Union County Health Department

CLIENT'S BILL OF RIGHTS

1. Clients have the right to healthcare that is accessible and meets professional standards.
2. Clients have the right to courteous and individualized healthcare that is equitable, humane, and given without discrimination as to race, color, creed, sex, national origin, source of payment, or ethical or political beliefs.
3. Clients have the right to information about their diagnosis, prognosis, and treatment – including alternatives to care and risks involved – in terms they and their families can readily understand, so that they can give their informed consent.
4. Clients have the legal right to informed participation in all decisions concerning their healthcare and the right to refuse treatment, to the extent permitted by law, and to be informed of the medical consequences of their actions.
5. Clients have the right to information about the qualifications, names, and titles of personnel responsible for providing their healthcare.
6. Clients have the right to refuse observation by those not directly involved in their care.
7. Clients have the right to privacy during interview, examination, and treatment.
8. Clients have the right to privacy in communicating and visiting with staff.
9. Clients have the right to refuse treatments, medication, or participation in research and experimentation, without punitive action being taken against them.
10. Clients have the right to coordination and continuity of healthcare.
11. Clients have the right to appropriate instruction or education from healthcare personnel so that they can achieve an optimal level of wellness and an understanding of their basic health needs.
12. Clients have the right to confidentiality of all records (except as otherwise provided for by law or third-party payer contracts) and all communication, written or oral, between clients and healthcare providers.
13. Clients have the right to examine and receive an explanation of his/her bill regardless of source of payment.
14. The client has the right to know what rules and regulations apply to his conduct as a client.

Client Signature: _____ Date: _____

Witness: _____

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UNION COUNTY HEALTH DEPARTMENT CLIENT RESPONSIBLITIES

1. You are responsible for treating all staff and other clients with respect and consideration.
2. You are responsible for answering all questions regarding program eligibility and medical history, etc., completely and correctly to the best of your knowledge.
3. You are responsible for keeping your appointments and obtaining the phone number to call in advance if you have to cancel the appointment.
4. You are responsible for paying all bills when service is provided, unless other arrangements have been made.
5. You are responsible for obeying rules and regulations as posted by the Health Unit or explained by the staff. Some of these rules are:
    A. Monitor and control the behavior of your children while at the clinic.
    B. No food or drink allowed in clinic.
    C. Dispose of garbage in appropriate containers.
6. If you have Medicaid, you must bring your Medicaid card with you to clinic appointments.
7. If you are referred for special care, emergency room, or for hospitalization for a higher level of care, you will be responsible for payment of any services such rendered.

I understand if I miss more than three (3) scheduled medical appointments in a six month period or do not provide 24 hour notice of cancellation of an appointment more than three (3) times in a six month period, I may be disenrolled from primary care medical services provided by the Union County Health Department.

I understand if I miss more than two (2) scheduled DENTAL medical appointments in a six month period or do not provide 24 hour notice of cancellation of an appointment more than two (2) times in a six month period, I may lose routine dental care services for six (6) months, though emergency services will still be provided.

I understand that either the Health Care Program I am enrolled in or my Health Insurance Carrier may require me or my child to have a Physical Exam yearly if we receive primary care services. If I decline these services or fail to fulfill this requirement for myself or my child, I understand I may be disenrolled from primary care medical services provided by the Union County Health Department.

I understand if I am disruptive or treat clients or staff of the Union County Health Department without respect and consideration, I may be disenrolled from primary care medical services provided by the Union County Health Department.

I understand if I do not receive medical services from the Union County Health Department for a period greater than fifteen (15) months, I may be disenrolled from primary care medical services provided by the Union County Health Department.

I understand if I have an insurance coverage change or my insurance lapses, I may be disenrolled from primary care medical services provided by the Union County Health Department.

I understand if the Union County Health Department has a change in primary care funding, I may be disenrolled from primary care medical services provided by the Union County Health Department.

I understand I have the right to appeal a disenrollment decision within thirty (30) days of receiving a 'Termination of Services' notice from the Union County Health Department. I must send a written request to have my case reviewed to:

Union County Health Department
Attention: Administrator
495 E Main St
Lake Butler, Florida 32054

I understand I have the right to file a grievance within thirty (30) days of the date the grievance occurred. I must send a written request to have my grievance reviewed to:

Union County Health Department
Attention: Administrator
495 E Main St
Lake Butler, Florida 32054

Client Signature: _____ Date: _____

Witness: _____ Date: _____

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