



Penn Medicine

Hospital of the  
University of  
Pennsylvania

Label Area

## GENERAL CONSENT FORM

**Thank you for choosing Penn Medicine.** Penn Medicine is part of the University of Pennsylvania and its Health System. The care you receive at Penn Medicine may include care by (the "Hospital"), the Clinical Practices of the University of Pennsylvania, Clinical Care Associates, and/or other affiliated practices or facilities, and each of their authorized agents, employees, and designees (all together, "Penn Medicine").

**I have read and understood each paragraph below, and by signing give consent voluntarily.**

*If signing electronically: I accept and I intend the signature(s) below to be legally binding and the equivalent of my handwritten signature.*

### Patient Signing:

Patient Printed Name

Patient Signature

Date

Time

### Legally Authorized Representative Signing

Print Name

Signature

Date

Time

Relationship to Patient

### Penn Medicine Representative Signing:

Print Name

Signature

Date

Time

Entity

**CONSENT TO CARE:** I present myself for outpatient care and/or admission to the Hospital or another Penn Medicine provider. I voluntarily consent to care including routine tests and treatment. I know that no guarantees have been made to me about the results of the care provided. I understand that Penn Medicine is part of the University of Pennsylvania, which is a teaching institution. I agree that those in training programs may take part in my care. I understand that for the purpose of my care, certain of my tissue(s), bodily substances and/or fluids may be removed and used, modified, disposed of, or transferred by Penn Medicine. I agree that any remaining tissue(s), bodily substances, and/or fluids may be used for education and research not specifically related to my care. If such material identifies me, research use will occur only with my permission. I understand that video, audio, and/or digital recordings/images of my treatment by Penn Medicine may be taken, and may be used for:

- Quality improvement and education, in which case the recordings/images will not become part of my medical record and will be erased after review. I have the right to decline the recording or image collection or its use for purposes of quality improvement and education; and
- Consultative services and treatment by healthcare providers at a distant site, such as another hospital, authorized by Penn Medicine, which may include interactive video, audio, and telecommunications technology (also known as "telemedicine"). Details of my health history, examinations, x-rays, tests and medical record may be reviewed by and discussed with these other healthcare providers at these distant sites and other hospitals.

Penn Medicine routinely suspends the resuscitative aspects of living wills, and Do Not Attempt Resuscitation Orders, during the pre-procedure, procedural and post-procedural period, unless I specifically tell my Penn Medicine providers otherwise. This applies to all invasive and operative procedures.

**CONSENT TO USE AND DISCLOSE PERSONAL HEALTH INFORMATION:** I understand and consent that Penn Medicine is permitted to use and disclose health information about me in any form including electronic for **treatment, payment, and healthcare operations** and as otherwise allowed by law. This includes sharing my health information with:

- Penn Medicine or outside providers involved in my care, and family members or friends involved in my care.
- People or parties responsible for payment for the care I receive, such as insurance companies, managed care companies, government programs and agencies such as Medicare, and each of their agents or auditors.

Label Area

**SPECIFIC CONSENT TO USE AND DISCLOSE SPECIAL RECORDS:**

I understand that Federal and state law specially protect health information and records relating to treatment for mental illness, HIV or AIDS, and/or drug or alcohol abuse ("Special Records"). Such laws allow Penn Medicine to use and share Special Records for my care and treatment and for other specific purposes. In other circumstances, Penn Medicine will obtain special patient consent to release records. Questions on privacy issues may be directed to [privacy@uphs.upenn.edu](mailto:privacy@uphs.upenn.edu).

**NOTICE OF PRIVACY PRACTICES:** I acknowledge receipt of Penn Medicine's Notice of Privacy Practices, which explains in more detail how my health information may be used and/or disclosed.

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**PATIENT RIGHTS AND RESPONSIBILITIES:** I have been informed of the Patient Bill of Rights and Responsibilities that explains my rights and responsibilities as a patient in a language and manner that I understand and a copy has been made available to me. Penn Medicine provides translated Patient Bill of Rights and Responsibilities to assist patients and families on its website, <http://www.pennmedicine.org/for-patients-and-visitors/patient-information/patient-rights-and-safety/patient-rights> and language interpretation services are available, as needed.

