RIVERS HEALTH
A member of Marshall Health Network

Mason County Schools | On-Site Healthcare

Enrollment Packet

Rivers Health is proud to provide medical care for students and employees at Mason County Schools

Please take the completed form inside this packet to your school office for delivery to the Rivers Health Nurse Practitioner or email her at schoolbasedhealth@pvalley.org.

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Rivers Health is pleased to support the Mason County School system and their nursing staff by providing on-site healthcare to students and employees.

Medical services are available on a rotating schedule during the school day. Charlotte Reed, FNP-BC, works in collaboration with a Rivers Health physician. Charlotte can diagnose, treat illness, prescribe medications, and work with your family physician and school nurse.

Charlotte Reed, FNP-BC
Mason County Schools
On-Site Healthcare
304.593.8822

Quick Treatment for Minor Illnesses & Injuries

- Cold / flu
- Ear infection
- Minor wounds and abrasions
- Sinus infection
- Sports physicals
- Wellness checks

Benefits Include:

- Parents save valuable work time and expenses by not having to leave work or drive to school
- Mason County School employees save time
- Students don't have to miss school
- Prescriptions are called to your pharmacy of choice

WEEKLY SCHEDULE

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Hannan Jr/Sr High School 8:00am - 11:30am	**Leon & Roosevelt Elementary** 8:00am - 11:30am	**Wahama Jr/Sr High School** 8:00am - 11:30am	**Point Pleasant Primary School** 8:00am - 11:30am	**Point Pleasant Intermediate School** 8:00am - 11:30am
Ashton Elementary 12:00pm - 3:30pm	**Point Pleasant Jr/Sr High School** 12:00pm - 3:30pm	**New Haven Elementary** 12:00pm - 3:30pm	**Beale Elementary** 12:00pm - 3:30pm	**Point Pleasant Jr/Sr High School** 12:00pm - 3:30pm

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Rivers Health (RH) is pleased to support the Mason County School System and their nursing staff by providing medical care to students and employees. Medical services are available on a rotating schedule during the school day. The FNPs work in collaboration with a RH physician and are qualified to diagnose, treat illness and prescribe medications. The FNPs also work with your family physician and school nurse.

- Parents save valuable work time and expenses by not having to leave work or drive to school
- Mason County School employees save time
- Students don't have to miss school
- Prescriptions are called to your pharmacy of choice
- To access medical services on-site by a FNP from RH, please take a few moments to complete the enclosed forms in this packet.

<u>Services and treatments provided may include and are not limited to the following:</u>

- Minor illness and injuries like the following: (cold/flu, sinus infection, ear infection, sore throat, minor wounds/abrasions, sports physicals)
- Annual well checks
- Counseling
- Health education
- Immediate care
- Preventive care

For more information, please call the Family Nurse Practitioner at 304.593.8822.

Locations

Ashton Elementary
Beale Elementary
Hannan Jr/Sr High School
Leon Elementary
Mason County Career Center
New Haven Elementary
Point Pleasant Intermediate
Point Pleasant Jr/Sr High School
Point Pleasant Primary
Roosevelt Elementary
Wahama Jr/Sr High School

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ENROLLMENT FORM

For Mason County School's School Based Medical Services

Sponsored by Rivers Health

FOR STUDENTS 17 YEARS OF AGE AND YOUNGER

A parent or legal guardian must complete these forms.

FOR STUDENTS AND EMPLOYEES 18 YEARS OF AGE AND OLDER

The patient must complete these forms.

