HALIFAX HEALTH

Thank you for choosing Halifax Health - Primary Care as your healthcare provider. We are honored to care for you and your family. Our primary care providers offer everything from sports injuries to physicals, common colds and preventive medicine so you can maintain a healthy lifestyle.

Halifax Health made a promise to serve all the people of our community more than 90 years ago. By choosing Halifax Health as your healthcare partner, you now have access to our entire network of specialists, experts and hospitals providing care no other area hospitals can offer, including the area's only Comprehensive Stroke Center, Comprehensive Lung Program, Level II Trauma Center, OB Emergency Department, Level III Neonatal ICU, Pediatric ICU and Behavioral Services. We serve as the area's most preferred Hospice Care and offer home health with Care at Home.

Our partnerships extend your continuum of care with:
› UF Health Heart and Vascular Surgery at Halifax Health
› UF Health Neurosurgery at Halifax Health
› Hailfax Health - Center for Transplant Services affiliated with UF Health
› Halifax Health | Brooks Rehabilitation - Center for Inpatient Rehabilitation
› Halifax Health | Brooks Rehabilitation - Outpatient Rehabilitation
› Halifax Health | Brooks Rehabilitation - Pediatric Rehabilitation

Exceptional emergency care and hospital locations:
› Halifax Health Medical Center of Daytona Beach
› Halifax Health - Medical Center of Port Orange
› Halifax Health | UF Health - Medical Center of Deltona

Halifax Health is the only area health system with the expertise to be the only one you need. We are honored to be your provider of choice and ready to help you Live Your Life Well.

DAYTONA BEACH
201 N. CLYDE MORRIS BLVD.
SUITE 240
T: 386.425.4822

DELTONA
2090 SAXON BLVD.,
SUITE B
T: 386.425.3300

DELTONA
3400 HALIFAX CROSSING BLVD.
SUITE 120A
T: 386.425.6810

ORMOND BEACH
1688 W. GRANADA BLVD.,
SUITE 2A
T: 386.425.4460

PORT ORANGE
1165 DUNLAWTON AVE.
SUITE 105
T: 386.425.4787

NEW SMRYNA BEACH
807 STATE ROAD 44
T: 386.425.5554

halifaxhealth.org

0820-4044

HALIFAX HEALTH
PATIENT REGISTRATION

Today's Date:_____

Patient's Name:_____ Birthdate:_____ Gender:_____ Age:_____

If patient is a minor, child lives with: ❑ Mother ❑ Father ❑ Both ❑ Guardian ❑ Other:_____

Address:_____ City/State/Zip:_____

Email Address:_____

Do you want access to the Halifax Health Patient Portal? ❑ Yes ❑ No

Marital Status:_____ S.S. #:_____ Maiden Name:_____ Race:_____

Phone:_____ Alternate Phone:_____ Religion:_____

School:_____ Grade:_____

EMERGENCY CONTACT INFORMATION

Name:_____

Address:_____ City/State/Zip:_____

Phone:_____ Alternate Phone:_____ Relationship:_____

GUARANTOR'S EMPLOYMENT INFORMATION

Employer:_____ Occupation:_____

Address:_____ Work Phone:_____

INSURANCE INFORMATION

Insurance:_____ Policy #:_____ Group #:_____

Address:_____ City/State/Zip:_____

Insured Name:_____ Ins. Phone #:_____

Insured Birthdate:_____ Relationship to Patient:_____

HALIFAX HEALTH

HEALTH HISTORY

In order to obtain a comprehensive evaluation of your health, your doctor asks that you carefully complete each question. Your answers will be documented confidentially into our electronic health record.

Name:_____ Birthdate:_____ Today's Date:_____

DRUG ALLERGIES: (please list known reaction to each, especially if life-threatening)

Drug Name:	**Reaction:**

CURRENT MEDICATIONS: (please list the name of all medications and supplements with dosage and frequency)

Drug Name:	**Dosage:**	**Frequency:**

PHARMACY INFORMATION: (please list the name, address and phone number of your preferred pharmacy)

