Patient Rights & Responsibilities

PATIENT RIGHTS

Portneuf Medical Center encourages respect for the personal preferences and values of each individual and supports the Rights of each patient and resident of the Center, or their representative as follows:

- The right to considerate and respectful care.
- The right to ask for and receive relevant, current, and understandable information concerning their diagnosis treatment and prognosis from their physicians and other direct caregivers.
- The right to consent to or refuse a treatment, as permitted by law and hospital policy, and in case of such refusal, the right to other appropriate care and services that the Center provides or transfer to another facility.
- The right to have advance directives (such as a Living Will or Durable Power of Attorney for health care) and to have the intent of such directives honored to the extent permitted by law and hospital policy.
- The right to respectful and compassionate care that provides effective pain management, the treatment of presenting symptoms, and responsiveness to the patient's social, emotional, and spiritual needs.
- The right to every consideration of privacy during consultation, examination, and treatment.
- The right to expect all communications and records pertaining to medical care and to have the information explained or interpreted as necessary, except when restricted by law.
- The right to review their own records pertaining to medical care and to have the information explained or interpreted as necessary, except when restricted by law.
- The right to expect that, within its capacity and policies, the Center will make a reasonable response to a request for appropriate and medically-indicated care and services, including evaluation, service and/or referral as indicated by the urgency of the case. If transfer is recommended and requested, the patient will be informed of risks, benefits, and alternatives, and will not be transferred until the other institution has indicated acceptance.
- The right to ask and be informed of the existence of business relationships among the Center, educational institutions, other health care providers, or insurers that may influence the patient's treatment and care.
- The right to consent or decline to participate in research affecting care or requiring direct patient involvement, and if such participation is declined, to be entitled to the most effective care the Center can otherwise provide.
- The right to be informed of realistic care alternatives when hospital care is no longer appropriate.
- The right to be informed of Center policies and practices that relate to patient care and treatment, including charges for services and payment methods, and to be informed of available resources for resolving questions and concerns about care and treatment, such as ethics committees and patient representative and advocacy programs.

PATIENT RESPONSIBILITIES

The collaborative nature of health care requires that patients and residents participate in their care by fulfilling certain *responsibilities*. Patients, residents, and/or families or designated representatives are responsible for:

- Requesting additional information or clarification about their health status or treatment when information and instructions are unclear.
- Follow instructions, accept consequences, and follow rules and regulation.
- Ensuring that the Center has a copy of their advance directive if one has been completed.
- Informing physicians and other caregivers if there are problems in following prescribed treatment.
- Treating other patients, physicians, caregivers and Center staff with consideration and respect and recognizing that alternative care may be recommended if their behavior is considered unreasonably disruptive.
- Providing necessary information for insurance claims and for working with the Center to make payment arrangements when necessary.
- Show respect and consideration for meeting financial commitments.
- Recognizing the impact of their lifestyle on their personal health.
- Providing information about past illnesses, hospitalizations, medications and other matters related to health status.

COMPLAINT RESOLUTION & GRIEVANCE PROCESS

During your stay you and your family are encouraged to discuss questions about your care and hospital environment with hospital personnel and physician. These individuals will assist in resolving issues or concerns. Call 239-1152.

If the patient or family member has a concern that is not promptly resolved after speaking with staff present, they may file a grievance. The grievance may be written or verbal and should be directed to:

Administration, Portneuf Medical Center
777 Hospital Way, Pocatello, ID 83201
Phone: (208) 239-1002

A patient or family also has the right to file a grievance with the following (regardless if the hospital's grievance process has been used):

The Bureau of Facility Standards
3232 Elder Street, Boise, ID 83705
Phone: (208) 334-6626

Office of Quality Monitoring
The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
Phone: 800-994-6610
Fax: (630) 792- 5636
Complaint@jointcommission.org

Patient Label

Do Not Place Below This Line.

Advance Directives

In addition to having the right to have your medical treatment options explained to you by your physician, you have the right to accept or refuse medical treatment and the right to have your advance medical directives followed *if you become incapacitated or unable to communicate.*

Advance directives are documents, which indicate your choices for future health care. The purpose of advance directives is to give you more control over your medical care, ensuring that physicians and family members have no doubt about how much life-prolonging technology you would want. There are three kinds of advance directives: Living Will, Durable Power of Attorney, and POST (Physician Orders for Scope of Treatment).