STUDENT OR MASON COUNTY SCHOOL SYSTEM EMPLOYEE INFORMATION

Name: _____

Email Address: _____

Cell: _____

Address: _____

City/State/Zip:_____

Grade: _____ Gender: _____ Race: _____

Preferred Language: _____

PARENT / GUARDIAN INFORMATION

Father: _____ Email:_____

Phone: (H)_____ (W)_____ (C)_____

Mother: _____ Email_____

Phone: (H)_____ (W)_____ (C)_____

Guardian: _____ Email_____

Phone: (H)_____ (W)_____ (C)_____

Alternate Contact:_____ Email_____

Phone: (H)_____ (W)_____ (C)_____

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Consent for Treatment and Testing, Patient Satisfaction Surveys, Guarantee of Account and Assignment

CONSENT FOR TREATMENT

CONSENT is hereby given to Rivers Health, Inc. (RH) and the Physicians, Healthcare Providers, and staff who are taking care of me to order such laboratory tests (including HIV-related testing), administer such anesthetics and medications and to perform such medical and/or surgical procedures that are deemed necessary on an outpatient/emergency basis or to be admitted as an inpatient if so ordered by my attending physician. Consent is also given for pictures/videos to be taken for medical or scientific purposes. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the result of evaluation and treatment at RH. I understand that among those who treat patients at RH are medical, nursing and other healthcare personnel in training who may be present and participating in my care as part of their education.

I understand that I may receive a survey by phone, text, mail, or email from Press Ganey asking about my satisfaction with my care and services while a patient at RH. I understand that the email address provided may be used to invite me to enroll in RH's patient portal. I may also receive calls from RH staff to follow up on my care and treatment

GUARANTEE OF ACCOUNT AND ASSIGNMENT OF INSURANCE BENEFITS

I accept responsibility for payment of all charges and fees for hospital and professional services covering hospitalization and/or outpatient/emergency testing and treatment services. I understand that RH will bill my insurance carrier on my behalf for all charges incurred; however, I agree that I am responsible for the full amount of my account. I agree to provide all information necessary to bill my insurance carrier and to cooperate with requests by RH or my insurance carrier necessary to get my bill paid including without limitation submitting coordination of benefit inquiries. I further authorize any insurance benefits that are reimbursable for such services to be paid directly to RH and consent to the release of any medical information that may be required to verify the justness of any claim made as a result of this hospitalization and/or outpatient/emergency testing and treatment and payment thereof. I agree that RH and its employees, agents, servicers, debt collectors, independent contractors, successors and/or assigns (hereafter collectively referred to as "RH") may call me through the use of any dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice or message, even if I am charged for the call or message. I expressly agree that such automated calls may be made by RH to any telephone number (including numbers assigned to any paging, cellular, or mobile service, or any service for which I am charged for the call) that I have provided previously or may provide in the future in connection with my account. I expressly consent to such automated calls. I also expressly agree that this permission applies to the use of text messaging and email. With such consent, I specifically waive any claim I may have against RH for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. §227.

I understand that, with certain exceptions, Physicians and Healthcare Providers who provide services to me are not employees of RH, but are independent contractors who will separately bill for their services. I hereby accept responsibility for payment of all professional services rendered by Point Imaging (XRAY), MidAtlantic Anesthesia ("ANESTHESIA") and St. Mary's Medical Center (PATHOLOGY/LAB) and other organizations that provide services such as reference laboratory services during my hospitalization and/or outpatient/emergency testing and treatment services. I authorize my insurance company or third party payor to pay directly to X-RAY, LAB, ANESTHESIA and other organizations described above, as their interests appear, all benefits due me, if any, by reason of services rendered, and I further authorize and consent to the release of any medical information that may be required to verify the justness of any claim made as a result of these services. These organizations will bill my insurance carrier on my behalf for all charges incurred; however, I agree that I am responsible for the full amount of my account.

THE UNDERSIGNED HAS READ THE FORGOING AND UNDERSTANDS AND ACCEPTS.