Pharmacy Name:	**Address:**	**Phone:**

MEDICAL PROBLEMS: (list every medical problem that you have including high cholesterol, diabetes, high blood pressure, abnormal pap smear, cancer, kidney/liver disease, prostate problems, anxiety/depression, nasal allergies, arthritis, heart attack, heart murmur, stroke, blood clots, hepatitis, asthma, emphysema/COPD, migraines, thyroid disorder, anemia, ulcers/heart burn, hemorrhoids, gout, kidney stones, seizures, rheumatic fever, glaucoma, dizziness/fainting, sexually transmitted diseases/genital herpes, and AIDS/HIV – include year of onset for each)

Medical Problem		**Medical Problem**	
_____	Year_____	_____	Year_____
_____	Year_____	_____	Year_____
_____	Year_____	_____	Year_____
_____	Year_____	_____	Year_____

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HALIFAX HEALTH

HEALTH HISTORY

(CONTINUED)

SURGERIES / HOSPITALIZATIONS: (e.g., tonsils, appendix, gallbladder, cataracts, stents, breast biopsy, tubes tied, plastic surgery, prostate – include year of surgery/hospitalization)

Surgery/Hospitalization		Surgery/Hospitalization	
_____	Year_____	_____	Year_____
_____	Year_____	_____	Year_____
_____	Year_____	_____	Year_____
_____	Year_____	_____	Year_____

FAMILY HISTORY: (e.g., high cholesterol, heart disease, high blood pressure, stroke, diabetes, thryroid, glaucoma, cancer – breast, colon, prostate, ovarian)

	Living	Age / Age at Death	Health Problems	Cause of Death
Father:				
Mother:				
Siblings:				
Grandparents:				

Please list any illnesses that are prominent in other family members:_____

SOCIAL HISTORY:

Marital Status: ❑ Single ❑ Married ❑ Partnered ❑ Divorced ❑ Separated

Occupation:_____ **Employer:**_____

Number & Ages of

Children:_____

Tobacco Use: ❑ Current ❑ Quit ❑ Never If current, year started_____

If current: Cigarettes ❑ No ❑ Yes – _____ packs/day

Cigars ❑ No ❑ Yes – _____ cigars/week

Smokeless ❑ No ❑ Yes – _____ cans/day

If quit: Year started_____ Year quit_____ On average, how many packs per day did you smoke?_____

Does anyone in your home smoke: ❑ Yes ❑ No

Illegal Drugs: Have you ever, or do you currently, use any illegal drugs? ❑ Yes ❑ No

HIV Risk: Do you have any habits that make you at increased risk for HIV? ❑ Yes ❑ No (tattoos, body piercings, blood transfusion)

Alcohol Use: ❑ No ❑ Yes – type of alcohol_____ Average number of drinks per day_____

Exercise: Do you exercise at all? ❑ No ❑ Yes – how many times per week?_____ Type_____

Seatbelt Use: ❑ 100% ❑ 75% ❑ 50% ❑ 25% ❑ 0%

Sun Exposure: ❑ Frequently ❑ Occasionally ❑ Rarely ❑ Past **Sunscreen:** ❑ Yes ❑ No

Caffeine Intake: Number of drinks per day ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5+ Type_____

HMC 3814

HALIFAX HEALTH

HEALTH HISTORY

(CONTINUED)

HEALTH MAINTENANCE / PREVENTIVE CARE:

	Month / Year	Results
Cholesterol Panel	_____	_____
TB Skin Test	_____	_____
Breast Exam	_____	_____ Doctor_____
Mammogram	_____	_____
Pap Smear	_____	_____
Bone Density Test	_____	_____
PSA (Prostate Blood Test)	_____	_____

Do you have a Gynecologist for yearly exams? If so, who?_____

Stool checked for blood: _____ _____ ❑ Mail-in cards ❑ Rectal exam

Stress Test _____ ❑ Normal ❑ Abnormal Type ❑ Treadmill ❑ Nuclear

Colonoscopy _____ ❑ Normal ❑ Internal Hemorrhoids ❑ Diverticulosis ❑ Polyps

Doctor_____ Next Colonoscopy due in _____ years

IMMUNIZATIONS:

	Month / Year		
Tetanus Booster	_____	Did shot include pertussis (Tdap)? ❑ Yes ❑ No ❑ Unsure	
Flu Vaccine	_____		
Pneumonia Vaccine	_____		
Shingles Vaccine	_____		
HPV Vaccine	_____	2nd Shot_____	3rd Shot_____
Hepatitis A Vaccine	_____	2nd Shot_____	
Hepatitis B Vaccine	_____	2nd Shot_____	3rd Shot_____
Hepatitis A/B Combo	_____	2nd Shot_____	3rd Shot_____
TB Skin Test	_____		

