



## HORIZON HEALTH CENTER

### CONSENT TO MEDICAL EXAM AND TREATMENT

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I consent to the medical exam and treatment which may be performed during the clinic visit, including emergency treatment or services, and which may include but not limited to laboratory procedures and testing, including routine testing for HIV (Human Immunodeficiency Virus) medical or surgical treatment or procedures, anesthesia, pharmaceutical products, and other diagnostic procedures rendered to me under the instructions of my primary health provider. I understand that:

1. I have the right to consent or refuse any proposed procedure or treatment.
2. I will not be involved in any research or experimental procedure without my knowledge and consent.

### **⌘ Your Rights as a Consumer in this Center ⌘**

#### **You have a Right:**

- To be treated with dignity and respect
- To considerate and respectful quality care
- To a reasonable response to your requests for treatment, within the scope of the health center's mission, capacity, and regulations
- To confidential treatment. You also have the right to approve or disapprove the release of any disclosures or records, except when release is required by law
- To understand why certain procedures and tests are required, and why we request certain information
- To discuss with your clinician any questions or problems about your medical care
- To prompt and effective pain management, and to be informed by staff about available measures
- To be informed of your current medical; condition unless medically contraindicated (as documented by a physician in your chart)
- To be informed of available treatment options
- To access any information contained in your medical record
- The responsibility to participate in decisions about the intensity and scope of your treatment, within the limits of the health center's mission, and applicable laws
- To accept medical care, or to refuse treatment, to the extent permitted by law and to be informed of the medical consequences of refusing treatment
- To care which takes into consideration your psychosocial, spiritual, and cultural values
- To express grievances to our staff and governing authority, and to recommend change in policies and procedures
- To participate in the consideration of ethical issues that arise in your care
- To be free from mental and physical abuse, free from exploitation, and free from chemical, physical and other types of restraints
- To join with other clients or individuals to work for improvements in client care
- Your guardian, next of kin, or legally authorized responsible person can exercise your rights for you if you have been medically or legally determined to be unable to participate yourself
- To excise civil and religious liberties, including the right to independent decisions
- To not be discriminated against because of age, race, religion, nationality, sex or ability to pay
- To be informed of any research or experimentation which could affect your care. You may then decide whether or not you want to participate in it
- Be made aware of advanced directives, and to know how this organization will respond to such advance directives
- To not be deprived of any constitutional, civil and/or legal rights solely because of receiving services from this facility
- To be informed of the name and professional status of health care professional, and of fees and related charges
- To be informed of these rights as evidenced by written acknowledgement or staff documentation in the medical record, and offered a written copy of the rights statements
- To not be required to perform work for the facility unless the work is part of the patient's treatment and is performed voluntarily by the patient

## **🦋Your Responsibilities as a Consumer in this Center🦋**

- To keep appointments or call to reschedule
- To respect the personal rights and private property of other clients and staff
- To be honest with the information you give us
- To follow instructions
- To pay bills promptly so we can continue to help you
- To ask questions, and to inform us promptly if there are any changes in health

Advanced Directives:             Yes         No             On File

Additionally, I hereby permit Horizon Health Center to share my information with its key facilities and service provider partners: Jersey City Medical Center, Hoboken University Medical Center, Christ Hospital, Bayonne Medical Center, Newark Beth Israel Medical Center and Health-e-CITi-NJ.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

### **Privacy Notice**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing his consent. As provided in our notice; the terms of our notice may change, if we change our notice; you may obtain a revised copy by asking someone at front desk or contacting Loida Colon at 201-451-6300 x309

You have the right to request that we restrict how protected hearth information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction; but if we do; we are bound by our agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment; payment and health care operations. You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent.

Initial\_\_\_\_\_

### **Patient Grievance Procedure**

If a patient has a grievance and/or recommendation, she/he should first be directed to the Clinic Coordinator and/or Director of the Department of the clinic in which the complaint occurred. If a resolution of the complaint or grievance cannot be achieved at this point; the patient will be directed to the Medical Director. If the Medical Director cannot resolve the complaint or grievance at this point, the patient will be asked to notify the Chief Executive Officer (CEO), in writing, regarding the grievance. The Chief Executive Officer shall then resolve the matter and notify the patient in writing of the resolution.