_____ /_____ /_____

Signature of Patient or Responsible Party | Relationship to Patient | Date

_____ /_____

Witness | Date

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Minor Consent for Treatment

☐See attached note

☐Consent obtained from: _____ at _____

RH Representative Signature:_____

☐Unable to reach parent/guardian- Comments: _____

PLEASE READ AND INITIAL APPLICABLE SECTIONS	APPLICABLE	INITIAL
I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to or obtain from the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.	Medicare patients only	
I acknowledge that I have received a statement of my rights while I am a Medicare hospital patient.	Medicare patients only	
By initialing this line, I do NOT want RH to bill insurance for my care and treatment; I will be responsible for paying for my bill in full.	All patients	
I acknowledge that I received or was offered a copy of RH's Notice of Privacy Practices	All patients	
Privacy Code _____	Inpatient/OBS	

Directory

I understand that Rivers Health maintains a directory to assist members of the public who are looking for patients in the Hospital. That directory includes the patient's name, location in the Hospital, and the patient's religious affiliation which is disclosed only to clergy. I understand if my name is not in the directory, I will be treated as a "confidential/no publicity" patient and no information about me, including my presence in the Hospital, will be disclosed to members of the public.

☐ Include my information in the directory _____ INITIAL

☐ Do not include my information in the directory _____ INITIAL

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Student or Mason County School System Employee Insurance Information

Please check all that apply and send a copy of the front and back of your insurance card(s)

Patient Name:	SS#: Marital Status:
Guardian's Cell Phone:	Patient Phone or Cell Phone:
Maiden Name:	Date of Birth:
Primary Care (Family) Physician & Phone:	Mother's First Name:
Employer's Name & Address:	Employer's Phone:
Patient's Occupation:	Next of Kin & Relationship:
Next of Kin Phone:	Next of Kin Address:

RESPONSIBLE PERSON (SUBSCRIBER) INFORMATION

Responsible Person's Name:	Responsible Person's SS#:
Responsible Person's Address:	Phone #:
Responsible Person's Employer Name & Address:	Responsible Person's Occupation:
Responsible Person's Date of Birth:	Employer Phone:

INSURANCE INFORMATION

Insurance Name: (**PRIMARY**)	Policy #
Subscriber's Name:	Group #
Insurance Address:	

Insurance Name: (**SECONDARY**)	Policy #
Subscriber's Name:	Group #
Insurance Address:	

Signature of Parent or Legal Guardian if 17 years of age & younger

Date

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NAME: _____

Please list any medical problems: _____

_____

Please list any previous surgeries: _____

_____

Please list any family history of medical problems (like diabetes, heart disease, cancer): _____

_____

Social History
Educational level _____ Years completed _____

Tobacco use
Yes ____ How many packs per day ____ ☐ Never Used ☐ Considering Quitting ☐ Not considering quitting ☐ Secondhand Exposure

Alcohol use
☐ None ☐ 0-2 per day ☐ 2+ per day

Substance abuse
☐ None ☐ Cocaine/Crack ☐ Amphetamines ☐ Hallucinogens ☐ Tranquilizers/Sedatives ☐ Opiates ☐ Painkillers ☐ Cub/Designer drugs
☐ Inhalants ☐ Heroin ☐ Injection drugs ☐ Marijuana

Abuse: Physical Abuse ☐ Yes ☐ No Emotional Abuse ☐ Yes ☐ No Sexual Abuse ☐ Yes ☐ No

Allergies: _____

Current Medications (please include any over the counter and herb supplements)

Medication Name	**Strength/Route/Frequency**
_____	_____
_____	_____
_____	_____
_____	_____

Pharmacy _____ **Location** _____

_____

The Rivers Health Family Nurse Practitioner will also provide annual/routine wellness exams for students and Mason County School Employees on-site at school locations.

_____ **Please initial here if your child has not had an annual/routine well child exam from his/her doctor and you would like the RH Nurse Practitioner to provide your child with a well-child exam.**

_____ **Please initial here if you are 18 years of age and older and have not had an annual/routine exam from your doctor and you would like the RH Nurse Practitioner to provide you with an annual exam.**

_____ _____
Signature of Parent or Legal Guardian if 17 years of age & younger
Signature of Patient if 18 years of age and older

Date

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Notice of Privacy Practices

Rivers Health, INC.

And other health care providers, which are members of our system, including the following:

Rivers Health Therapy Center
RH Physician Practice Services

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

WE HAVE LEGAL DUTY TO PROTECT HEALTH INFORMATION ABOUT YOU.