DIABETIC EXAMS:

	Month / Year	Results
Dilated Eye Exam	_____	_____ Doctor_____
Hemoglobin A1C	_____	_____
Urine Test for Protein	_____	_____

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HALIFAX HEALTH

Please check symptoms that apply to you currently or on a chronic basis:

GENERAL SYMPTOMS	YES	NO
Appetite loss		
Dizziness		
Fatigue		
Fever		
Generalized weakness		
Unintentional weight loss		
EYES		
Discharge		
Halos		
Irritation		
Recent visual changes		
EAR/NOSE/THROAT		
Allergy/sinus problems		
Difficulty swallowing		
Disruptive snoring		
Hearing loss		
Nasal congestion		
Post nasal drig		
Runny nose		
Sneezing		
Voice change		
CARDIOVASCULAR		
Chest pain/discomfort		
Leg cramps		
Irregular heart beat		
Swelling of hands		
Passing out		
Swelling of ankles		
RESPIRATORY		
Chest congestion		
Cough		
Blood cough		
Shortness of breath		
Sleep disturbed due to breathing		
Wheezing		

GASTROINTESINAL	YES	NO
Bloating		
Stomach pain		
Bowel changes		
Constipation		
Diarrhea		
Heartburn/Indigestion		
Black stools		
Nausea		
Rectal bleeding		
Vomiting		
MEN ONLY		
Decreased libido		
Decreased urinary flow		
Penis discharge		
Painful urination		
Erectile dysfunction		
Bloody urination		
Incontinence		
Urinating > 1/night		
Urinary frequency		
Urinary hesitancy		
WOMEN ONLY		
Breast pain		
Decreased libido		
Painful urination		
Painful intercourse		
Bloody urination		
Incontinence		
Menstrual irregularity		
Nipple discharge		
Pelvic pain		
Urinary frequency		
Urinary urgency		
Vaginal discharge		
Vaginal dryess		
MUSCULOSKELETAL		
Back pain		
Joint pain		
Joint swelling		
Muscle aches		

SKIN	YES	NO
Acne		
Hair loss		
Nail changes		
Itchiness		
Rash		
Suspicious lesions		
NEUROLOGIC		
Trouble walking		
Double vision		
Frequent falls		
Headaches		
Muscle weakness		
Numbness		
Seizures		
Sudden loss of vision		
Tremors		
PSYCH		
Anxiety		
Depression		
Insomnia		
ENDO		
Excessive thirst		
Excessive urination		
Temperature intolerance		
HEME		
Abnormal bleeding		
Bruise easily		
Enlarged lymph nodes		
ALLERGY		
Eye itching		
Hives		
Recurrent infection		
Seasonal allergies		

HALIFAX HEALTH
MEDICAL CENTER OF DAYTONA BEACH: 303 N. CLYDE MORRIS BLVD., DAYTONA BEACH, FL 32114
MEDICAL CENTER OF PORT ORANGE: 1041 DUNLAWTON AVE., PORT ORANGE, FL 32127
EMERGENCY DEPARTMENT OF DELTONA: 3300 HALIFAX CROSSINGS BLVD., DELTONA, FL 32738
TWIN LAKES SURGERY CENTER: 1890 LPGA BLVD., DAYTONA BEACH, FL 32117

Patient Name
Adm. Date Dr.
Date of Birth Age Sex
MR # Visit #

CONSENT FOR E-PRESCRIBING

I agree that Halifax Health may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

You have the right to revoke this authorization at any time. For further instructions, refer to Our Notice of Privacy Practices.

_____ (Initials) Yes, I give permission for requesting medication history.

_____ (Initials) No, I do not give permission for requesting medication history.

Signed:

X_____ _____ _____
(Signature of Patient/Guardian/Representative) (Date/Time) (Relationship if not Patient)

X_____ _____
(Signature of Witness) (Date/Time)

LGL INS FORM

HALIFAX HEALTH

MEDICAL CENTER OF DAYTONA BEACH: 303 N. CLYDE MORRIS BLVD., DAYTONA BEACH, FL 32114
MEDICAL CENTER OF PORT ORANGE: 1041 DUNLAWTON AVE., PORT ORANGE, FL 32127
TWIN LAKES SURGERY CENTER: 1890 LPGA BLVD., DAYTONA BEACH, FL 32117

Patient Name
Adm. Date Dr.
Date of Birth Age Sex
MR # Visit #

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE CONSENT FOR USE OF INFORMATION FOR COMMUNICATIONS

Acknowledgment of Receipt of Privacy Notice. Our Notice of Privacy Practices, receipt of which you acknowledge by signing this form, provides information about how we may use and disclose protected health information about you. As provided for in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting us at the address below. You have the right to revoke this authorization at any time. For further instructions, refer to Our Notice of Privacy Practices.

