

## Care Agreement and Notices

This form contains facts you should know about your health care at Mercy Medical Ministry. If there is any part of this form that is unclear you can ask questions about it. At the bottom of the form, there is a place for you to sign your name so that we know you have read this form (or had it read to you) and agree to receive health care from us.

Mercy Medical Ministry offers primary care at our clinic with the following services available to you:

- Prescription Assistance Program (PAP) evaluation for uninsured patients
- Medication teaching by pharmacy
- Wellness exams
- Women's Health screening exams
- Referral to specialists
- Spiritual encouragement
- Laboratory testing

Your health care team consists of volunteer and staff medical doctors, nurse practitioners, physician assistants, medical students, nurses, other health care professionals, and students of health sciences. They will work together to diagnose and treat you. You will have an attending provider who has primary responsibility for your care.

We do not perform disability evaluations or complete forms for Food Stamp Programs.

### Patient Rights and Responsibilities

Our Practice is committed to providing quality health care. It is our pledge to provide this care with respect and dignity. In keeping with this pledge and commitment, we present the following Patient Rights and Responsibilities:

#### ***You have the right to:***

- A personal clinician who will see you on an on-going, regular basis.
- Competent, considerate and respectful health care, regardless of race, creed, age, sex or sexual orientation.
- A second medical opinion from the clinician of your choice, at your expense.
- A complete, easily understandable explanation of your condition, treatment and chances for recovery.
- The personal review of your own medical records by appointment and in accordance with applicable State and Federal guidelines.
- Confidential management of communication and records pertaining to your medical care.
- Information about the medical consequences of exercising your right to refuse treatment.
- The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency situation.
- Be free from mental, physical and sexual abuse.
- Humane treatment in the least restrictive manner appropriate for treatment needs.
- An individualized treatment plan.
- Have your pain evaluated and managed.
- Refuse to participate as a subject in research.

- An explanation of your medical bill regardless of your insurance and the opportunity to personally examine your bill.
- The expectation that we will take reasonable steps to overcome cultural or other communication barriers that may exist between you and the staff.
- The opportunity to file a complaint should a dispute arise regarding care, treatment or service or to select a different clinician.

***You are responsible for:***

- Knowing your health care clinician's name and title.
- Giving your clinician correct and complete health history information, e.g. allergies, past and present illnesses, medications and hospitalizations.
- Providing staff with correct and complete name, address, telephone and emergency contact information each time you see your clinician so we can reach you in the event of a schedule change or to give medical instructions.
- Providing staff with current and complete insurance information, including any secondary insurance, each time you see your clinician.
- Signing a "Release of Information" form when asked so your clinician can get medical records from other clinicians involved in your care.
- Telling your clinician about all prescription medication(s), alternative, i.e. herbal or other, therapies, or over-the-counter medications you take. If possible, bring the bottles to your appointment.
- Telling your clinician about any changes in your condition or reactions to medications or treatment.
- Asking your clinician questions when you do not understand your illness, treatment plan or medication instructions.
- Following your clinician's advice. If you refuse treatment or refuse to follow instructions given by your health care clinician, you are responsible for any medical consequences.
- Keeping your appointments. If you must cancel your appointment, please call the health center at least 24 hours in advance.
- Paying copayments at the time of the visit or other bills upon receipt.
- Following the office's rules about patient conduct; for example, there is no smoking in our office.
- Respecting the rights and property of our staff and other persons in the office.

**Nondiscrimination Notice**

As a recipient of federal financial assistance, Mercy Medical Ministry does not exclude, deny benefits to, or otherwise discriminate against any person on the grounds of race, color, or national origin, or on the basis of disability or age in admission to, participation in, or receipt of the services and benefits of any of its programs and activities or in employment therein, whether carried out by Mercy Medical Ministry directly or through a contractor or any other entity with whom Mercy Medical Ministry arranges to carry out its programs and activities.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Section 1557 of the Patient Protection and Affordable Care Act of 2010, and Regulations of the U.S. Department of Health and Human Services issued pursuant to the Acts, Title 45 Code of Federal Regulations Part 80, 84, and 91.

(Other Federal Laws and Regulations provide similar protection against discrimination on grounds of sex and creed.)

In case of questions concerning this notice, or in the event of a desire to file a complaint alleging violations of the above, please contact:

Mercy Medical Ministry  
Laura Bell, CRNP, Executive Director  
Clinic: 334-501-1081  
TTY: 711

Mercy Medical Ministry provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats), and free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages. These formats are available through Video Remote Interpretation (VRI) and Over the Phone Interpretation (OPI) services.

#### **Language Assistance Services:**

Spanish ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al Traditional Chinese 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電

Korean 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 번으로 전화해 주십시오

Vietnamese CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Arabic ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم

German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer

French ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez

Gujarati ધ્યાન: તમેગજુ રાતી બોલેછે, ભાષા સહાય સેવાઓ વવના મલ્ૂયેતમારા માટેઉપલબ્ધ છે. કોલ

Tagalog PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa

Hindi ध्यान दें: आे हेंदीबिलते हेद , त भाषा सदाय ा सहवाओी कह प्रभार सह मुक् ह कह लेए उहेब्ध द । कौी

Laotian ໂປດຊາບ: ຖ້າວ່າ ທ່ານ ວ່າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍ ບໍ່ ມີ ຄ່າ ອາດ ທີ່ ທ່ານ ໃຫ້ ທ່ານ. ໂທ

Russian ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (телетайп

Portugese ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para

Turkish DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. irtibat numaralarını arayın.

Japanese 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。まで、お電話にてご連絡ください。

# Care Agreement and Notice Signature

By signing below, it shows that you have read this document and agree to receive health care from Mercy Medical Ministry. If there is any part of this form that is unclear, be sure to ask questions about it.

\_\_\_\_\_  
Print Name (patient or person authorized to sign)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If signed by person other than patient, specify relationship to patient: \_\_\_\_\_