C N S N T

PATIENTS' RIGHTS
THE RIGHTS OF PATIENTS INCLUDE, BUT ARE NOT LIMITED TO THE RIGHT TO:

1. Considerate and respectful care, and to be made comfortable. You have the right to respect for your cultural, psychosocial, spiritual, and personal values and beliefs, beliefs and preferences.
2. Have a family member (or other representative of your choosing) and your own physician notified promptly of your admission to the hospital.
3. Know the name of the licensed health care practitioner who has primary responsibility for coordinating your care and the names and professional relationships of other physicians and non-physicians who will see you.
4. Receive information about your health status, course of treatment, prospects for recovery and outcomes of care (including unanticipated outcomes) in terms you can understand. You have the right to participate in the development and implementation of your plan of care. You have the right to participate in ethical questions that arise in the course of your care, including issues of conflict resolution, withholding resuscitative services, and forgoing or withdrawing life-sustaining treatment.
5. Make decisions regarding medical care, and receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse a course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, alternate courses of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.
6. Request or refuse treatment, to the extent permitted by law. However, you do not have the right to demand inappropriate or medically unnecessary treatment or services. You have the right to leave the hospital even against the advice of members of the medical staff, to the extent permitted by law.
7. Be advised if the hospital/licensed health care practitioner 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.
8. Reasonable responses to any reasonable requests made for service.
9. Appropriate assessment and management of your pain, information about pain, pain relief measures and to participate in pain management decisions. You may request or reject the use of any or all modalities to relieve pain, including opiate medication, if you suffer from severe chronic intractable pain. The doctor may refuse to prescribe the opiate medication, but if so, must inform you that there are physicians who specialize in the treatment of severe chronic intractable pain with methods that include the use of opiates.
10. Formulate advance directives. This includes designating a decision maker if you become incapable of understanding a proposed treatment or become unable to communicate your wishes regarding care. Practitioners who provide care, whether in the hospital setting or in our clinics, shall comply with these directives. All patients' rights apply to the person who has legal responsibility to make decisions regarding medical care on your behalf.
11. Have personal privacy respected. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. You have the right to be told the reason for the presence of any individual. You have the right to have visitors leave prior to an examination and when treatment issues are being discussed. Privacy curtains will be used in semi-private rooms.
12. Confidential treatment of all communications and records pertaining to your care in the hospital or health centers. You will receive a separate "Notice of Privacy Practices" that explains your privacy rights in detail and how we may use and disclose your protected health information.
13. Receive care in a safe setting, free from verbal or physical abuse or harassment. You have the right to access protective services including notifying government agencies of neglect or abuse.

14. Be free from restraints and seclusion of any form used as a means of coercion, discipline, convenience, or retaliation by staff.
15. Reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of the persons providing the care.
16. Be informed by the physician, or a delegate of the physician, of continuing health care requirements following discharge from the hospital. Upon your request, a friend or family member may be provided this information also.
17. Know which hospital or health center rules and policies apply to your conduct while a patient.
18. Designate visitors of your choosing, if you have decision-making capacity, whether or not the visitor is related by blood or marriage, unless:
    - No visitors are allowed.
    - The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff or other visitor to the health facility, or would significantly disrupt the operations of the facility.
    - You have told the health facility staff that you no longer want a particular person to visit.

    However, a health facility may establish reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors. The health facility must inform you (or your support person, where appropriate) of your visitation rights, including any clinical restrictions or limitations. The health facility is not permitted to restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.
19. Have your wishes considered, if you lack decision-making capacity, for the purposes of determining who may visit. The method of that consideration will be disclosed in the hospital policy on visitation. At a minimum, the hospital shall include any persons living in your household and any support person pursuant to federal law.
20. Examine and receive an explanation of the hospital's or health center's bill regardless of the sources of payment.
21. Exercise these rights without regard to sex, race, color, religion, ancestry, national origin, age, disability, medical condition, marital status, sexual orientation, educational background, economic status or the source of payment for care.
22. File a grievance. If you want to file a grievance with the hospital, you may do so by writing or calling:
    Patient Relations
    2500 Alhambra Ave.
    Martinez, CA 94553
    925-370-5144.

