



RIVERSIDE – SAN BERNARDINO COUNTY INDIAN HEALTH, INC.

PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

RSBCIHI is committed to providing high-quality, culturally appropriate health care to the communities we serve. We believe that every patient deserves to be treated with respect, dignity, and concern.

We consider you a partner in your health. When you are well informed, participate in treatment decisions, and communicate openly with your doctor and other health care professionals, together we partner in your decision making process.

As an RSBCIHI health care patient, you have the right to:

1. Be given a copy of your rights and responsibilities for receiving health care.
2. Be given professional care without regard to age, race (applicable to eligibility for services), ethnicity, religion or religious, culture, language, physical or mental disability (including learning disabilities, intellectual disabilities, and past or present history of mental illness), socioeconomic status, sex, sexual orientation, gender identity or expression, color, marital status, national origin, or membership in any other protected classes as set forth in state or federal law.
3. Receive considerate care that respects your personal value and belief systems. Receive care that respects your cultural, psychosocial, spiritual and personal values, beliefs and preferences.
4. Be informed, prior to or at the time of receipt of any service, of services available in the Program, and conditions or limitations applying to them, the charges for those services, and eligibility qualifications.
5. Be advised of third party (e.g. Medicare, Medi-Cal, private insurance, county indigent programs, etc.) coverage available for Program services and charges, and procedures for obtaining such coverage.
6. Be able to obtain from the provider complete and current information concerning diagnosis, recommended treatment and prognosis in terms that the patient can reasonably understand. When it is not advisable to give such information to the patient, the information shall be made available to a person designated by the patient or to a legally authorized person.
7. Know, by name, the provider and other health care professionals responsible for coordinating one's care. To know which provider is primarily responsible for your care. Be given the right to change your primary care provider or obtain a second opinion, if one is available.
8. Be given the opportunity to participate in decisions involving one's care, and when appropriate to include family in patient care decisions, treatment, and education.
9. Receive from the provider information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include, but not necessarily be limited to, the specific procedure and/or treatment, the significant risks involved, and the probable duration of incapacitation.
10. Be provided with information concerning alternatives for care of treatment when alternatives exist or if the patient requests data about alternatives.
11. Accept or Decline treatment to the extent permitted by law and be informed of the clinical consequences of such refusal.
12. Receive every consideration of privacy concerning the patient's health care.
13. Be afforded the opportunity to participate or refuse participation in any experimental care or research activities affecting your care or treatment.
14. Receive reasonable continuity of care. The patient shall be advised in advance what appointment times and providers are available and when. The Program shall provide a mechanism whereby the patient is informed by the provider of the patient's continuing health care needs.
15. Be assured of confidential treatment of all records. Patient records and all information contained therein shall not be released to any individual or organization outside the Program **unless** such release is: 1) required for the patient's care or treatment; 2) compelled by law; or 3) necessary for receipt of third-party contract funds.
16. Receive information about Advance Directives and/or an Advance Health-Care Directive, and/or name an individual to make health-care decisions for you if you become incapable of making said decisions.
17. Examine and receive an explanation of the bill regardless of source of payment.
18. Appropriate assessment and management of pain.
19. To complain about care, to have complaints reviewed, and when possible, resolved.
20. To receive a copy of the Program's Notice of Privacy Practice as mandated by the Health Insurance Portability and Accountability Act of 1996



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As an ambulatory health care patient, you have the responsibility to:

1. Assume a share of the responsibility for your own health and well being and for proper and prudent use of the services and facilities of the Program. These responsibilities include the following specific actions by patients: Parents are expected to carry out the same responsibilities for the care of their children.
2. Providing, to the best of your knowledge, an accurate and complete description of your present condition and past medical history, including past illnesses, medications (including over-the counter products and dietary supplements) and hospitalizations.
3. Notify the receptionist at least 24 hours in advance if it is necessary to cancel any appointment or any transportation services arranged by the Program.
4. Arrive at your clinic at least 15 minutes before your scheduled appointments. Be familiar and adhere to our missed and late appointment policy.
5. Follow the treatment plan prescribed, take all medications as instructed, and ask questions about anything not understood.
6. Provide the name and addresses of other doctors, dentists, or sources of care, and other prescribed medications, and where such care and medications was received.
7. Provide timely, complete and accurate information about income, insurance, family or tribal status and other factors needed to determine eligibility for Program services and any charges to be paid.
8. Enroll and maintain current status in any insurance or government programs, such as Medi-Cal or Medicare, which will help pay for care received. **(RSBCIHI is a Payor of Last Resort for ALL PRC Patients.) Should you directly receive payment from your insurance carrier for services rendered by and paid for by RSBCIHI, such payment is to be submitted to RSBCIHI upon receipt. Otherwise, you will be subject to reimbursement to RSBCIHI for the amount of the payment.**
9. Secure prior approval from the Program for any services to be rendered by other doctors, dentists, clinics, hospitals or other sources of care which the program is expected to pay for. All DIRECT CARE PATIENTS are financially responsible for charges incurred as a result of any ambulance service or other healthcare costs associated with care outside the RSBCIHI facility.
10. Maintain helpful living habits, including a balanced diet, adequate exercise, rest, and the avoidance of alcohol, drugs, and tobacco is recommended.
11. Inform RSBCIHI about any living will, medical power of attorney, advance directive or other directive that could affect your care.
12. Be an active participate in promoting the good health of yourself and your family: **TAKE CHARGE OF YOUR HEALTH and ask your healthcare provider any questions about your care, treatment, or services received from us.**
13. Be considerate of RSBCIHI personnel and other patients, treat them in a courteous and respectful manner. Avoiding the use of obscene language, threatening remarks, or other inappropriate or disruptive behavior .
14. Comply with all COVID-19 related policies and procedures. Comply with facility Mask Requirement , Covid Screening Process and practicing social distancing.

Any person on program property who appears to be under the influence of alcohol, drugs, or engage in threatening, abusive, disorderly or violent language or conduct, or who has on his/her person any weapon or dangerous instrument may be refused services. Furthermore, such a person may be treated as a trespasser and removed from the premises. In addition, any patient who repeatedly violates any of these patient responsibilities may be refused Program services. Referral to other sources of care will be made for such patients.

Signature of Patient or Guardian

Date

Printed Name of Patient

DOB

HR#

White-Pt. Registration

Canary-Patient