



NOTICE OF RIGHTS AND RESPONSIBILITIES

APM has adopted the following policies in regard to Patients' Rights and Responsibilities.

RIGHTS

You Have the Right to:

1. Receive care in a respectful and courteous manner. Not to be discriminated against and to receive care in a safe setting, free from abuse or harassment.
2. Receive privacy concerning your medical care. Discussions and consultations of your care, as well as examinations, treatments and records, are confidential and should be conducted in a discreet manner.
3. Know the names of the employees and the medical staff members that treat you.
4. Be fully informed about a treatment or procedure, and the expected outcome before it is performed. Refuse treatment as permitted by law.
5. Know the provisions that APM has arranged for handling emergency care and after hours care.
6. Have all reasonable requests responded to promptly and adequately within the capacity of APM.
7. Be informed by a Medical Staff member of your continuing health care requirements after discharge from APM. You may have a designee assigned to receive this information.
8. Review your bill and receive a detailed explanation of all fees for specific services, regardless of the payment source.
9. Have your rights apply to any person with the legal responsibility to make medical care decisions for you.
10. An interpreter or use of alternative communication techniques/aids as needed.
11. Know that APM does not honor advance directives. However, you may notify staff regarding any advance directives you have in place. That information will be passed with your medical chart in the event that you must be transferred to another facility. State law and forms on this issue are provided through:
Virginia Department for the Aging
1610 Forest Avenue, Suite 100
Richmond, VA 23229
Phone: 1-800-552-3402
www.vda.virginia.gov/advmedir.asp.
12. To know that APM is privately owned and managed by a group of physicians who have been credentialed to work here.
13. Know what responsibilities you have as a patient.

RESPONSIBILITIES

You have the Responsibility to:

1. Observe the rules and regulations of APM for your treatment. Be considerate of other patients and facility personnel
2. Read and understand all consents you sign. Report to the staff if you do not understand the planned course of your treatment and what is expected of you.
3. Follow up on your doctor's instructions, take medications when prescribed, and ask any question you might have concerning your health care.
4. Inform providers of your current health status, and all medications you take including over-the-counter products and supplements.
5. Act responsibly in your treatment plan, and comply with treatment recommendations. Failure to do so can adversely impact the desired clinical results.
6. Indicate if you feel your privacy and/or safety is being violated.
7. Provide a responsible adult to transport you home after procedures. Have a responsible adult be accountable for you at home after procedures if specified.
8. Pay financial obligations stated in our financial policy
9. Be respectful of APM's staff, property and equipment. To be considerate of the rights of other patients and healthcare workers, and not interfere with the general functioning of the facility.
10. File a grievance within 30 days of the occurrence if you feel your rights have been violated. Office of Medicare Beneficiary Ombudsman is listed below, as well as the State agency to which you can report complaints.

APM Spine and Sports Physicians

Practice Administrator
Phone: (757)422-2966
Fax: (757)422-4563

Virginia Department of Health Professions

Perimeter Center
9960 Mayland Drive
Henrico, Virginia 23233-1463
Phone: (804)527-1560
Fax: (804)527-4424
www.enfcomplaints@dhp.va.gov

Office of Medicare Beneficiary Ombudsman

www.medicare.gov.Ombudsman/activities.asp

Phone: (800) MEDICARE (1-800-633-4227)
TTY: 1-877-486-2048
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

I declare that I have read, understand and agree to the above rights and responsibilities.

Patient Signature (Parent or Guardian, if under 18)

Date

Witness Signature (Employee/Representative of APM)

Date