We are required to protect the privacy of health information about you and that can be identified with you, which we call "protected health information," or "PHI" for short. We must give you notice of our legal duties and privacy practices concerning PHI:

- We must protect PHI that we have created or received about your past, present, or future health condition, health care we provide to you, or payment for your health care.
- We must notify you about how we protect PHI about you.
- We must explain how, when and why we use and/or disclose PHI about you.
- We may only use and/or disclose PHI as we have described in this Notice.

This Notice describes the types of uses and disclosures that we may make and gives you some examples. In addition, we may make other uses and disclosures, which occur as a byproduct of the permitted uses and disclosures described in this Notice.

We are required to follow the procedures in this Notice. We reserve the right to change the terms of this Notice and to make new notice provisions effective for all PHI that we maintain by first:

- Posting the revised notice in our offices;
- Making copies of the revised notice available upon request (either at our offices or through the contact person listed in this Notice); and
- Posting the revised notice on our website.

1. We may use and disclose PHI about you to provide health care treatment to you.

We may use and disclose PHI about you to provide, coordinate or manage your health care and related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others. For example, we may disclose your protected health information to a pharmacy to fulfill a prescription, to a laboratory to order a blood test, or to a home health agency that is providing care in your home.

2. We may use and disclose PHI about you to obtain payment for services.

Generally, we may use and give your medical information to others to bill and collect payment for the treatment and services provided to you. Before you receive scheduled services, we may share information about those services with your health plan(s). For example, if certain procedures are recommended, we may need to disclose information to your health insurer to get prior approval for the procedure. We may also disclose protected health information to your insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan.

3. We may use and disclose your PHI for health care operations.

We may use and disclose PHI in performing business activities, which we call "health care operations". These "health care operations" allow us to improve the quality of care we provide and reduce health care costs. Examples of the way we may use or disclose PHI about you for "health care operations" include the following:

- Quality assessment and improvement activities.
- Employee review activities.
- Training programs including those in which students, trainees, or practitioners in health care learn under supervision.
- Accreditation, certification, licensing or credentialing activities.
- Reviewing and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs.
- Business management and general administrative activities.
- In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

4. We may use and disclose PHI under other circumstances without your authorization.

- We may use and/or disclose PHI about you for a number of circumstances in which you do not have to consent, give authorization or otherwise have an opportunity to agree or object. Those circumstances include:
- When the use and/or disclosure is required by law.
  For example, when a disclosure is required by federal, state or local law or other judicial or administrative proceeding.
- When the use and/or disclosure is necessary for public health activities. For example, we may disclose PHI about you if you have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.
- When the disclosure relates to victims of abuse, neglect or domestic violence.
- When the use and/or disclosure is for health oversight activities. For example, we may disclose PHI about you to a state or federal health oversight agency, which is authorized by law to oversee our operations.

- When the disclosure is for judicial and administrative proceedings. For example, we may disclose PHI about you in response to an order of a court or administrative tribunal.
- When the disclosure is for law enforcement purposes. For example, we may disclose PHI about you in order to comply with laws that require the reporting of certain types of wounds or other physical injuries.
- When the use and/or disclosure relates to descendants. For example, we may disclose PHI about you to a coroner or medical examiner for the purpose of identifying you should you die.
- When the use and/or disclosure relates to a cadaveric organ, eye or tissue donation purposes.
- When the use and/or disclosure relates to medical research. Under certain circumstances, we may disclose PHI about you for medical research.
- When the use and/or disclosure is to avert a serious threat to health or safety. For example, we may disclose PHI about you to prevent or lessen a serious and eminent threat to the health or safety of a person or the public.
- When the use and/or disclosure relates to specialized government functions. For example, we may disclose PHI about you if it relates to military and veterans' activities, national security and intelligence activities, protective services for the President, and medical suitability or determinations of the Department of State.
- When the use and/or disclosure relates to correctional institutions and in other law enforcement custodial situations. For example, in certain circumstances, we may disclose PHI about you to a correctional institution having lawful custody of you.