    The grievance committee will review each grievance and provide you with a written response within 30 days. The written response will contain the name of a person to contact at the hospital, the steps taken to investigate the grievance, the results of the grievance process, and the date of completion of the grievance process. Concerns regarding quality of care or premature discharge will also be referred to the Utilization Review Department.
23. File a complaint with the California Department of Public Health regardless of whether you use the hospital's grievance process. The phone number and address is:

    Dept. of Public Health Center
    805 Marina Bay Parkway
    Building P, 1st Floor
    Richmond, CA 94804-6403
    (510) 620-3900

Services Provided Are Not Free: If you do not have health insurance or program coverage for you or your family, you may be eligible for Medi-Cal, Healthy Families, California Children's Services, Basic Health Care, the Health Coverage Initiative, or other health coverage programs. If you are not eligible for any health coverage program, or if you are liable for high medical costs after your insurance pays, you may be eligible for a discount on your medical bill by the CCHS Policy 707-C Discount Payment Program or the CCHS Policy 708-C Charity Care Program.

Contact the Financial Counseling Department at 1-800-771-4270 for further information and application assistance. Financial Counselors are available Monday - Friday from 7 A.M. to 6 P.M. California Health and Safety Code 127410.

Our mission is to provide safe and effective health care to those in need. To better serve you, we ask that you:

- Be considerate of other patients, staff, and visitors.
- Provide an accurate and complete description of past medical history, illnesses, medications, hospitalizations, and present condition.
- Cooperate with physicians and others caring for you.

C N S N T

CONSENT TO SERVICES AND CONDITIONS OF SERVICES AND OF ADMISSION

MEDICAL/SURGICAL TREATMENT CONSENT: The undersigned consents to the procedures that may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services, which may include but are not limited to laboratory procedures, x-ray examinations, dental, medical or surgical treatment or procedures, anesthesia, or hospital services rendered the patient under the general and special instructions of the patient's physician or of any other member of the hospital or health center's medical staff, including physician residents, dentists and independent contract physicians. The undersigned further agrees to the provisions expressed on the reverse side of this form.

TEACHING PROGRAM: The undersigned understands that Contra Costa Health Services, Contra Costa Regional Medical Center and Contra Costa Health Centers are teaching institutions and that residents, interns, and health care students, under the supervision of professional staff, may be involved in providing medical and/or health care.

CONSENT TO RELEASE MEDI-CAL ELIGIBILITY: The undersigned authorizes the Contra Costa County Employment and Human Services Department to release information concerning the status of the patient's Medi-Cal application, and to send information regarding the patient's Medi-Cal eligibility to the Contra Costa Health Services Department. The undersigned also authorizes the above Agency to send Contra Costa Health Services a Letter of Authorization, to allow the Medi-Cal program to be billed for any medical services received at a county facility that may be covered by the Medi-Cal program.

CONSENT TO TELEPHONE CONTACT / TELEPHONE CONSUMER PROTECTION ACT: I authorize Contra Costa Health Services, Contra Costa Regional Medical Center and Health Centers to contact me about obtaining potential financial assistance for my account(s) and/or for collection services and their successors, assigns, affiliates or agents to contact me at any telephone number associated with my account(s), including landline and/or wireless telephone numbers, whether provided in the past, present or future. I agree that methods of contact may include autodialed calls, artificial or prerecorded voice messages, automatic telephone dialing systems, and/or text messages, as applicable. I agree to notify the hospital with any limitations and may revoke this agreement by calling 925-370-5220.

FINANCIAL AGREEMENT: The undersigned promises to reimburse the County of Contra Costa for any services not covered by Medicare, Medi-Cal, insurance, or any other health care compensation carrier, at the rates established by the Contra Costa County Board of Supervisors during the time this consent is in effect. This consent is valid and in effect for any hospital, outpatient, emergency or other medical care and/or services rendered to the patient at any time within 365 days from the date indicated below. The undersigned further agrees to use any damages or indemnity paid to or on behalf of the patient as a result of the injury or illness which necessitated this care to reimburse the county up to the amount billed, but not to exceed the rates set by the Board of Supervisors.
—continued on reverse

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and received a copy of the "Patients' Rights", and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

_____ _____
DATE SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE

_____ _____
WITNESS TO SIGNATURE IF REPRESENTATIVE, STATE RELATIONSHIP

If patient unable to sign, STATE REASON: _____ Date _____ By _____

ADVANCE DIRECTIVE (ED, inpatient)