**ASSIGNMENTS OF BENEFITS:** In exchange for the care and services I am receiving from Penn Medicine, I hereby give and assign to Penn Medicine, including its Hospitals and providers, the right to receive payment directly for all insurance and other health benefits to which I am entitled, and/or which may be payable on my behalf. I understand that this is called an "assignment of benefits" and that Penn Medicine, its Hospitals, and/or providers may be called my "assignees." I agree that they can sue anyone in their own names as my assignee and obtain payment for charges relating to my care and payment for lawyers' fees resulting from collection efforts. I understand that I may be required to pay for charges for my care that others do not pay on my behalf.

**MEDICARE BENEFITS:** I request that payment of Medicare benefits be made on my behalf to the Hospital, Penn Medicine or its providers for any care or services provided to me. I authorize them to give the Centers for Medicare & Medicaid Services and its agents any information about me (or the person I signed for) needed to determine Medicare benefits. I have provided accurate information about Medicare secondary payors.

**FINANCIAL RESPONSIBILITY:** Even if I have insurance, I may be responsible for charges for my care that others do not pay on my behalf. I agree that within forty-five (45) days after Penn Medicine provides care to me (or the person I signed for), or the bill for such care is given to me or whomever is responsible for payment, I will pay Penn Medicine any unpaid charges. If the matter is sent to a collection agency or lawyer for collection, I will pay the outstanding charges and all lawyers' fees and collection expenses.

**RIGHT OF SUBROGATION AND LIEN:** I understand and agree that the Hospital, Penn Medicine or its providers are "subrogated" to (substituted for me) and have the right to recover from any person or company legally responsible (whether by contract, tort, or some other way) for paying the charges for care provided to me. Also, if I make a legal claim against any person or company for compensation for the injuries or illness for which I am being treated, I agree that, to the extent permitted by law, Penn Medicine shall have a "lien" against (right to) any money I recover and I direct that any lawyers representing me pay this lien from the funds recovered before they distribute any funds to me. This right of subrogation and this lien will not include any money already paid to Penn Medicine. I agree to take, and to assist Penn Medicine in taking, whatever action is necessary to protect their subrogation rights (rights of substitution) and liens.

**SEVERABILITY:** If any part of this consent form is declared to be invalid, illegal or unenforceable, the rest of this consent form will not be invalid. This does not take away any rights I, my employer, or my insurance company may have under any existing contracts with Penn Medicine, or any statutory rights I may have.

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**VALUABLES:** I have been advised not to bring money or other valuables to the Hospital, excluding required co-insurance fees, or to send any such items that I have brought home with family or friends. I understand that the Hospital maintains facilities for the safekeeping of money and valuables. I understand that Penn Medicine is not responsible for any loss or damage to personal property (including dentures, glasses and prosthetic devices) unless deposited with the Hospital for safekeeping, and I hereby release Penn Medicine from any such responsibility.



# HIPAA: Notice of Privacy Practices – July 2021

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access To This Information. Please Review It Carefully.

## WE ARE COMMITTED TO YOUR PRIVACY

We understand that information about you and your health is very personal. We strive to protect our patients' privacy. We are required by law to maintain the privacy of our patients' protected health information ("PHI"). We are also required to provide notice of our legal duties and privacy practices with respect to PHI and to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of this Notice and to make a new Notice effective for all PHI we maintain. You can obtain a copy of a new notice at <https://www.pennmedicine.org/for-patients-and-visitors/patient-information/hipaa-and-privacy/hipaa-notice-of-privacy-practices> or by contacting the Penn Medicine Privacy Office as described below.

## WHO THIS NOTICE APPLIES TO

The terms of this Notice apply to Penn Medicine, consisting of the Perelman School of Medicine at the University of Pennsylvania and the University of Pennsylvania Health System and its subsidiaries and affiliates, including but not limited to the Hospital of the University of Pennsylvania, Pennsylvania Hospital, Penn Presbyterian Medical Center, Chester County Hospital, Lancaster General Health, Lancaster General Hospital, Lancaster General Medical Group, The Heart Group of Lancaster General Health, Lancaster General Health – Columbia Center, Penn Medicine Home Health Lancaster General Health, Penn Medicine Princeton Health, Penn Medicine Princeton Health Behavioral Health, Penn Medicine Princeton Medicine Physicians, Penn Medicine Home Health Princeton Health, Penn Medicine Hospice Princeton Health, the Clinical Practices of the University of Pennsylvania, Clinical Care Associates, Good Shepherd Penn Partners, Clinical Health Care Associates of New Jersey, Presbyterian Center for Continuing Care, and Penn Medicine at Home. This Notice also applies to the physicians, licensed professionals, employees, volunteers, and trainees seeing and treating patients at Penn Medicine-owned and operated care settings. This Notice does not apply to non-employed Penn Medicine providers in their private medical offices.