5. You can object to certain uses and disclosures.

Unless you object, we may use or disclose PHI about you in the following circumstances:

- We may share your name, your room number, and your condition in our patient listing with clergy and with people who ask for you by name. We also may share your religious affiliation with clergy.
- We may share with a family member, relative, friend or other person identified by you, PHI directly related to that person's involvement in your care or payment for your care. We may share with a family member, personal representative or other person responsible for your care PHI necessary to notify such individuals of your location, general condition or death.
- We may share with a public or private agency (for example, American Red Cross) PHI about you for disaster relief purposes. Even if you object, we may still share the PHI about you, if necessary for the emergency circumstances.

If you would like to object to our use or disclosure of PHI about you in the above circumstances, please call our contact person listed on the cover page of this Notice.

6. We may contact you to provide appointment reminders.

We may use and/or disclose PHI to contact you to provide a reminder to you about an appointment you have for treatment or medical care.

7. We may contact you with information about treatment, services, products or health care providers.

We may use and/or disclose PHI to manage or coordinate your healthcare. This may include telling you about treatments, services, products and/or other healthcare providers. We may also use and/or disclose PHI to give you gifts of a small value.

8. We may contact you for fund-raising activities.

We may use and/or disclose PHI about you, including disclosure to a foundation, to contact you to raise money for the hospital and its operations. We would only release contact information and the dates you received treatment or services at the hospital. If you do not want to be contacted in this way, you must notify in writing our contact person listed on the last page of this Notice.

** ANY OTHER USE OR DISCLOSURE OF PHI ABOUT YOU REQUIRES YOUR WRITTEN AUTHORIZATION **

Under any circumstances other than those listed above, we will ask for your written authorization before we use or disclose PHI about you. If you sign a written authorization allowing us to disclose PHI about you in a specific situation, you can later cancel your authorization in writing. If you cancel your authorization in writing, we will not disclose PHI about you after we receive your cancellation, except for disclosures which were being processed before we received your cancellations.

WE HAVE LEGAL DUTY TO PROTECT HEALTH INFORMATION ABOUT YOU.

1. You have the right to request restrictions on uses and disclosures of PHI about you.

You have the right to request that we restrict the use and disclosure of PHI about you. We are not required to agree to your requested restrictions. However, even if we agree to your request, in certain situations your restrictions may not be followed. These situations include emergency treatment, disclosures to the Secretary of the Department of Health and Human Services, and uses and disclosures described in subsection 4 of the previous section of this Notice. You may request a restriction by contacting the Rivers Health Privacy Officer at 304-675-4340 Ext. 1161.

2. You have the right to request different ways to communicate with you.

You have the right to request how and where we contact you about PHI. For example, you may request that we contact you at your work address or phone number or by email. Your request must be in writing. We must accommodate reasonable requests, but, when appropriate, may condition that accommodation on your providing us with information regarding how payment, if any, will be handled and your specification of an alternative address or other method of contact. You may request alternative communications by contacting the Rivers Health Privacy Officer at 304-675-4340 Ext. 1161.

3. You have the right to see and copy PHI about you.

You have the right to request to see and receive a copy of PHI contained in clinical, billing and other records used to make decisions about you. Your request must be in writing. We may charge you related fees. Instead of providing you with a full copy of the PHI, we may give you a summary or explanation of the PHI about you, if you agree in advance to the form and cost of the summary or explanation. There are certain situations in which we are not required to comply with your request. Under these circumstances, we will respond to you in writing, stating why we will not grant your request and describing any rights you may have to request a review of our denial. You may request to see and receive a copy of PHI by contacting the Rivers Health Privacy Officer at 304-675-4340 Ext. 1161.

4. You have the right to request amendment of PHI about you.

You have the right to request that we make amendments to clinical, billing and other records used to make decisions about you. Your request must be in writing and must explain your reason(s) for the amendment. We may deny your request if: 1) the information was not created by us (unless you prove the creator of the information is no longer available to amend the record); 2) the information is not part of the records used to make decisions about you; 3) we believe the information is correct and complete; or 4) you would not have the right to see and copy the record as described in paragraph 3 above. We will tell you in writing the reasons for the denial and describe your rights to give us a written statement disagreeing with the denial. If we accept your request to amend the information we will make reasonable efforts to inform others of the amendment, including the persons you name who have receive PHI about you and who need the amendment. You may request an amendment of your PHI by contacting the Rivers Health Privacy Officer at 304-675-4340 Ext. 1161.