LIVING WILL

If you are 18 years of age and of sound mind, you may complete a *Living Will* which describes your preferences for life-sustaining treatment. Idaho's *Living Will* allows you to specify one of the following options should you become terminally ill and unable to communicate your wishes:

- That all medical treatment and care, including nutrition and hydration, necessary to restore or sustain your life, be provided you.
- Those artificial life-sustaining procedures be withheld or withdrawn *with* the exception of nutrition and hydration.
- Those artificial life-sustaining procedures be withheld or withdrawn *including* nutrition and hydration.

The *Living W*ill takes effect ONLY if your physician believes you are permanently unconscious or that death is near, AND you are unable to tell others your wishes. You may cancel your *Living Will* at any time, as long as you are of sound mind. A *Living Will* requires two witnesses to your signature, but does not have to be notarized.

DURABLE POWER OF ATTORNEY

If you are at least 18 years of age or older and of sound mind, you may complete a *Durable Power of Attor*ney which designates an individual to be your health care agent (or surrogate) to make health care decisions for you if you lose the ability to make decisions yourself. The individual you select as your health care agent should be someone who understands the kind of medical treatment you do and do not want. You may also designate an alternate to act for you if the first person you designate is unable to act as your agent. As long as you are of sound mind, you may cancel your *Durable Power of Attorney* and make a new one.

A *Durable Power of Attorney* goes in effect ONLY if you are unable to make your own health care decisions. A *Durable Power of Attorney* does not have to be notarized, but there are restrictions on who can serve as your health care agent, as well as who can witness the document.

POST (Physician Orders for Scope of Treatment)
A document completed by a patient and authenticated by their physician. This form is registered with the State and available online at http://www.sos.idaho.gov/general/hcdr.htm. This document transcends institutions and may follow a patient from one setting into the next. This is a supplement to other advance directives. This document replaces the former Idaho DNR/Comfort One Orders.

For more information on Advance Directives or assistance in completing these documents, contact Case Management at 239-1468. Advance Directives forms are available in Admissions, Convenient Care, Family Medicine and on the inet.

PATIENT RIGHTS & RESPONSIBILITIES (continued other side)

Patient Label

Do Not Place Below This Line.

YOUR RIGHTS AS A PATIENT TO MAKE MEDICAL TREATMENT DECISIONS

WHO DECIDES ON THE MEDICAL TREATMENT I RECEIVE IF I HAVEN'T MADE A "LIVING WILL" OR NAMED A PERSON TO CARRY OUT "DURABLE POWER OF ATTORNEY FOR HEALTH CARE"?

Family members, with your doctor and other care givers or counselors will usually decide what is best for you; if you are too ill to decide. Most of the time this works. Sometimes, everyone doesn't agree about what to do. It is helpful to let everyone know what you want and whom you want your doctor to listen to. Treatment decisions can be hard to make. It will help your family and doctor if they know in advance what you want. You can let your family and doctor know your wishes by writing an Advanced Directive to include a "Living Will" and/or a "Durable Power of Attorney for Health Care".

I, (Print Name)_____have received the information on the previous pages and above and I understand my rights to make, or not make a "Living Will" and a "Durable Power of Attorney for Health Care".

I have an "Advanced Directive": ❑YES ❑NO

I have presented a copy of my Advanced Directive to the Admissions Clerk: ❑YES ❑NO

I <u>DESIRE</u> to make an Advanced Directive: ❑YES ❑NO

I have been given the paperwork to complete my Advanced Directive and understand that if I need assistance that I can ask the nursing staff or Case Management for help by dialing 239-1468.

* Patient/Representative Signature: _____
If Representative, Name and Relationship to Patient and reason patient is unable to sign

_____	_____	_____
Name	**Relationship**	**Reason Patient unable to sign**

Photo copy given to Patient/ Representative for their records

Patient Label

Do Not Place Below This Line.

YOUR RIGHTS AS A PATIENT TO MAKE MEDICAL TREATMENT DECISIONS

YOUR RIGHTS:

RIGHT TO CHOOSE:
You have the right to accept or refuse medical treatment at any time, including foregoing or withdrawing life-sustaining treatment or withholding resuscitative service.

EXPLANATION OF TREATMENT:
Your doctor will tell you what medical treatments are available for you. Your doctor will tell you what side effects the treatment may have. You can choose the treatment you feel is best, if more than one is available. You do not have to accept any treatment you do not want.

HOW CAN I TELL MY DOCTOR WHAT TREATMENT I WANT?
Idaho law allows you to accept or refuse medical treatment. You can tell your doctor when you want the treatments. The doctor must use your information in deciding your treatment. Your wishes must be made a part of your medical record.

WHAT IF I BECOME TOO ILL TO DECIDE ABOUT MY MEDICAL TREATMENTS?
Before you become too ill to decide about your medical treatment, you can let your family and doctor know your wishes by writing a "Living Will" and "Durable Power of Attorney for Health Care".

"DURABLE POWER OF ATTORNEY FOR HEALTH CARE":

WHERE DO I GET A "DURABLE POWER OF ATTORNEY FOR HEALTH CARE FORM"?
Your doctor, nurse, hospital or nursing home can tell you where to get the form and how to get help to fill it out. The completed form is a "Durable Power of Attorney for Health Care".

WHEN IS THE "DURABLE POWER OF ATTORNEY FOR HEALTH CARE" EFFECTIVE?
It is only effective when you are too ill to make your own health care decisions.

CAN I CHANGE THE PERSON I NAME TO CARRY OUT MY "DURABLE POWER OF ATTORNEY FOR HEALTHY CARE"?
Yes, while you are of sound mind, you can change your "Durable Power of Attorney for Health Care". You can cancel your "Durable Power of Attorney for Health Care" at any time.

HOW WILL THE PERSON I CHOOSE KNOW WHAT I WANT?
Once you select a person, talk with them. Tell them what types of medical treatment you do or do not want.

WHAT IS A "LIVING WILL"?

A "Living Will" is a document telling doctors what to do if you are too ill to decide. A "Living Will" gives you three (3) choices.

1. You want the doctors to do everything possible to keep you alive
2. You want to die a natural death. You want to be given food, water and comfort measures.
3. You want to die a natural death. You do not want to be given food or water by artificial means, but you will not be denied comfort measures.

WHEN IS A "LIVING WILL" EFFECTIVE?
The "Living Will" takes effect only if you are unable to tell others your wishes. The living will takes effect if the doctors believe you are permanently unconscious or the doctor believes death is near and you cannot communicate.

IS THIS THE SAME AS AN ORDINARY WILL?
No, it only tells what kind of health care you want given.

WHAT ARE THE REQUIREMENTS FOR SIGNING A "LIVING WILL"?
You must be an adult of sound mind.

CAN I CHANGE MY MIND?
Yes, you can cancel your "Living Will" at any time while you are of sound mind. You can change or make a new "Living Will" at any time.

WILL SIGNING A "LIVING WILL" OR "DURABLE POWER OF ATTORNEY" FOR HEALTH CARE AFFECT ANY INSURANCE COVERAGE I MAY HAVE?
No.

WILL I STILL BE TREATED IF I DON'T MAKE A "LIVING WILL" OR A "DURABLE POWER OF ATTORNEY FOR HEALTH CARE"?
Yes. You do not have to complete these forms.

Portneuf MEDICAL CENTER

Advance Directives

This Advance Directives packet contains a living will, which allows you to say what kind of medical treatment you will receive in the event that you are unable to let those wishes be known. The packet also contains a Durable Power of Attorney for Health Care, which allows you to appoint someone to make health care decisions for you if you are unable to do so.

INFORMATION YOU SHOULD KNOW BEFORE YOU COMPLETE YOUR LIVING WILL / DPA

1. A living will is a legal document, which allows you to choose whether you will receive artificial life-sustaining procedures or be allowed to die naturally, in the event that you have a terminal medical condition or you are in a persistent vegetative state.

2. The Living Will applies only to the question of continuing or discontinuing **artificial** life-sustaining procedures. IT IS NOT A "DNR" (Do Not Resuscitate) or "NO CODE" ORDER.

3. If you are interested in a DNR, please speak with your physician.

4. The Living Will goes into effect when a doctor* certifies that death is imminent and that the life-sustaining procedures would serve **only** to prolong artificially your life or that you are in a persistent vegetative state.

5. The phrase "administration of nutrition and hydration" refers to food and water provided by artificial means such as: through a tube feeding or an IV.

6. You may choose Box A, B, or C. Note Box B has additional choices

7. Express your wishes to your family, friends, lawyer, religious counselor, and primary physician so they know and understand what you want to have done. Give copies of the Advance Directives to these people as well. You may also wish to have several extra copies of the Advance Directives on hand to take with you if you are ever hospitalized.

8. There is no time limit on the duration of the Advance Directives. To revoke it you can destroy it or make a separate document revoking it. Health care provider will utilize the most current Advance Directive. All prior documents will be null and void.

9. If there are any questions, please call:

Portneuf Medical Center
Social Services 239-1468

*Effective July 1, 2007 Per HB119, no longer requires two (2) doctors.

LIVING WILL AND DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Date of Directive: _____

Name of person executing Directive: _____

Address of person executing Directive: _____

_____

A Living Will
A Directive to Withhold or to Provide Treatment

1. I willfully and voluntarily make known my desire that my life shall not be prolonged artificially under the circumstances set forth below. This Directive shall be effective only if I am unable to communicate my instructions and:

   a. I have an incurable or irreversible injury, disease, illness or condition, and a medical doctor who has examined me has certified:

      1. That such injury, disease, illness or condition is terminal; and
      2. That the application of artificial life-sustaining procedures would serve only to prolong artificially my life; and
      3. That my death is imminent, whether or not artificial life-sustaining procedures are utilized.

   OR

   b. I have been diagnosed as being in a persistent vegetative state.

In such event, I direct that the following marked expression of my intent be followed and that I receive any medical treatment or care that may be required to keep me free of pain or distress.

Check one box and initial the line after such box:

☐ _____ I direct that all medical treatment, care, and procedures necessary to restore my health and sustain my life be provided to me. Nutrition and hydration, whether artificial or non-artificial, shall not be withheld or withdrawn from me if I would likely die primarily from malnutrition or dehydration rather than from my injury, disease, illness or condition.

OR

☐ _____ I direct that all medical treatment, care and procedures, including artificial life-sustaining procedures, be withheld or withdrawn, except that nutrition and hydration, whether artificial or non-artificial shall not be withheld or withdrawn from if, as a result, I would likely die primarily from malnutrition or dehydration rather than from my injury, disease, illness or condition, as follows:

Patient Label

Do not place label below line

(*If none of the following boxes are checked and initialed, then both nutrition and hydration, of any nature, whether artificial or non-artificial, shall be administered.)*

Check one box and initial the line after such box:

☐ _____ A. Only hydration of any nature, whether artificial or non artificial, shall be administered.

☐ _____ B. Only nutrition, of any nature, whether artificial or non artificial, shall be administered.

☐ _____ C. Both nutrition and hydration, of any nature, whether artificial or non-artificial shall be administered.

OR

☐ _____I direct that all medical treatment, care and procedures be withheld or withdrawn, including withdrawal of the administration of artificial nutrition and hydration.

2. If I have been diagnosed as pregnant, this Directive shall have no force during the course of my pregnancy.

3. I understand the full importance of this Directive and am mentally competent to make this Directive. No participant in the making of this Directive or in its being carried into effect shall be held responsible in any way for complying with my directions.

4. Check one box and initial the line after such box:

☐ _____ I have discussed these decisions with my physician and have also completed a Physician Orders for Scope or Treatment (POST) form that contains directions that may be more specific than, but are compatible with, this Directive. I hereby approve of those orders and incorporate them herein as if fully set forth.

OR

☐ _____ I have not completed a Physician Orders for Scope of Treatment (POST) form. If a POST form is later signed by my physician, then this living will shall be deemed modified to be compatible with the terms of the POST form.

1. DESIGNATION OF HEALTH CARE AGENT

None of the following may be designated as your agent:

(1) your treating health care provider;
(2) a non-relative employee of your treating health care provider;
(3) an operator of a community care facility; or
(4) a non relative employee of an operator of a community care facility.
If the agent or an alternate agent designated in this Directive is my spouse, and our marriage is thereafter dissolved, such designation shall be thereupon revoked.

I do hereby designate and appoint the following individual as my attorney in fact (agent) to make health care decisions for me as authorized in this Directive.

(Insert name, address and telephone number of one individual only as your agent to make health are decisions for you.)

Name of Health Care Agent: _____

Address of Health Care Agent: _____

Telephone Number of Health Care Agent: _____

For the purposes of this Directive, "health care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose or treat an individual's physical condition.

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE

By this portion of this Directive, I create a durable power of attorney for health care. This power of attorney shall not be affected by my subsequent incapacity. This power shall be effective only when I am unable to communicate rationally.