We are committed to excellence in providing state-of-the-art health care services through the practice of patient care, education, and research. Below is a description of how your health information will be used and disclosed to advance this mission.

## USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION THAT DO NOT REQUIRE AN AUTHORIZATION

**Treatment.** For example, doctors, nurses, and other staff members involved in your care will use and disclose your PHI to coordinate your care or to plan a course of treatment for you.

**Payment.** For example, we may disclose information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you.

**Health Care Operations.** For example, we may disclose your PHI for billing or interpreter support. We may use your PHI to conduct an evaluation of the treatment and services provided or to review staff performance. We may disclose your PHI for education and training purposes to doctors, nurses, technicians, medical students, residents, fellows and others.

**Health Information Exchanges.** We participate in initiatives to facilitate electronic sharing of patient information, including but not limited to Health Information Exchanges (HIEs). HIEs involve coordinated information sharing among HIE members for purposes of treatment, payment, and health care operations. You may

opt out of Penn Medicine's information sharing through its HIE activities. If you wish to opt out, please speak with your patient/customer services associate or contact the Penn Medicine Privacy Office as described below. More information about HIEs can be found through the Patient Privacy Options page of the Penn Medicine website: <https://www.pennmedicine.org/for-patients-and-visitors/patient-information/hipaa-and-privacy/patient-privacy-options>.

**Our Facility Directory.** We use information to maintain an inpatient directory listing your name, room number, general condition and, if you wish, your religious affiliation. Unless you choose to have your information excluded from this directory, the information (except for religious affiliation) may be disclosed to anyone who requests it by asking for you by name. This information, including your religious affiliation, may also be provided to members of the clergy, even if they do not ask for you by name. If you wish to have your information excluded from this directory, please contact your patient/customer services associate.

**To Persons Involved in Your Care.** As long as you do not object, we may, based on our professional judgment, disclose your PHI to a family member or other person if they are involved in your care or paying for your care. Similarly, we may also disclose limited PHI to an entity authorized to assist in disaster relief efforts for the purpose of coordinating notification to someone responsible for your care of your general condition or location.

**Fundraising.** We may contact you at times to donate to a fundraising effort on our behalf. If you wish to opt out of receiving these communications, please visit: <http://www.pennmedicine.org/fundraising-opt-out>.

## Communicating with You.

We will use your PHI to communicate with you about a number of important topics, including information about appointments, your care, treatment options and other health-related services, payment for your care, and opportunities to participate in research, provided this research outreach is approved by the University of Pennsylvania Institutional Review Board (IRB) and/or the IRB of Record, see Research section below.

We urge you to sign up for our patient portal to send and receive communications conveniently and securely and to share your preferences for how we contact you. The patient portal is [www.MyPennMedicine.org](http://www.MyPennMedicine.org), or for LGH, [www.MyLGHealth.org](http://www.MyLGHealth.org).

We may also contact you at the email, phone number or address that you provide, including via text messages, for these communications. If your contact information changes, it is important that you let us know. Texting and email are not 100% secure. Regarding text messages, please note that message and data rates may apply and you will have an opportunity to opt out.

**Research.** We may use and disclose your PHI as permitted by applicable law for research. This is subject to your authorization and/or oversight by the University of Pennsylvania IRB, committees charged with protecting the privacy rights and safety of human subject research.

As an academic medical center, Penn Medicine supports research and may contact you to invite you to participate in certain research activities. If you do not wish to be contacted for research purposes, please tell your patient/customer services associate, or for LGH, please contact the LG Health Research Institute. In such case, we will use reasonable efforts to prevent research-related outreach. Note that Penn Medicine may continue to use your PHI for research purposes as described above and your care providers may discuss research with you.



**Business Associates.** At times, we need to disclose your PHI to persons or organizations outside Penn Medicine who assist us with our payment/billing activities and health care operations. We require these business associates and their subcontractors to appropriately safeguard your PHI.