5. You have the right to a listing of disclosures we have made.

If you ask our contact person in writing, you have the right to receive a written list of certain of our disclosures of PHI about you. You may ask for disclosures made up to six (6) years before your request (not including disclosures made prior to April 14, 2003). We are required to provide a listing of all disclosures except the following:

- For your treatment
- For billing and collection of payment for your treatment
- For our health care operations
- Made to or requested by you, or that you authorized
- Occurring as a byproduct of permitted uses and disclosures
- Made to individuals involved in your care, for directory or notification purposes, or for other purposes
- Allowed by law when the use and/or disclosure relates to certain specialized government functions relates to correctional institutions and in other law enforcement custodial situations)
- As part of a limited set of information which does not contain certain information which would identify you.

The list will include the date of the disclosure, the name (and address if available) of the person or organization receiving the information, a brief description of the information disclosed, and the purpose of the disclosure. If, under permitted circumstances, PHI about you has been disclosed for certain types of research projects, the list may include different types of information.

If you request a list of disclosures more than once in 12 months, we can charge you a reasonable fee. You may request a listing of disclosures by contacting the Rivers Health Privacy Officer at 304-675-4340 Ext. 1161.

6. You have the right to a copy of this Notice.

You have the right to request a paper copy of this Notice at any time by contacting the Rivers Health Privacy Officer at 304-675-4340 Ext. 1161. We will provide a copy of this Notice no later than the date you first receive service from us (except for emergency services, and then we will provide the Notice to you as soon as possible).

YOU MAY FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES

If you think we have violated your privacy rights, or you want to complain to us about our privacy practices, you can contact the Privacy Officer listed below:

Rivers Health
2520 Valley Drive
Point Pleasant, WV 25550
Phone: 304-675-4340 ext. 1611
E-mail: pbrooker@pvalley.org

You may also send a written complain to the United States Secretary of the Department of Health and Human Services.
If you file a complaint, we will not take any action against you or change our treatment of you in any way.