Use of Health Information for Communications: Halifax Health periodically sends out information on healthcare services, treatment options, community news, events and other health related topics. Please indicate a preference by initialing one of the following statements.

_____ (Initials) Yes, Halifax Health may communicate with me about healthcare services, community news, events and other health related issues.

_____ (Initials) No, I do not wish to receive these communications from Halifax Health.

Signed:

X_____ _____ _____
(Signature of Patient/Guardian/Representative) (Date) (Relationship if not Patient)

Inquiries about our privacy practices can be directed to:
Halifax Health
Health Information Management
303 North Clyde Morris Boulevard
Daytona Beach, Florida 32114
(386) 254-4040

Office Use Only

LGL INS FORM

HALIFAX HEALTH

AUTHORIZATION TO RELEASE MEDICAL INFORMATION CONCERNING OUTPATIENT TREATMENT TO FAMILY MEMBERS FOR CARE AND NOTIFICATION PURPOSES

Patient Name
Adm. Date Dr.
Date of Birth Age Sex
MR # Visit #

We are frequently contacted by individuals, identifying themselves as family members or friends, who request information about a patient's condition. To protect your privacy, we will not discuss your medical condition with anyone without your consent. Please complete the following if you want us to share information regarding your medical condition with members of your family or friends.

I, _____, PIN #_____, hereby authorize Halifax Health and/or my provider, _____, to release information regarding my medical condition and treatments to the following individuals:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Information that I do not want shared with these individuals include:_____

_____

_____

❑ *I authorize Halifax Health to leave messages on my voicemail regarding appointments or services.*

I understand that this document applies only to outpatient treatment at Halifax Health, and is valid for the extent of my treatment, unless I provide a specific date, and the document will become a permanent part of my medical record. I understand that it is my sole responsibility to complete another authorization form should I decide to add or remove individuals from this list.

Patient or Legal Representative:_____ Date:_____

Relationship if not patient:_____

Patient unable to sign because:_____

Witness:_____ Date:_____

HALIFAX HEALTH

MEDICAL CENTER OF DAYTONA BEACH: 303 N. CLYDE MORRIS BLVD., DAYTONA BEACH, FL 32114
MEDICAL CENTER OF PORT ORANGE: 1041 DUNLAWTON AVE., PORT ORANGE, FL 32127
TWIN LAKES SURGERY CENTER: 1890 LPGA BLVD., STE. 200, DAYTONA BEACH, FL 32117

Patient Name
Adm. Date Dr.
Date of Birth Age Sex
MR # Visit #

CONSENT TO HOSPITAL CARE AND RELEASE OF INFORMATION ASSIGNMENT OF INSURANCE BENEFITS ACCEPTANCE OF FINANCIAL RESPONSIBILITY

Consent to Hospital Care. I am presenting myself for hospital care, which may include Inpatient Care, Emergency Care, and Outpatient Testing or Treatment. I hereby voluntarily authorize and consent to such care, including any tests, examinations, diagnostic procedures, surgical and medical treatment, or other hospital care which my doctor, the hospital and its agents and employees, or other persons caring for me may judge as necessary and beneficial to me. No guarantees have been made to me about the outcome of this care. This consent shall also apply to the admission and hospital care of a newborn infant delivered to me during this hospitalization.

Consent to Assignment of Insurance Benefits and Appeal Rights. I request payment of authorized insurance benefits (health, casualty or otherwise) including Medicare benefits due for any services furnished by or in the hospital, or through one of its affiliated corporations, including physician and contracted services, be made to the providers(s) of the services(s). This is not a specific designation of how payments must be applied. I hereby authorize the hospital to apply any payments made by me and/or on my behalf by a third party payer first toward the account referenced, until satisfied, then to any other existing indebtedness to the hospital. If payment of a claim is denied or reduced by the third party payer, I authorize the hospital or its agent to pursue reconsideration of the claim, an appeal, a fair hearing and/or other remedy on my behalf.