**Other Uses and Disclosures.** We may be permitted or required by law to make certain other uses and disclosures of your PHI without your authorization. Subject to conditions specified by law, we may release your PHI:

- for any purpose required by law
- for public health activities, including required reporting of disease, injury, birth and death, for required public health investigations, and to report adverse events or enable product recalls
- to government agencies if we suspect child/elder adult abuse or neglect. We may also release your PHI to government agencies if we believe you are a victim of abuse, neglect or domestic violence
- to your employer when we have provided screenings and health care at their request for occupational health and safety
- to a government oversight agency conducting audits, investigations, inspections and related oversight functions
- in emergencies, such as to prevent a serious and imminent threat to a person or the public
- if required by a court or administrative order, subpoena or discovery request
- for law enforcement purposes, including to law enforcement officials to identify or locate suspects, fugitives or witnesses, or victims of crime
- to coroners, medical examiners and funeral directors
- if necessary to arrange organ or tissue donation or transplant
- for national security, intelligence, or protective services activities
- for purposes related to your workers' compensation benefits

## **USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION BASED ON A SIGNED AUTHORIZATION**

Except as outlined above, we will not use or disclose your PHI for any other purpose unless you have signed a form authorizing the use or disclosure. You may revoke an authorization in writing, except to the extent we have already relied upon it.

In some situations, a signed authorization form is required for uses and disclosures of your PHI, including:

- most uses and disclosures of psychotherapy notes
- uses and disclosures for marketing purposes
- disclosures that constitute the sale of PHI
- uses and disclosures for certain research protocols
- as required by privacy law. The confidentiality of substance use disorder and mental health treatment records as well as HIV-related information maintained by us is specifically protected by state and/or federal law and regulations. Generally, we may not disclose such information unless you consent in writing, the disclosure is allowed by a court order, or in other limited, regulated circumstances.

## **YOUR RIGHTS**

**Access to Your PHI.** Generally, you can access and inspect paper or electronic copies of certain PHI that we maintain about you. You may readily access much of your health information without charge using the patient portal, which is [www.MyPennMedicine.org](http://www.MyPennMedicine.org) or, for LGH, [www.MyLGHealth.org](http://www.MyLGHealth.org). You may also access your information through the Health Information Management department, which you can contact at [HIMRequests@uphs.upenn.edu](mailto:HIMRequests@uphs.upenn.edu). In line with set fees under federal and state law, we may charge you for a copy of your medical records.

**Amendments to Your PHI.** You can request amendments, or changes, to certain PHI that we maintain about you that you think may be incorrect or incomplete. All requests for changes must be in writing, signed by you or your representative, and state the reasons for the request. If we decide to make an amendment, we may also notify others who have copies of the information about the change. Note that even if we accept your request, we may not delete any information already documented in your medical record.

**Accounting for Disclosures of Your PHI.** In accordance with applicable law, you can ask for an accounting of certain disclosures made by us of your PHI. This request must be in writing and signed by you or your representative. This does not include disclosures made for purposes of treatment, payment, or health care operations or for certain other limited exceptions. An accounting will include disclosures made in the six years prior to the date of a request.

**Restrictions on Use and Disclosure of Your PHI.** You can request restrictions on certain of our uses and disclosures of your PHI for treatment, payment, or health care operations. We are not required to agree but will attempt to accommodate reasonable requests when appropriate.

**Restrictions on Disclosures to Health Plans.** You can request a restriction on certain disclosures of your PHI to your health plan. We are only required to honor such requests when services subject to the request are paid in full. Such requests must be made in writing and identify the services to which the restriction will apply.

**Confidential Communications.** You can request that we communicate with you through alternative means or at alternative locations, and we will accommodate reasonable requests. You must request such confidential communication in writing to each department you would like to accommodate the request.

**Breach Notification.** We are required to notify you in writing of any breach of your unsecured PHI without unreasonable delay and no later than 60 days after we discover the breach.

**Paper Copy of Notice.** You can obtain a paper copy of this Notice, even if you agreed to receive an electronic copy. This Notice is available on our website in several different languages at <https://www.pennmedicine.org/for-patients-and-visitors/patient-information/hipaa-and-privacy/hipaa-notice-of-privacy-practices>.