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Patient Bill of Rights

1. A patient has the right to know the ownership of the hospital and any other provider from whom he or she receives services, care or equipment.
2. A patient has the right to be free of restraints or seclusion, except when used as a last resort, to protect the patient or others from imminent harm, or when medically necessary and there is no other less restrictive means available to help the patient be safe.
3. A patient has the right to make informed decisions regarding his or her care or services, including managing pain effectively.
4. A patient has the right to respectful care given by competent personnel. This includes the right to be free from verbal, mental, physical and sexual abuse, neglect and exploitation.
5. A patient has the right, upon request, to be given the name of his or her attending physician, the names of all other physicians directly participating in his or her care, and the names and functions of other healthcare persons having direct contact with the patient within one hour of admission.
6. A patient has the right to every consideration of his or her confidentiality, except as provided by law or third-party contractual agreements.
7. A patient has the right to know which hospital rules and regulations apply to his or her conduct as a patient.
8. A patient has the right to expect emergency procedures to be implemented without unnecessary delay.
9. A patient has the right to quality care and high professional standards that are continually maintained and reviewed.
10. A patient has the right to full information in layman's terms concerning his or her diagnosis, treatment and prognosis, including information about alternative treatments and possible complications, as well as the effect when treatments are refused. When it is not medically advisable to give such information to the patient, the information shall be given on his or her behalf to the patient's next of kin or other designated surrogate.
11. A patient has the right to assistance in obtaining consultation with another physician at the patient's request and expense.
12. The patient has the right to choose whether or not to participate in research, investigational or experimental studies, or clinical trials.
13. A patient has the right to refuse any drugs, treatment or procedure including forgoing or withdrawing life-sustaining treatment or withholding resuscitation services offered by the hospital to the extent permitted by law, and a physician shall inform the patient of the medical consequences of the patient's refusal of any drugs, treatment or procedure. A patient has the right to formulate advanced directives and to have those directives followed.
14. A patient has the right to medical and nursing services without discrimination based upon race, color, sex, sexual preference, national origin, handicap or source of payment or ability to pay.
15. A patient has the right to effective communication and to receive information in a manner that he or she understands, including skilled interpreters, if needed.
16. A patient has the right to be transferred to another facility for care that cannot be provided at Rivers Health only after he has received complete information concerning the needs for transfer and any alternatives to such a transfer.
17. A patient has the right to request transfer to another facility of his or her choice, for any reason, and Rivers Health will assist in making arrangements for this transfer.
18. A patient has the right to examine and receive a detailed explanation of his or her bill. Patients can receive full information and counseling on the availability of known financial resources for healthcare by calling the Financial Counselor at 304-675-4340 Ext. 1394 or Patient Financial Services at 304-675-1020.
19. A patient has the right to choose his or her provider for follow-up care and to be made aware of any relationship between that provider and the hospital or treating physician.
20. A patient has the right to access any individual or agency which is authorized to act on his or her behalf or to assert or protect the rights of patients.
21. A patient has the right to be informed of his or her rights at the earliest possible moment in the course of his/her hospitalization.
22. A patient has the right to access any information contained in his or her medical records without undue delay. Patients who wish to have a copy of his or her medical record can call 304-675-4340 Ext. 1355. An appointment to view the completed medical record may be made by calling this same number.
23. Patients have the right to request that the Hospital not disclose protected health information related to a given service or Hospital visit to their health insurance carrier if they are going to be responsible for full payment for that service or Hospital visit. To request this type of restriction, the patient needs to notify the Registration Clerk at the time of registration or notify Patient Financial Services within seventy-two (72) hours after services are provided or the patient is discharged by calling (304) 675-1020.

24. A patient has the right to wear appropriate personal clothing and religious or other symbolic items, unless medically contraindicated or presents a risk of harm to others.
25. The patient has the right to privacy.
26. A patient has the right to expect reasonable safety, in so far as the hospital practices and environment are concerned.
27. A patient has the right to present complaints regarding the quality of care they receive without compromising their future access to care.
28. The patient has the right to have his or her or her property respected.
29. The patient has the right to appropriate assessment and management of pain.
30. The patient has the right to an environment that preserves dignity and contributes to a positive self-image.
31. A patient has the right to receive visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner, (including a same sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time.

Patient Responsibilities

1. Active involvement: A patient is responsible for active participation in his or her care to the extent that he or she is capable. When appropriate, surrogates may act in this role.
2. Providing information: A patient is responsible to provide, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medication, and other matters relating to his or her health. He or she has the responsibility to report perceived risks in their care and unexpected changes in his/her condition to the responsible practitioner.
3. Asking questions: A patient is responsible for asking questions when he or she doesn't understand care, treatment and services or what he or she is expected to do.
4. Following instructions: A patient is responsible for following the treatment plan recommended by the practitioner primarily responsible for his or her care. The patient has a responsibility to express any concerns about his/her ability to follow the proposed care plan or course of care, treatment and services. Every effort is made to adapt the plan to the specific needs and limitations of the patients. When such adaptations are not recommended, patients and their families are informed of the consequences of the care, treatment and service alternatives and not following the proposed course. This may include following the instructions of nurses and allied health personnel as they carry out the coordinated plan of care, implementing the responsible practitioner's orders and enforcing the applicable hospital rules and regulations. The patient is responsible for keeping appointments and, when unable to do so for any reason, should notify the responsible practitioner or the hospital.
5. Accepting consequences: The patient is responsible for the outcomes if he or she refuses treatment or does not follow the practitioner's care, treatment and service plan. The patient is responsible for assuring that the financial obligations of his or her healthcare are fulfilled promptly if possible.
6. Following rules and regulations: The patient is responsible for following hospital rules and regulations affecting patient care and conduct.
7. Showing respect and consideration: The patient and family are responsible for being considerate of the rights of other patients and hospital personnel and for assisting in the control of noise, smoking, and the number of visitors. The patient and family are also responsible for being respectful of the property of other persons and of the hospital.
8. Maintaining personal property: The patient is responsible for the safekeeping of his or her property or valuables. These should be sent home or sent to the safe when admitted to hospital. The patient should report missing items immediately.
9. Managing pain: The patient is responsible for working with the doctor or nurse to develop a pain management plan, for asking for pain relief when pain first begins, and for telling the doctor or nurse if pain is not relieved.