Lien on Third Party Liability Proceeds. I understand and acknowledge that hospital expressly reserves the right to secure payment of some or all of its charges by recording a statutory hospital lien. I understand and acknowledge that the amount demanded by hospital from third party source(s) may and likely will exceed the amount that would otherwise be payable under my health insurance or health plan coverage.

Acceptance of Financial Responsibility and Consent to Review of Credit Reports. I understand that I am responsible for, and agree to pay, upon presentation or demand, any charges that are my responsibility not covered or not paid by any applicable insurance, including reasonable attorney fees if legal action is filed to collect. I understand some fees for physicians, non-physician practitioners and/or contracted services may not be included in my hospital bill. I will receive separate billing for these services as well as from my physician and other practitioners who are involved in my treatment, including, but not limited to, pathologist, radiologist, and anesthesiologist. These bills may include supervisory services for tests performed. I consent to the review of credit reports by the hospital and/or its authorized agents. I understand that I am entitled to a complete detailed billing upon request (§ 395.301, Florida Statutes).

Notice: I agree that in order for Halifax Health or any affiliated agents to service my account(s) or to collect any amounts due, I may be contacted by telephone at any telephone number associated with my account, including wireless telephone numbers that could result in billable charges. Methods for contact may include the use of pre-recorded/artificial voice messages and/or use of an automatic (predictive) dialing service(s), as applicable.

Notice: Although the hospital may participate in your health plan, a physician involved in your care may or may not be a participating provider. This may affect coverage for professional services. We suggest you contact your plan's member services representative for a coverage determination.

Notice: The care and treatment received at Halifax Health facilities may be provided by physicians or other individuals who are agents of the Halifax Hospital Medical Center tax district, or other governmental body. These agents include, but are not limited to, training program faculty, residents, fellows, and students; cardiovascular surgeons; trauma surgeons; neurosurgeons; anesthesiologists; radiologists; oncologist/hematologists; psychiatrists; and physicians providing admitting and on-call consultative services. Any liability that may arise from their care and treatment is limited as provided by law.

Notice: Halifax Health may use your personal information, including your Social Security Number, to verify the accuracy of the information you provide; for insurance and payment purposes; to help identify and prevent fraud or other criminal activity; to match, verify, or retrieve existing information; to help prevent medical errors; or for research activities.

Use and Disclosure of Protected Health Information. I consent to the use and disclosure of medical information about me for treatment, payment and health care operations as described in the hospital's Notice of Privacy Practices. I understand that I have the right to review the Notice prior to signing this consent. I acknowledge having received the Notice at this or a prior visit.

Use and Disclosure of HIV-AIDS, Mental Health and Substance Abuse Information. I understand that the information used or disclosed as described in the Notice of Privacy Practices may include information about Acquired Immunodeficiency Syndrome (AIDS), AIDS-related complex, tests for or infection with the Human Immunodeficiency Virus (HIV), psychiatric conditions, alcoholism or substance abuse.

I acknowledge that providing false information to a hospital with the intent to defraud the hospital in order to obtain goods or services is a crime under Florida law (§ 817.50, Florida Statutes).

I acknowledge receipt of Halifax Health's notice of *Patient Rights and Responsibilities*, including grievance procedures.

I/we certify that the signature(s) below represent consent and acknowledgement for the above. I/we fully understand the above and agree to all terms stated herein.

Signature of Patient / Guarantor / Representative _____ Date _____ Time _____

Relationship if Not Patient _____

Signature of Witness _____ Date _____ Time _____

PATIENT UNABLE TO SIGN BECAUSE: _____

Signature of Witness _____ Date _____

Patients' Rights and Responsibilities

HALIFAX HEALTH

As a patient at Halifax Health you have certain rights and responsibilities which are important to us and you. We want to be certain you are aware of them and urge you to read through this summary.

YOUR RIGHTS

Access to Care:
You are assured of impartial access to treatment or accommodations that are available or medically indicated without regard for race, creed, sex, national origin, ability to pay, age, handicap, or whether or not you have executed advance directives.