Do you have an Advance Directive?	☐ Yes	☐ No
If yes, is a copy on file?	☐ Yes	☐ No
If not on file will you provide us a copy?	☐ Yes	☐ No

If "no" please select one of the following:

____ Conflicts with personal/religious beliefs

____ I do not wish to provide/do not have one

If "no", was an Advance Directive pamphlet given to you? ☐ Yes ☐ No

____ Unable to Determine/Reason _____

Signature _____ Date _____

_____
INTERPRETER IDENTIFICATION NUMBER

ACKNOWLEDGMENT OF HIPAA NPP

____ I have received a copy of the Contra Costa County Notice of Privacy Practices.

____ I declined to receive a copy of the Contra Costa County Notice of Privacy Practices.

Signature _____

Date _____

C N S N T

CONSENT TO SERVICES AND CONDITIONS OF SERVICES AND OF ADMISSION, CONT.

FINANCIAL AGREEMENT, continued: The undersigned waives the statute of limitations on this matter for a period of 10 years. This agreement and waiver is binding on the undersigned, his or her heirs, assigns, administrators, and executors.

The undersigned authorizes the Social Security Administration to release to Contra Costa Health Services Department information concerning the status of the patient's Social Security benefits, including the type of benefit, amount receiving, and the effective date. The undersigned also authorizes the above agency to release information about the patient's Medicare benefit, including the effective date.

ASSIGNMENT OF BENEFITS: The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to Contra Costa County of any insurance benefits otherwise payable to or on behalf of the patient for this hospitalization and/or these outpatient services, including emergency services if rendered, in an amount not to exceed the County's regular charges. A photocopy of this authorization shall be considered as effective and valid as the original.

The undersigned authorizes and directs the attorney, claims adjustor, insurance company and any person(s), company or corporation who may effect a settlement or payment of any claim for damages or indemnity that the patient may have arising from the injury or illness which necessitated this hospital care and/or outpatient services, to deduct the amount of the charges of these services from any sum due the patient and to pay that amount directly to Contra Costa County and the undersigned hereby assigns that amount to Contra Costa County.

I hereby authorize Contra Costa Health Services or its representative, including a third party vendor, to prepare, complete, and file any paperwork, or documents, including medical and financial records necessary to process claims under a pharmaceutical assistance or drug reimbursement program. I assign all benefits due and received on my behalf to Contra Costa Health Services.

RELEASE OF INFORMATION FOR REIMBURSEMENT: The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, Contra Costa County may disclose portions of the patient's record, including his/her medical and psychiatric records, to any person or corporation which is or may be liable for all or any portion of the charges, including but not limited to insurance companies, health care service plans, workers's compensation carriers, Social Security Administration, and peer review organizations.

NURSING CARE: The undersigned understands that Contra Costa Regional Medical Center and Contra Costa Health Centers provide only general duty nursing care unless the physician orders more intensive nursing care to be provided.

PERSONAL VALUABLES: The undersigned understands and agrees that this hospital maintains a safe for the safekeeping of money and valuables and that the hospital is not liable for any loss or damage to money, jewelry, documents, or any other personal property, which is not deposited in the safe. The liability of the hospital for loss of any personal property which is deposited with the hospital for safekeeping is limited by statute to five hundred dollars ($500.00) unless a written receipt for a greater amount has been obtained from the hospital by the patient.

CONSENT TO PHOTOGRAPH: The undersigned consents to the taking of pictures (digital, video, still photography) of the patient's medical or surgical condition or treatment for the purpose of diagnosis or treatment, or for medical education conducted by the hospital or health centers.

LEAVING HOSPITAL AGAINST ADVICE: In the event the patient elects to leave the hospital against the advice of a physician, I, the patient, or the patient's representative, hereby release the County of Contra Costa, its officers, agents, servants, employees, and physicians, from any and all responsibility for any ill effects which may result from leaving.

DRUGS & ALCOHOL: Patients admitted to Contra Costa Regional Medical Center shall not use or possess any alcohol or drug or drug appliance/apparatus not prescribed by or on behalf of the attending physician and dispensed by the hospital staff during the patient's current stay.