Newborns, Children & Adolescents

1. The family or guardian of a newborn, child or adolescent patient has the right and responsibility to be involved in the patient's assessment, treatment and continuing care, including pain management.
2. The family or guardian of a newborn, child or adolescent patient has the right to be provided with support in dealing with illnesses that are particularly traumatic because of the duration, severity or effect on the patient's physical or psychological development. Such support will be provided through the hospital's Social Services Department.

3. A newborn, child or adolescent patient, who is separated from normal daily living experiences by a course of treatment for more than a week, has the right to expect that provisions will be made for a physical environment appropriate to the age, size and needs of the patient that is designed to encourage its use and provide comfort and security; activities appropriate to the age and development of the patient; and peer and group interaction.
4. A newborn, child or adolescent patient has the right to be provided with services through referral, consultations or contractual agreement when such services are not available at the hospital.
5. A newborn, child or adolescent patient has the right to have conflicts regarding his or her care resolved, with adolescents being involved in the decision process to the extent provided by law. The hospital will coordinate efforts to resolve conflicts between physicians, parent/guardians and other caregivers through the resources of the Social Services Department and legal counsel.
6. A child or adolescent patient whose treatment necessitates a significant absence from school has the right to appropriate educational services which will meet that educational process. Such services will be arranged through the Social Services Department with the assistance of the respective school district.
7. A newborn, child or adolescent patient who is transferred from one setting to another (within the hospital or to another facility) has the right to have his or her need for continuing treatment, continuing education and support for normal development assessed, documented and communicated to the medical personnel in charge of the new setting.
8. When a newborn, child or adolescent patient has a need identified beyond the scope of the hospital's resources, the patient has the right to prompt transfer to an alternate facility providing such needed services.
9. A minor has the right, under West Virginia Case Law, to receive information and to the extent that he or she is capable of being involved in the informed consent process.

Individual Concerns

As a patient, you have the right to complain about your care, accommodations or treatment without fear of retaliation or denial of treatment. If a problem occurs, please refer the complaint to your patient care provider. If the matter is not resolved, contact the manager for your nursing unit or department. You can do this on Monday through Friday between 8 a.m. and 4 p.m. by calling the hospital operator and asking for the manager for your nursing unit or department. Between 4 p.m. and 8 a.m. on weekdays or 24 hours a day on weekends and holidays, call the hospital operator and ask for the Nursing Supervisor.

- If the problem remains unresolved, please contact the Patient Relations Coordinator at **(304) 675-4340 Ext. 1321**, Monday through Friday, between 8 a.m. and 4:30 p.m.
- For concerns involving our Long-Term Care/Skilled Nursing Facility, please call Jessica Bryant, Social Worker at
- **(304) 675-5236 Ext. 3515.**
- For concerns involving any medical office location, please call **(304) 675-4340 Ext 1321.**
- You may also contact Administration at **(304) 675-4340 Ext. 1360,** Monday through Friday, between 8 a.m. and 4 p.m.

The public may also notify the Joint Commission about concerns of quality of care and/or patient safety by calling 1-800-994-6610 or e-mailing complaint@jointcommission.org.

You also have the right to file your complaint with the West Virginia Office of Health Facilities Licensure and Certification (OHFLAC) at:

West Virginia Department of Health and Human Resources
Office of Health Facility Licensure and Certification
408 Leon Sullivan Way
Charleston, WV 25301-1713
(304) 558-0050

RIVERS HEALTH
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