## **ADDITIONAL INFORMATION**

**Complaints.** If you believe your privacy rights have been violated, you can file a complaint with the Penn Medicine Chief Privacy Officer, Office of Audit, Compliance & Privacy, St. Leonard's Court, 3819 Chestnut Street, Suite 214, Philadelphia, PA 19104.

You can also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C.

A complaint must be made in writing and will not in any way affect the quality of care we provide you.

**For further information.** If you have questions about this Notice, or requests regarding privacy, please contact the Penn Medicine Privacy Office at 215-573-4492 or [privacy@uphs.upenn.edu](mailto:privacy@uphs.upenn.edu).

**Effective Date.** This Notice of Privacy Practices is effective July 1, 2021.

## Patient Bill of Rights & Responsibilities

*As a health care facility within the University of Pennsylvania Health System (UPHS), we are committed to delivering quality medical care to you, our patient, and to making your stay as pleasant as possible. The following, "Statement of Patient's Rights," endorsed by the administration and staff of this facility, applies to all patients. In the event that you are unable to exercise these rights on your own behalf, then these rights are applicable to your designated legally authorized representative. As it is our goal to provide medical care that is effective and considerate within our capacity, mission, and philosophy, applicable law and regulations, we submit these to you as a statement of our policy.*

### STATEMENT OF PATIENT'S RIGHTS

**You have the right** to respectful care given by competent personnel which reflects consideration of your cultural and personal values and belief systems and which optimizes your comfort and dignity.

**You have the right**, upon request, to be given the name of your attending physician, the names of all other physicians or practitioners directly participating in your care, and the names and roles of other health care personnel, having direct contact with you.

**You have the right** to every consideration of privacy concerning your medical care program. Case discussion, consultation, examination, and treatment are considered confidential and should be conducted discreetly, giving reasonable visual and auditory privacy when possible. This includes the right, if requested, to have someone present while physical examinations, treatments, or procedures are being performed, as long as they do not interfere with diagnostic procedures or treatments. This also includes the right to request a room transfer if another patient or a visitor in the room is unreasonably disturbing you and if another room equally suitable for your care needs is available.

**You have the right** to have all information, including records, pertaining to your medical care treated as confidential except as otherwise provided by law or third-party contractual arrangements.

**You have the right** to know what hospital policies, rules and regulations apply to your conduct as a patient.

**You have the right** to expect emergency procedures to be implemented without unnecessary delay.

**You have the right** to good quality care and high professional standards that are continually maintained and reviewed.

**You have the right** to full information in layperson's terms, concerning diagnosis, treatment, and prognosis, including information about alternative treatments and possible complications. When it is not medically advisable that such information be given to you, the information shall be given on your behalf to your designated/legally authorized representative. Except for emergencies, the physician must obtain the necessary informed consent prior to the start of any procedure or treatment, or both.

**You have the right** to not be involved in any experimental, research, or donor program unless you have, or your designated/legally authorized representative has, given informed consent prior to the actual participation in such a program. You or your designated/legally authorized representative may, at any time, refuse to continue in any such program to which informed consent has previously been given.

**You have the right** to accept medical care or to refuse any drugs, treatment, or procedure offered by the institution, to the extent permitted by the law, and a physician shall inform you of the medical consequences of such refusal.

**You have the right** to assistance in obtaining consultation with another physician at your request and expense.

**You have the right** to expect good management techniques to be implemented within this health care facility considering effective use of your time and to avoid your personal discomfort.

**You have the right** to examine and receive a detailed explanation of your bill.

**You have the right** to full information and counseling on the availability of known financial resources for your health care.

**You have the right** to expect that the health care facility will provide a mechanism whereby you are informed upon discharge of continuing health care requirements following discharge and the means for meeting them.

**You have the right** to seek review of quality of care concerns, coverage decisions, and concerns about your discharge.

You cannot be denied the right of access to an individual or agency authorized to act on your behalf to assert or protect the rights set out in this section.

**You have the right** to have a family member or representative of your choice and your physician notified promptly of your admission to the hospital.

**You have the right** to medical and nursing services without discrimination based upon age, sex, race, color, ethnicity, religion, gender, disability, ancestry, national origin, marital status, familial status, genetic information, gender identity or expression, sexual orientation, culture, language, socioeconomic status, domestic or sexual violence victim status, source of income, or source of payment.