Initial\_\_\_\_\_

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**I certify that I have read the above and I am satisfied with the content and significance and that I or my duly authorized agent may execute the form and accept its terms.**

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date



**I hereby grant permission that Horizon Health Center may contact me at:**

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Alternate Phone:** \_\_\_\_\_

**In case of emergency please contact:**

**Name:** \_\_\_\_\_ **Relation:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Relation:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Relation:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Patient** \_\_\_\_\_ **Witness** \_\_\_\_\_ **Date** \_\_\_\_\_

**If patient is a minor (Legal Guardian)** \_\_\_\_\_

**Patient** \_\_\_\_\_ **Witness** \_\_\_\_\_ **Date** \_\_\_\_\_



# HORIZON HEALTH CENTER

## ADVANCE DIRECTIVE

### 1. Appointment of a Health Care Representative/Proxy

I, \_\_\_\_\_ being of sound mind, willfully and voluntarily designate the following person as my health care representative to make any and all health care decision for me in the event that I become incapable of making decisions for myself. With this designation, I trust that this person will act in my best interest and in accord with my wishes.

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

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Telephone Home \_\_\_\_\_ Work \_\_\_\_\_

If the person I have named above is unable to act as my health care representative, I hereby designate the following person(s) to do so:

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

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Telephone Home \_\_\_\_\_ Work \_\_\_\_\_

2. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

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Telephone Home \_\_\_\_\_ Work \_\_\_\_\_

**Continue to Part II on the other side.**

If you are not completing an Instruction Directive/Living Will, please go to Part III (Signature and Witnesses) on the other side.

**For more information regarding Advance Directives, please contact the Human Resources Department.**

**II.**



## Health Care Instructions Directive/Living Will

The following health care instructions directive exercises my right to make decisions concerning my health care. This directive is intended to provide clear and convincing evidence of my wishes to be followed in the event that I lack the capacity to make or communicate my treatment decisions.

I, \_\_\_\_\_, being of sound mind, willfully and voluntarily make known my wishes regarding my health care in the event that I can no longer make or communicate my decisions.

If my health condition, as determined by my attending physician and at least one additional physician, fits any of the following criteria: a) if I become permanently unconscious, b) if I have a terminal illness, c) if the life-sustaining treatment is experimental and not proven therapy or d) if I have a serious irreversible condition and the likely risks and burdens associated with the treatment would outweigh the likely benefits; or unwanted medical intervention would be inhumane, all of the following statements are consistent with my wishes:

- |  |   |
|--|---|
| I <input type="checkbox"/> do <input type="checkbox"/> do not want | cardiac resuscitation.                                |
| I <input type="checkbox"/> do <input type="checkbox"/> do not want | mechanical respiration.                               |
| I <input type="checkbox"/> do <input type="checkbox"/> do not want | blood or blood products.                              |
| I <input type="checkbox"/> do <input type="checkbox"/> do not want | kidney dialysis.                                      |
| I <input type="checkbox"/> do <input type="checkbox"/> do not want | antibiotics.  |
| I <input type="checkbox"/> do <input type="checkbox"/> do not want | chemotherapy/radiation therapy.                       |
| I <input type="checkbox"/> do <input type="checkbox"/> do not want | simple diagnostic tests (blood work/x-rays)           |
| I <input type="checkbox"/> do <input type="checkbox"/> do not want | artificial or invasive forms of nutrition.            |
| I <input type="checkbox"/> do <input type="checkbox"/> do not want | artificial or invasive forms of hydration.            |
| I <input type="checkbox"/> do <input type="checkbox"/> do not want | to make an anatomical gift of all or part of my body. |

If yes, specify: All organs  Only these organs \_\_\_\_\_

I also direct that I be given all medically appropriate care necessary, including pain medications, to make me comfortable and to maintain my personal hygiene and dignity, even if they dull consciousness and indirectly shorten my life.

### Additional Comments or Directions:

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### III. Signature and Witnesses

By signing below, I indicate that I understand and agree with the contents of this document.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**I declare that the person who signed this document appears to be of sound mind and free of duress or undue influence. I am 18 years of age or older, am not designated as the health care representative/proxy nor am I the patient's physician.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

