America's Family Doctors

Patient Bill of Rights and Responsibilities

We want to encourage you, as a patient at America's Family Doctors (AFD), to speak openly with your health care team, take part in your treatment choices, and promote your own safety by being well informed and involved in your care. Because we want you to think of yourself as a partner in your care, we want you to know your rights as well as your responsibilities as a patient of AFD.

Your rights:

- You have the right to receive considerate, respectful and compassionate care in a safe setting regardless of your age, gender, race, national origin, religion, sexual orientation, gender identity, or disabilities.
- You have the right to receive care in a safe environment free from all forms of abuse, neglect, or mistreatment.
- You have the right to be called by your proper name and to be in an environment that maintains dignity and adds to a positive self-image.
- You have the right to be told the names of your providers, nurses, and all health care team members involved in your care.
- You have the right to be told by your provider about your diagnosis and possible prognosis, the benefits and risks of treatment, and the expected outcome of treatment, including unexpected outcomes.
- You can expect full consideration of your privacy and confidentiality in care discussions, exams, and treatments. You may ask for an escort during any type of exam.
- You have the right to access protective and advocacy services in cases of abuse or neglect.
- You, and family, and friends with your permission, have the right to participate in decisions about your care, treatment and services provided, including the right to refuse treatment to the extent permitted by law. If you leave the clinic against the advice of your provider, AFD and the providers will not be responsible for any medical consequences that may occur.
- You have the right to agree or refuse to take part in medical research studies. You may withdraw from a study at any time without impacting your access to standard care.
- You have the right to give permission for students to be involved in your care.
- You have the right to receive detailed information about your charges.
- You can expect that all communication and records about your care are confidential, unless disclosure is permitted by law. You have the right to see or get a copy of your medical records.
- You have the right to give or refuse consent for recordings, photographs, films, or other images to be produced or used for internal or external purposes other than identification, diagnosis, or treatment. You have the right to withdraw consent up until a reasonable time before the item is used.
- You have the right to voice your concerns about the care you receive and have them addressed without fear of it affecting your care.

Your Responsibilities:

- You are expected to provide complete and accurate information, including your full name, address, home telephone number, date of birth, Social Security number, insurance carrier and employer and update AFD immediately with any changes to any of the before mentioned information.

- You are expected to bring your insurance card and photo ID to each appointment for verification purposes.
- You should provide AFD with a copy of your advance directive if you have one.
- You are expected to provide complete and accurate information about your health and medical history, including present condition, past illnesses, hospital stays, medicines, vitamins, herbal products, and any other matters that pertain to your health, including perceived safety risks.
- You are expected to ask questions when you do not understand information or instructions. If you believe you can't follow through with your treatment plan, you are responsible for telling your provider.
- You are responsible for outcomes if you do not follow the care, treatment and services plan.
- You are expected to recognize and respect the rights of other patients, families and staff of AFD.
- You are expected to provide complete and accurate information about your health insurance coverage and to pay your bills in a timely manner.
- You are expected to be familiar with your insurance policy and what services it will or will not cover.
- You have the responsibility to keep appointments, be on time, and call your health care provider if you cannot keep your appointments.
- You have the responsibility to make appointments for regular follow up and refill visits. These are not appropriate walk in visits.

Patient Financial Responsibility

America's Family Doctors, PLLC appreciates the confidence you have shown in choosing us to provide for your health care needs. The services you have elected to participate in, implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will bill your insurance carrier/s on your behalf. However, you are ultimately responsible for payment in full of your bill.

Many insurance companies have additional stipulations that may affect your coverage. **It is ultimately the patient's responsibility to know your coverage and benefits.** You are responsible for any amounts not covered by your insurance. If your insurance carrier denies any part of your claim, or if you elect to continue services past your coverage/policy period, you will be responsible for your balance in full. **It is the patient's responsibility to obtain referrals or authorizations required by the insurance carrier to be seen at AFD Clinics.**

If payment is denied for lack of authorization, I understand that I am responsible for payment in full.

I understand I am responsible for payment of any deductible and/or co-pay/co-insurance as determined by my contract/policy with my insurance carrier. AFD expects these payments at time of service. This is a contract between you and your insurance carrier. Payment of all co-pays is expected at the time the service is rendered for the patient.

I understand that I will be responsible for any co-pay and/or co-insurance and/or deductible if I choose to discuss other issues at the time of my annual physical exam.

I fully understand that I am ultimately responsible for any and all charges associated with my account and that if I fail to pay any amount due, I will also be responsible for all collection fees, court costs, attorney fees and any other charges incurred in the collection of any balance due. I further understand that a fee of, as much as **35%,** will be added to my total account balance in accordance with this facility's contract with its collection agency.

Signature:_____

Date:_____