy Practices, you may file a written complaint to our Privacy Contact at the 3525 N. University, Peoria Illinois 61604 address or with the Secretary of the U.S. Department of Health and Human Services. Our Privacy Contact can also be reached by calling (855) 476-5837. We will not penalize or charge you for filing a complaint with our Privacy Contact.

VIII. Additional Rights; Effective Date.

This notice of Privacy Practices has been prepared to reflect your rights under the Health Insurance Portability and Accountability Act. If state law provides you with greater access to information, or provides greater protection to that information, than as described in this policy, then Provider shall follow the provisions of state law. Examples of such state laws are the Mental Health and Developmental Disabilities Confidentiality Act, and the AIDS Confidentiality Act and the Genetic Information Privacy Act. In addition, if a Federal law creates a greater protection for the information described in this Policy, the Provider shall follow the provisions of such federal law. An example of such a Federal Law is the Federal Drug Abuse, Prevention, Treatment and Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment, and Rehabilitation Act of 1970.

HIPAA Receipt of Notice of Privacy Practice



PATIENT CONSENT & AUTHORIZATION STATEMENT

1

I, _____, acknowledge that I have received a Notice of Privacy Practices from Solvera Health. I understand that I have rights under the Health Insurance Portability and Accountability Act (HIPAA) as to the ways my protected health information (PHI) may be disclosed. I understand that if I have any questions or concerns about my PHI that I can contact Solvera Health and speak with the privacy officer who will provide additional information and address any concerns I may have.

2

PATIENT SIGNATURE

DATE

PARENT / LEGAL GUARDIAN SIGNATURE

RELATIONSHIP TO
PATIENT

In recognition of our responsibility in rendering patient care, these rights and responsibilities are affirmed in the policies and procedures of Solvera Healthcare Center, Inc. (SHCC)

The Patient Has The *Right*

To be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy

To prompt and reasonable response to questions and requests.

To know who is providing medical services and who is responsible for his or her care

To know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

To know what rules and regulations apply to his or her conduct.

To be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

To refuse treatment, except as otherwise provided by law.

To be given, upon request, full information, and necessary counseling on the availability of known financial resources for his or her care.

To know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.

To receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

To receive a copy of reasonably clear and understandable, itemized bill and, upon request, to have charges explained.

To receive impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.

To receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

To know if medical treatment is for purposes of experimental/research and to give his or her consent or refusal to participate in such experimental research.

To express grievances regarding any violation of his or her rights, as stated in Illinois law, through the grievance procedure of the health care provider or health care facility, which served him or her, and to the appropriate state-licensing agency.

To participate in decisions involving their health care, unless contraindicated by concerns for their health.

To appropriate assessment and management of pain.

In recognition of our responsibility in rendering patient care, these rights and responsibilities are affirmed in the policies and procedures of Solvera Healthcare Center, Inc. (SHCC)

A Patient Is Responsible

For providing Solvera Healthcare Center, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.

For reporting unexpected changes in his or her condition to the health care provider.

For reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

For following the treatment plan recommended by the health care provider.

For consideration and respect of SHCC staff and property

For keeping appointments and when he or she is unable to do so for any reason, for notifying the health care facility.

For his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

For assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

For assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

For following facility rules and regulations affecting patient care and conduct.

For asking what to expect regarding pain, pain management and other options available.