SPECTRUM
HEALTH SERVICES

5201 Haverford Ave , Philadelphia, PA 19139-1401
Phone: 2154712761 Fax: 2154726092

Name: **D.O.B**

PATIENT BILL OF RIGHTS

POLICY

The statement of rights will be prominently posted in the reception area and a copy of this statement will be given to each patient. The health center will treat its patients with dignity and respect. The rights of our patients, including but not limited to the following, will continue to be recognized. Such statements shall include:

You have:

1. The right to be treated with respect.
2. The right to know about your medical condition.
3. The right to consent to or refuse any treatment or tests.
4. The right to be told about your medications and all treatments.
5. The right to receive treatment without discrimination as to race, religion, gender, national origin, disability, sexual orientation, source of payment, or age.
6. The right to ask for another doctor or counselor.
7. The right to keep information about your visit and all records private.
8. The right to emergency care.
9. The right to ask questions and get answers.
10. The right to leave the health center against medical advice; the medical provider and/or health center will not be responsible if you leave against advice.
11. The right to refuse to be part of a study or research.

12. The right to complain if there is a problem.

13. The right to receive and appointment within a reasonable amount of time.

STATEMENT OF PATIENT RESPONSIBLITIES

As a patient of Spectrum Health Services you have certain responsibilities. These responsibilities include:

1. The responsibility to treat other patients, employees, and volunteers of Spectrum Health Services with consideration and courtesy even at times when you disagree, and/or are unhappy about other actions.

2. The responsibility to provide the health center staff the information it needs, and to be honest. We request that the information be accurate and complete.

3. Failure to comply with your responsibilities and the level of severity may result in discontinuation of service or discharge.

I HAVE REVIEWD THE PATIENT BILL OF RIGHTS AND RESPONISBILITIES AND AGREE TO THE ABOVE STATEMENT BY SIGNING BELOW:

PATIENT SIGNATURE: _____ DATE:

PSR SIGNATURE: _____ DATE: