PATIENT RIGHTS AND RESPONSIBILITIES

Boise State University Health Services is committed to supporting and protecting the rights of each of our patients. With these rights also come patient responsibilities. Active participation in your health care will assure the best outcomes.

YOUR RIGHTS:

- To accept or refuse any care or treatment
- To receive treatment regardless of your age, race, gender, sexual orientation or religion
- To be treated with respect, consideration and dignity
- To receive care in a safe environment
- To privacy of care
- To know who will be providing your care and treatment
- To participate in decisions about your care and treatment
- To receive accurate, easily understood information about your health care concerns and the care you are receiving
- To work with your provider on a treatment plan you are comfortable with and will adhere to
- To receive education and counseling
- To select or change your health care provider
- To confidentiality of your records
- To review your medical records
- To have your concerns heard and reviewed in an objective and timely manner

YOUR RESPONSIBILITIES:

- To provide accurate information regarding your medical history
- To be active in making decisions regarding your care
- To ask questions to seek clarification if you do not understand your treatment plan
- To follow the treatment plan prescribed by your health care provider
- To show courtesy and respect to health care personnel and other patients
- To keep your appointments and arrive on-time
- To cancel or reschedule as far in advance as possible so that the time may be used to treat other patients
- To communicate with your provider if your condition worsens or does not follow the expected course
- To provide useful feedback about services and policies
- To provide accurate information about sources of payment
- To fulfill your financial obligations and to pay for care as promptly as possible
- To inform your health care provider of any advanced directives that could affect your care

I have read and understand the rights afforded to me as a patient and the responsibilities I have while I receive care.

____________________________________________  ______________________________
Printed Patient Name  Date

______________________________________________________  ______________________
Patient Signature  University ID Number

Revised June 2014 MMD