APEX MEDICAL CENTER

PATIENT CONSENT TO RESUSCITATIVE MEASURES

NOT A REVOCATION OF ADVANCE DIRECTIVES OR MEDICAL POWERS OF ATTORNEY

ALL PATIENTS HAVE THE RIGHT TO PARTICIPATE IN THEIR OWN HEALTH CARE DECISIONS AND TO MAKE ADVANCE DIRECTIVES OR TO EXECUTE POWERS OF ATTORNEY THAT AUTHORIZE OTHERS TO MAKE DECISIONS ON THEIR BEHALF BASED ON THE PATIENT'S EXPRESSED WISHES WHEN THE PATIENT IS UNABLE TO MAKE DECISIONS OR UNABLE TO COMMUNICATE DECISIONS. THIS CENTER RESPECTS AND UPHOLDS THOSE RIGHTS.

HOWEVER, UNLIKE IN AN ACUTE CARE HOSPITAL SETTING, THIS CENTER DOES NOT ROUTINELY PERFORM "HIGH RISK" PROCEDURES. MOST PROCEDURES PERFORMED IN THIS FACILITY ARE CONSIDERED TO BE OF MINIMAL RISK. OF COURSE, NO PROCEDURE IS WITHOUT RISK. YOU WILL DISCUSS THE SPECIFICS OF YOUR PROCEDURE WITH YOUR PHYSICIAN WHO CAN ANSWER YOUR QUESTIONS AS TO ITS RISKS, YOUR EXPECTED RECOVERY AND CARE AFTER YOUR PROCEDURE.

THEREFORE, IT IS OUR POLICY, REGARDLESS OF THE CONTENTS OF ANY ADVANCE DIRECTIVE OR INSTRUCTIONS FROM A HEALTH CARE SURROGATE OR ATTORNEY IN FACT, THAT IF AN ADVERSE EVENT OCCURS DURING YOUR TREATMENT AT THIS FACILITY WE WILL INITIATE RESUSCITATIVE OR OTHER STABILIZING MEASURE AND TRANSFER YOU TO AN ACUTE CARE HOSPITAL FOR FURTHER EVALUATION. AT THE ACUTE CARE HOSPITAL FURTHER TREATMENT OR WITHDRAWAL OF TREATMENT ALREADY BEGUN WILL BE ORDERED IN ACCORDANCE WITH YOUR WISHES, ADVANCE DIRECTIVE OR HEALTH CARE POWER OF ATTORNEY. YOUR AGREEMENT WITH THIS POLICY BY WAY YOUR SIGNATURE BELOW DOES NOT REVOKE OR INVALIDATE ANY CURRENT HEALTH CARE DIRECTIVE OR HEALTH CARE POWER OF ATTORNEY.

IF YOU DO NOT AGREE TO THIS POLICY, WE ARE PLEASED TO ASSIST YOU TO RESCHEDULE THE PROCEDURE.

PLEASE CHECK THE APPROPRIATE LINE IN ANSWER TO THESE QUESTIONS. HAVE YOU EXECUTED AN ADVANCE HEALTH CARE DIRECTIVE, A LIVING WILL, A POWER OF ATTORNEY THAT AUTHORIZES SOMEONE TO MAKE HEALTH CARE DECISIONS FOR YOU?

__ YES, I HAVE AN ADVANCE DIRECTIVE, LIVING WILL OR HEALTH CARE POWER OF ATTORNEY.

__ NO, I DO NOT HAVE AN ADVANCE DIRECTIVE, LIVING WILL OR HEALTH CARE POWER OF ATTORNEY.

__ I WOULD LIKE TO HAVE INFORMATION ON ADVANCE DIRECTIVES.

IF YOU CHECKED THE FIRST LINE "YES" TO THE QUESTION ABOVE, PLEASE PROVIDE US A COPY OF THAT DOCUMENT SO THAT IT MAY BE MADE A PART OF YOUR MEDICAL RECORD.

BY SIGNING THIS DOCUMENT, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ITS CONTENTS AND AGREE TO THE POLICY AS DESCRIBED. IF I HAVE INDICATED I WOULD LIKE ADDITIONAL INFORMATION, I ACKNOWLEDGE RECEIPT OF THAT INFORMATION.

BY: _____(PATIENT'S SIGNATURE)

PATIENT'S LAST NAME:	PATIENT'S FIRST NAME:	DATE:

IF CONSENT TO THE PROCEDURE IS PROVIDED BY ANYONE OTHER THAT THE PATIENT, THIS FORM MUST BE SIGNED BY THE PERSON PROVIDING THE CONSENT OR AUTHORIZATION.

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ITS CONTENTS AND AGREE TO THE POLICY AS DESCRIBED:
BY:_____(SIGNATURE)
_____(PRINT NAME)

Relationship to Patient:
__ COURT APPOINTED GUARDIAN
__ ATTORNEY IN FACT
__ HEALTH CARE SURROGATE
__ OTHER_____

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		Revision Date: 03/2015
POLICY: PATIENT BILL OF RIGHTS		
DEPARTMENT: ALL	Approved By: Administrator	

POLICY: At Apex Medical Center, each patient has the right to:

1.1 To receive care that respects your individual, cultural, spiritual and social values, regardless of race, color, creed, nationality, age, gender, disability or source of payment.

1.2 To request and receive medically appropriate treatment and services within the facility's capacity and mission and to know what services are available at the organization.

1.3 To receive respectful, considerate, compassionate care that manages your pain as well as possible, and promotes your dignity, privacy, safety and comfort. To expect reasonable continuity of care.

1.4 To receive a full explanation, in understandable language, of diagnosis, evaluation, treatment and prognosis in terms that are easily understood and that include benefits, risks involved, significant complications, and the outcome and alternative treatments available.