Execution/Formulation of Advance Directives:
You have the right to formulate advance directives including a living will and/or appointment of a healthcare surrogate. You have the right to have any or all advance directives made a part of your medical record, and the right to have the terms of such advance directives complied with by Halifax Health and its caregivers to the extent permitted by law.

You have the right to be transferred to another facility or to engage another physician if the facility or physician cannot respect your advance directive requests as a matter of conscience.

Respect and Dignity:
You have the right to considerate, respectful care with recognition of your personal dignity, values and beliefs.

End of Life Care:
You have the right to respectful, responsive end of life care.

Access to Pain Management:
You have the right to expect your pain to be treated appropriately.

Restraint Use:
You have the right to remain free of restraints unless clinically necessary.

Resolution of Conflicts:
In the event a conflict should arise, the Bioethics Committee of the facility charged with your care may be convened to assist with a resolution that is in keeping with your desires and the laws and regulations with which we must comply.

Privacy and Confidentiality:
You have the right to personal and information privacy. Pursuant to this, you may:

- Refuse to talk or see persons not connected with the hospital or directly involved in your care.
- Wear appropriate personal clothing or symbolic items if they do not interfere with diagnostic procedures, treatment or care.
- Be interviewed and examined in surroundings designed to assure visual and auditory privacy.
- Expect discussions and consultations involving your care to be conducted discreetly.
- Have medical records read only by individuals directly involved in your treatment, or individuals monitoring the quality of your care, or by individuals designated by written authorization by you or your legally authorized representative.
- Expect all communications and records pertaining to your care, including the source of payment for treatment, to be treated as confidential.
- Request transfer to another room if another patient or visitor in the room is disturbing you.
- Be placed in protective privacy when considered necessary for your personal safety and to expect at all times reasonable safety and a secure environment within Halifax Health.
- Expect that those not directly involved in your care may be present only with your permission.

Identity:
You have the right to know the identity and professional status of individuals providing services to you.

Protective Services:
You have the right to access protective services which may include guardianship, advocacy services, conservatorship, state survey and certification agencies, state licensure offices, protection and advocacy networks, and Medicare and Medicaid fraud and abuse offices.

Here are phone numbers at which many of these services may be reached:

Abuse Registry; Child, Adult, Elderly, Disabled Protective Services	800.962.2873
Medicare Customer Services	800.663.4227
Medicaid Office	800.273.5880; 904.798.4200
Agency for Health Care Administration Consumer Hotline	888.419.3456
Substance Abuse and Mental Health	800.663.4227
Developmental Disability Services	386.238.4607
Children & Families Program	866-762-2237

Information:
You have the right to obtain from your physician complete and current information concerning your diagnosis in terms you can reasonably understand, including unanticipated outcomes. When it is not medically advisable to provide you such information, the information should be made available to an appropriate person on your behalf.

You have the right to obtain information as to any relationship of Halifax Health to any other healthcare and educational institutions insofar as your care is concerned, and you have the right to know of the existence of any professional relationships among individuals, by name, who are treating you.

You Have the Right to Information Relating to Information Disclosure:
You have the right to request information regarding:

- Corporate form of the facility (public or private; nonprofit or profit; ownership and management; affiliation with other corporate entities).
- Accreditation status.
- Whether specialty programs meet guidelines established by specialty societies or other appropriate bodies.
- Volume of certain procedures performed.
- Consumer satisfaction measures.
- Clinical quality performance measures.
- Procedures for registering a complaint and for achieving resolution of that complaint.
- The availability of translation or interpretation services for non-English speakers and people with communication disabilities.
- Numbers and credentials of providers of direct patient care.
- Whether the facility's affiliation with a provider network would make it more likely that a consumer would be referred to health professionals or other organizations in that network.
- Whether there are any Federal health programs the facility has been excluded from.

Communication:
You have the right of access to people outside the facility within the scope of the facility's rules. You have the right of access to an interpreter and to important documents in large print or on cassette tapes, in Spanish and in French.

Consent and Consultation:
You have the right to reasonable, informed participation in decisions involving your care. Except in emergencies, such information for informed consent will include the specific procedure and/or treatment, the medically significant risks, and benefits and alternatives. Where medically significant alternatives for care or treatment exist, or when you request information concerning medical alternatives, you have the right to such information. You also have the right to know the name of the person responsible for the procedure and/or treatment and to collaborate with your physician regarding all healthcare decisions. In addition, you have, at your own request and expense, the right to consult with a specialist.

Clinical Trials:
You may be given information concerning a treatment option that is in the research stage. If this is the case, you have the right to refuse or to accept this treatment after appropriate information is given to you.

Refusal of Treatment:
You may refuse treatment to the extent permitted by law and in such event will be informed of the medical consequences of your actions. When the refusal of treatment by you or your legally authorized representative prevents the provision of appropriate care in accordance with professional standards, our relationship with you may be terminated upon reasonable notice, after any immediate acute illness is resolved.

Transfer and Continuity of Care:
You may not be transferred to another facility unless you have received a complete explanation of the need. The institution/physician to which you are to be transferred must first have accepted you.

You have the right to expect reasonable continuity of care, and that the hospital will provide a mechanism whereby you are informed by your physician or delegate of your continuing care requirements following your discharge from any affiliate of Halifax Health.

Visitation:
The patient/representative has the right to choose who may visit during their inpatient stay, regardless of whether the visitor is a family member, a spouse, a domestic partner (including a same-sex domestic partner), or other type of visitor. The patient/representative has the right to withdraw such consent to visitation at any time.

Hospital Charges:
You have the right to request and receive an itemized and detailed explanation of your total bill, regardless of the source of payment. At any time before, during or after hospitalization, patient accounting personnel are available during normal working hours to discuss financial arrangements or the details of any billing.

Patient Complaints/Grievances:
You have the right to expect that any concern you or your representative have, relative to your care, conditions or other issues related to our services will be taken seriously and promptly acted upon. Policies provide for follow-up and feedback to you or your representative relative to any concern. Any employee of the hospital, department managers, and/or the administrator on call will be pleased to receive and respond to your concern at any time during your stay or thereafter. Presentation of a complaint/grievance will not compromise your future access to care. You can freely voice complaints and recommend changes without being subject to coercion, discrimination, reprisal, or unreasonable interruption of care, treatment, and services.

1. You may contact:
   a) Any employee of Halifax Health.
   b) Unit/departmental manager by dialing zero (0) or by calling 386.226.4500.
   c) Nursing Administration at extension 54006.
   d) Administration at extension 54771.
   e) You may also contact any of the above by dialing zero (0) using any Halifax Health phone or by calling 386.226.4500 from an outside phone line.

2. An attempt will be made to resolve your complaints/ concerns/grievances immediately. If that cannot be accomplished, a thorough investigation will be conducted by appropriate personnel. It is our intent to complete a full review of the grievance and provide a written response within seven days of receipt of the grievance. If the grievance will not be resolved or if the investigation is not or will not be completed within 7 days, you will be notified. You or your representative will be given an estimated timeframe for the review to be completed.

3. You or your representative has a right to request a review by Kepro for quality of care issues. Additionally, any Medicare/Medicaid beneficiary has the right to a review by Kepro for coverage decisions and/or appeal for premature discharge. You may contact Kepro at 1-844-455-8708 with or without going through the grievance process offered by Halifax Health.

4. You or your representative may contact the Agency for Health Care Administration (AHCA) at 1.888.419.3456 and/or The Joint Commission (TJC) at 1.800.994.6610 directly with or without going through the grievance process offered by Halifax Health.

5. In its resolution of the grievance, Halifax Health will provide you with written notice of its decision that contains the name of the hospital contact person, the steps taken on your behalf to investigate the grievance, the results of the grievance process and the date of completion.

YOUR RESPONSIBILITIES

Provision of Information:
You have the responsibility to provide accurate and complete information about present complaints, past illnesses, hospitalizations, medication, and other matters relating to your health.

Compliance with Instructions:
You are responsible for following the treatment plan developed by your physician and cooperating with the caregivers implementing that plan. You are responsible for keeping appointments or for informing the physician or hospital in a timely manner if you are unable to do so.

Refusal of Treatment:
You are responsible for your actions if you refuse treatment.

Hospital Charges:
You are responsible for assuring that your financial obligations are fulfilled as promptly as possible and for working with Halifax Health representatives in the provision of reliable information on which financial support or insurance filings may be based.

Respect and Consideration:
As a patient you are responsible for following the rules and requirements of Halifax Health as outlined to you, and for being considerate of the rights of other patients and hospital personnel. Your assistance in the control of noise and activity in and about your room and the conduct of your visitors and guests will contribute to the quality of care shared by all patients.