**You have the right** to appropriate assessment and management of pain.

**You have the right**, in collaboration with your physician or health care provider, to make decisions involving your health care. This right applies to the family and/or guardian of neonates, children, and adolescents. Decisions may include the right to refuse drugs, treatment, or procedure offered by the hospital, to the extent permitted by law. Your health care provider will inform you of the medical consequences of the refusal of such drugs, treatment, or procedure.

While this health care facility recognizes your right to participate in your care and treatment to the fullest extent possible, there are circumstances under which you may be unable to do so. In these situations (for example, if you have been adjudicated incompetent in accordance with the law, are found by your physician to be medically incapable of understanding the proposed treatment or procedure, are unable to communicate your wishes regarding treatment, or are an unemancipated minor) your rights are to be exercised to the extent permitted by law, by your designated representative or other legally authorized person.

**You have the right** to make decisions regarding the withholding of resuscitative services or the foregoing of or the withdrawal of life-sustaining treatment within the limits of the law and the policies of this institution.

**You have the right** to receive care in a safe setting, and be free from all forms of abuse and harassment.

**You have the right** to be free from restraint and seclusion not medically necessary or used as a means of coercion, discipline, convenience or retaliation by staff.



**You have the right** to have your medical record read only by individuals directly involved in your care, by individuals monitoring the quality of care, or by individuals authorized by law or regulation.

**You have the right** to receive written notice that explains how your personal health information will be used and shared with other health care professionals included in your care. You or your designated/legally authorized representative, may, upon request, have access to all information contained in your medical records, unless access is specifically restricted by the attending physician for medical reasons.

**You have the right** to be communicated with in a manner that is clear, concise and understandable. If you do not speak English, you should have access, where possible, free of charge, to an interpreter. This also includes providing you with help if you have vision, speech, hearing or cognitive impairments.

**You have the right** to access protective services.

**You have the right** to be free from neglect, exploitation, and verbal, mental, physical and sexual abuse.

**You have the right** to participate in the consideration of ethical issues surrounding your care, within the framework established by this organization to consider such issues.

**You have the right** to formulate an advance directive, including the right to appoint a health care agent to make health care decisions on your behalf. These decisions will be honored by this facility and its health care professionals within the limits of the law and this organization's mission, values and philosophy. If applicable, you are responsible for providing a copy of your advance directive to the facility or caregiver.

You are not required to have or complete an "advance directive" in order to receive care and treatment in this facility.

When this facility cannot meet the request or need for care because of a conflict with our mission or philosophy or incapacity to meet your needs or request, you may be transferred to another facility when medically permissible. Such a transfer should be made only after you or your designated/legally authorized representative have received complete information and explanation concerning the needs for, and alternatives to, such a transfer. The transfer must be acceptable to the other institution.

**You have the right** to decide whether you want visitors or not during your stay here. You may designate those persons who can visit you during your stay. These individuals do not need to be legally related to you. They may include, for example, a spouse, domestic partner, including a same sex partner, another family member, or a friend. The hospital will not restrict, limit, or deny any approved visitor on the basis of race, color, national origin, religion, sex, gender identity or expression, sexual orientation or disability. The hospital may need to limit or restrict visitors to better care for you or other patients. **You have the right** to be made aware of any such clinical restrictions or limitations.

**You have the right** to designate a family member, friend, or other individual as a support person during the course of your stay or during a visit to a physician or other ambulatory care treatment.

**You have the right** to give or withhold informed consent to produce or use recordings, films or other images of you for purposes other than your own care, treatment or patient identification.

**You have the right**, without recrimination, to voice complaints regarding your care, to have those complaints reviewed, and, when possible, resolved.

## FOR FURTHER INFORMATION

If you have questions or problems concerning your healthcare please speak with your physician, nurse or other hospital or ambulatory practice representative before you leave the clinical site.