1.5 When medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person. This person shall receive all of the patient rights and responsibilities and shall exercise these rights.

1.6 To know it is your responsibility as a patient to provide accurate and complete information.

1.7 To expect that efforts will be made to provide you with the best of care during and after your procedure.

1.8 To know at all times the identity and professional status of all individuals providing any type of service. To request a second opinion or change physicians if other qualified providers are available. To know the credentials of the health care professionals providing your care. To be aware that the facility and its healthcare providers have malpractice insurance coverage and to be informed if a provider does not.

1.9 To participate in the decisions about your medical care and treatment plan, and to receive prompt/reasonable responses to questions or requests, except when such participation is contraindicated for medical reasons. To accept or refuse recommended tests or treatments, to the extent the law permits, and to be informed of the medical consequences of any actions taken. To receive from your physician information necessary to give informed consent prior to your procedure or treatment. To refuse to sign a consent form if there is anything you do not understand or agree to. To change your mind about any procedure to which you have consented.

1.10 To receive services that are accessible to those individuals with communications barriers such as visual impairment, hearing impairments, communication disorders, inability to read or follow directions, and non English speakers.

1.11 To be informed and to give or withhold consent if our facility proposes to engage in or perform research associated with your care or treatment.

1.12 To be informed of Advance Directives specific to the state of Nevada.

1.13 To expect that your advance directives/living will is honored when ethically possible and in accordance with state law. However; the facility WILL NOT honor a DNR (Do Not Resuscitate). In an emergency, we will act to employ all life saving measures while you are under our care and arrangements will be made for your transfer to a hospital that will follow your Power of Attorney.

1.14 To have patient disclosures and records treated confidentially, and patients are given the opportunity to approve or refuse their release, expect when release is required by law.

1.15 To receive marketing materials from the facility that are accurate and not misleading; to receive accurate reflection of the facility's accreditation standing with AAAHC.

1.16 To be made aware of our fee for services and payment policies.

1.17 The right to voice grievances, written and/or verbal regarding treatment or care that is (or fails to be) furnished. Grievances may be voiced to: Precision Surgery Center of Las Vegas, Attn: Administrator 1701 Bearden Drive, Suite 202, Las Vegas, Nevada, 89106. Phone: 702-984-4456
Also to the State of Nevada Division of Public and Behavioral Health at 4220 S. Maryland Pkwy. Suite 810, Bldg. D, Las Vegas, NV 89119Phone: 702-486-6515,
website: http://www.health.nv.gov/HCQC_HealthFacilities.htm

1.18 Medicare patients have the right to voice grievances directly to Medicare by contacting 1-800-633-4227, or online at: www.cms.hhs.gov/center/ombudsman.asp.

1.19 To be informed of available resources for resolving disputes, grievances, and conflicts; without fear of reprisal, and to be free from all forms of abuse (Verbal, Mental, Sexual, or Physical) mistreatment, neglect, harassment, or discrimination, and have access to facility level, state and federal assistance in clarifying ethical issues guiding treatment decisions.

1.20 To know that all alleged violations/grievances will be fully documented.

1.21 To know that all allegations must be immediately reported to a person in authority in the Center.

1.22 To know that only substantiated allegations must be reported to the State authority or the local authority, or both. To participate in the resolution of those issues.

1.23 To receive and examine an explanation of your bill regardless of the source of payment.

1.24 To obtain your medical records when requested. To ask that your medical record be corrected if you believe it is not accurate or not complete, or to be told how to add a statement that you disagree with information in the record.

1.25 To exercise these rights without being subject to discrimination or reprisal.

X_____ _____

Patient Signature Date

_____

Printed Name

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POLICY: PATIENT RESPONSIBILITIES		
DEPARTMENT: ALL	Approved By: Administrator	

POLICY: The following responsibilities apply to patients, family members, significant others, and/or decision-makers when they are acting for the patient:

1.1 To answer questions about your past illnesses, hospital stays, medicines, and other health matters when asked by a doctor or staff member; to include over-the-counter products, dietary supplements and any allergies or sensitivities. To cooperate with doctors and staff during your visit; and participate in your healthcare at the facility.

1.2 To provide complete and accurate information concerning past medical history, present complaints and other health matters.

1.3 To seek clarification when necessary to fully understand your health problems and proposed plan of action. To make it known when you do not clearly comprehend the course of your medical treatment and what is expected of you.

1.4 To make known to your physician, caregiver, and surgery facility, any advance directives or religious/cultural beliefs to be honored. However; the facility WILL NOT honor a DNR (Do Not Resuscitate). In an emergency, we will act to employ all life saving measures while you are under our care and arrangements will be made for your transfer to a hospital that will follow your Power of Attorney.

1.5 To follow the treatment plan and participate in the plan of care as ordered by the physician responsible for care, including the instructions of nurses and other health professionals when carrying out the physician's orders. The consequences of non-compliance or refusal of recommended treatment and instruction rests with you.

1.6 To follow rules, regulations, policies and procedure affecting patient care, confidentiality, conduct and safety. To report any perceived safety issue to any staff member.

1.7 To be considerate of the rights of others. To be respectful of all health care providers and staff, as well as other patients and property.

1.8 To provide information for insurance claims and for working with our business office to make payment arrangements when necessary.

1.9 To keep appointments or notify the facility when you are unable to do so.

2.0 To accept personal financial responsibility for any charges not covered by your insurance.

2.1 To provide a responsible adult to transport you home from the facility and remain with you for 24 hours if required by your provider.

This facility does not provide after hours care, or emergency care.

X_____

Patient Signature