3. GENERAL STATEMENT OF AUTHORITY GRANTED

I hereby grant to my agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this Directive or otherwise made known to my agent including, but not limited to, my desires concerning obtaining or refusing or withdrawing artificial life-sustaining care, treatment, services and procedures, including such desires set forth in a living will, Physician Orders for Scope of Treatment (POST) form, or similar document executed by me, if any.

(If you want to limit the authority of your agent to make health care decisions for you, you can state the limitations in paragraph 4, "Statement of Desires, Special Provisions, and Limitations", below. You can indicate your desires by including a statement of your desires in the same paragraph.)

4. STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS

(Your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, state your desire in the space provided below. You should consider whether you want to include a statement of your desires concerning artificial life-sustaining care, treatment, services and procedures. You can also include a statement of your desires concerning other matters relating to your health care, including a list of one ore more persons whom you designate to be able to receive medical information about you and/or to be allowed to visit you in a medical institution. You can also make your desires known to your agent by discussing your desires with your agent or by some other means. If there are any types of treatment that you do not want to be used, you should state them in the space below. If you want to limit in any other way the authority given your agent by this Directive, you should state the limits in the space below. If you do not state any limits, your agent will have broad powers to make health care decisions for you, except to the extent that there are limits provided by law.)

In exercising the authority under this durable power of attorney for health care, my agent shall act consistently with my desires as stated below and is subject to the special provisions and limitations stated in my Physician Orders for Scope of Treatment (POST) form, a living will, or similar document executed by me, if any. Additional statement of desires, special provisions, and limitations:

(You may attach additional pages or documents if you need more space to complete your statement.)

5. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH

A. General Grant of Power and Authority

Subject to any limitations in this Directive, my agent has the power and authority to do all of the following:

(1) request, review and receive any information, verbal or written, regarding my physical or mental health including, but not limited to, medical and hospital records;
(2) Execute on my behalf any releases or other documents that may be required in order to obtain this information;
(3) Consent to the disclosure of this information; and
(4) Consent to the donation of any of my organs for medical purposes.

(If you want to limit the authority of your agent to receive and disclose information relating to your health, you must state the limitations in paragraph 4, "Statement of Desires, Special Provisions, and Limitations", above.)

B. HIPAA Release Authority

My agent shall be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. The release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d and 45 CFR 160 and 164. I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, and the Medical Information Bureau, Inc. or other health care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment form me for such services, to give, disclose and release to my agent, without restriction, any past, present or future medical or mental health condition, including all information relating to the diagnosis of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. The authority given my agent shall supersede any other agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

6. SIGNING DOCUMENTS, WAIVERS, AND RELEASES

Where necessary to implement the health care decisions that my agent is authorized by this Directive to make, my agent has the power and authority to execute on my behalf all of the following:

(a) Documents titled, or purporting to be, a "Refusal to Permit Treatment" and/or a "Leaving Hospital Against Medical Advice"; and
(b) Any necessary waiver or release from liability required by a hospital or physician.

Patient Label

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7. **DESIGNATION OF ALTERNATE AGENTS**

(You are not required to designate any alternate agents but you may do so. Any alternate agent you designate will be able to make the same health care decisions as the agent you designated in paragraph 1 above, in the event that agent is unable or ineligible to act as your agent. If an alternate agent you designate is your spouse, he or she becomes ineligible to act as your agent if you marriage is thereafter dissolved.)

If the person designated as my agent in paragraph 1 is not available or becomes ineligible to act as my agent to make a health care decision for me or loses the mental capacity to make health care decisions for me, or if I revoke that person's appointment or authority to act as my agent to make health care decisions for me, then I designate and appoint the following persons to serve as my agent to make health care decisions for me as authorized in this Directive, such persons to serve are listed below:

A. First Alternate Agent

Name: _____

Address: _____

_____

Telephone Number: _____

B. Second Alternate Agent

Name: _____

Address: _____

_____

Telephone Number: _____

C. Third Alternate Agent

Name: _____

Address: _____

_____

Telephone Number: _____

8. **PRIOR DESIGNATIONS REVOKED**

I revoke any prior durable power of attorney for health care.

DATE AND SIGNATURE OF PRINCIPAL

(You must date and sign this Living Will and Durable Power of Attorney for Health Care.)
I sign my name to this Statutory Form Living Will and Durable Power of Attorney for Health Care on the date set forth at the beginning of this Form at:

_____

(Signature) (City, State)