<b>Chester County Hospital</b> 701 East Marshall Street West Chester, PA, 19380 (610) 431-5457	<b>Good Shepherd Penn Partners</b> 1800 Lombard Street Philadelphia, PA 19146 (215) 893-6533
<b>Hospital of the University of Pennsylvania</b> 1 Silverstein, 3400 Spruce Street Philadelphia, PA 19104 (215) 662-2575	<b>Lancaster General Hospital</b> 555 North Duke Street, P.O. Box 3555 Lancaster, Pennsylvania 17604-3555 (717) 544-5050
<b>Penn Presbyterian Medical Center</b> 185 Wright Saunders, 39 <sup>th</sup> & Market Streets Philadelphia, PA 19104 (215) 662-9100	<b>Pennsylvania Hospital</b> 1 Preston, 800 Spruce Street Philadelphia, PA 19107 (215) 829-8777

You may direct questions or concerns regarding the Health Insurance Portability and Accountability Act (HIPAA) / privacy related matters to the UPHS Privacy Office:

Electronic Mail: [privacy@uphs.upenn.edu](mailto:privacy@uphs.upenn.edu)

Telephone: (215) 573-4492

You may direct questions or concerns regarding accessibility or accommodations to the **University of Pennsylvania Health System Disability Access Officer** at (215) 615-4317.

If you or a family member thinks that a complaint or grievance remains unresolved through the hospital resolution process, or regardless of whether you have used the hospital's grievance process, **you have the right** to contact the following organizations about your concerns:

### **The Pennsylvania Department of Health**

#### **Division of Acute and Ambulatory Care**

P.O. Box 90

Harrisburg, PA 17120

(800) 254-5164

### **The Centers for Medicare and Medicaid Services**

(800) 633-4227

For concerns related to quality and/or safety of care issues (including premature discharge) or safety of the environment, contact:



**The Joint Commission**

Office of Quality and Patient Safety

One Renaissance Boulevard

Oakbrook Terrace, Illinois 60181

Fax: 630-792-5636

E-mail: [patientsafetyreport@jointcommission.org](mailto:patientsafetyreport@jointcommission.org)

For concerns related to disability accessibility or accommodations, contact:

**The United States Department of Justice**

950 Pennsylvania Avenue, NW

Civil Rights Division, Disability Rights Section – 1425 NYAV

Washington, D.C., 20530

Facsimile: (202) 307-1197

E-mail: [ADA.complaint@usdoj.gov](mailto:ADA.complaint@usdoj.gov)

For concerns related to discrimination or any civil rights concerns, contact:

**The U.S. Department of Health and Human Services, Office for Civil Rights,**  
electronically through the Office for Civil Rights Complaint Portal, available at:

<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

or by mail or phone at:

Centralized Case Management Operations

U.S. Department of Health and Human Services

200 Independence Avenue, SW Room 509F,

HHH Building Washington, D.C. 20201

Telephone: 1-800-868-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

**STATEMENT OF PATIENT RESPONSIBILITIES**

To foster our ability to provide safe, quality care you should act in accordance with UPHS policies, rules, and regulations and assume responsibility for the following:

This health care facility expects that you or your designated/legally authorized representative will provide accurate and complete information about present complaints, past illnesses, hospitalizations, medications, advance directives, and other matters relating to your health history or care in order for you to receive effective medical treatment.

In addition, you are responsible for reporting whether you clearly understand the planned course of action and what is expected of you.

It is expected that you will cooperate with all hospital personnel and ask questions if directions and/or procedures are not clearly understood.

You are expected to be considerate of other patients and health care personnel, to assist in the control of noise and visitors in your room, and to observe the non-smoking policy of this institution. You are also expected to be respectful of the property of other persons and the property of the University of Pennsylvania Health System. Threats, violence, disruption of patient care or harassment of other patients, visitors or staff will not be tolerated. You are also expected to refrain from conducting any illegal activity on UPHS property. If such activity occurs, UPHS will report it to law enforcement.

In order to facilitate your care and the efforts of the health care personnel, you are expected to help the physicians, nurses, and other health care personnel in their efforts to care for you by following their instructions and medical orders.

Duly authorized members of your family or designated/legally authorized representative are expected to be available to UPHS personnel for review of your treatment in the event you are unable to properly communicate with your health caregivers.

It is understood that you assume the financial responsibility of paying for all services rendered either through third-party payers (your insurance company) or being personally responsible for payment for any services which are not covered by your insurance policies.

It is expected that you will not take drugs which have not been prescribed by your attending physician and administered by appropriate staff and that you will not complicate or endanger the healing process by consuming alcoholic beverages or toxic substances during your hospital stay and or visit.

Our entire Penn Medicine team thanks you for choosing to receive your care here. It is our pleasure to serve and care for you.