GONZABA™ MEDICAL GROUP
Como Familia | Like Family®

PATIENT REGISTRATION FORM

DATE: **CHART#:**
GUARANTOR INFORMATION
LAST NAME: **FIRST NAME:** **MI:**
ADDRESS: **HOME PHONE:**
ADDRESS:
CITY/STATE: **ZIP CODE:**
****

PATIENT INFORMATION
LAST NAME: **FIRST NAME:** **MI:**
BIRTH DATE: **EMPLOYER PHONE:**
PRIMARY DOCTOR: **PRIVACY NOTICE:** Yes___ No ___

CONSENTS

CONSENT FOR TREATMENT-As a consenting adult and/or legal guardian, I agree to permit the physicians and staff at Gonzaba Medical Group to provide medical care to myself, my child or the patient I represent, as applicable. By signing below, I agree to permit the physician and staff at Gonzaba Medical Group to perform necessary or appropriate medical care including physical examination, diagnosis, photographing area of assessment and treatment. ____.

CONSENT FOR RELEASE OF MEDICAL RECORDS -I authorize Gonzaba Medical Group to release any medical information including diagnosis, x-rays, test results, reports, and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, continuity of care and medical treatment, as required or permitted by law. _____

ASSIGNMENT OF BENEFITS-I hereby assigns all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plans, to Gonzaba Medical Group. I understand that I am responsible to follow up with the insurance plan due to any discrepancy in coverage. I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize Gonzaba Medical Group to release all information necessary to secure
payment. _____

Opt-Out
As a patient of Gonzaba medical Group, we recognize how important your privacy is to you. By providing this information, you allow GMG to send you periodic emails and updates, including electronic newsletters, notification of account statuses and marketing communications. Gonzaba will not sell or share your contact information. If you prefer not to receive such information from us, please opt out now by checking the box below:
___ I "DO NOT" authorize GMG to send me periodic information by email or other communication.

I have read the Authorization for Consent for Treatment, Release of Medical Records, and Assignment of Benefits.

_____ _____
PATIENT OR LEGAL GUARDIAN SIGNATURE **DATE**

_____ _____
IF NOT PATIENT, RELATIONSHIP TO PATIENT **DATE**

_____ _____
WITNESS **DATE**

ACKNOWLEDGEMENT OF REVIEW OF
PATIENT RIGHTS AND RESPONSIBILITIES/NOTICE OF PRIVACY PRACTICES
GONZABA MEDICAL GROUP

I have reviewed and understand Gonzaba Medical Group Notice of Privacy Practices, which explains how my medical information will be used and disclosed and how I can get access to my medical information. I know that I may have a copy of the Notice. I also know that from time to time, Gonzaba Medical Group may revise the Notice of Privacy Practices. If I want the revised notice, I know I must ask for it.

_____
Signature of Patient or Personal Representative Date

_____
Name of Patient

_____
Patient ID DOB

_____
Name of Authorized Personal Representative

_____
Description of Personal Representative's Authority to Act for Patient

RECORD OF PROVIDER'S BEST EFFORTS TO OBTAIN
ACKNOWLEDGEMENT OF NOTIVE OF PRIVACY PRACTICES:

Is this employee responsible for obtaining a patient signature acknowledging receipt of the group's Notice of Privacy Practices ____Yes____No

Considering the recent, did you use "Good Faith Efforts" to obtain the patient's signature acknowledging the Notice of Privacy practices? ____Yes____No

Describe efforts and reason you were not able to obtain written acknowledgement:

_____ _____
Employee Name Job Title

_____ _____
Employee Signature Privacy Officer Signature

_____
Date

GONZABA MEDICAL GROUP
AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

_____
Patient Name **Date**

_____
DOB **SSN**

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of1996 [45CFR/164.508]. I request and authorize GONZABA MEDICAL GROUP to release health care information for the patient named above to:

___ I "DO NOT" authorize the release of my PHI to anyone other than myself.

_____
Name

_____
Address

_____
Phone

_____
City,State,Zip

This request and authorization applies to:

___Health care information relating to the following treatment, condition or dates of treatment (SPECIFY):

_____

___ All health care information

___ Other (SPECIFY):

_____

I understand that my express consent may be required to release any health care information related to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, pregnancy, psychiatric or mental health disorders or drug and/or alcohol use.

I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, pregnancy, psychiatric or mental health disorders or drug and/or use; you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

I also understand that this authorization may be revoked by me at any time verbally or in writing, except to the extent that action has been taken in reliance there on. I also understand that by disclosing my health care information, GONZABA MEDICAL GROUP cannot guarantee the recipient will use or disclose in violation of the Privacy Rules.

_____ _____
Signature of Patient or Authorized Representative Date Signed

_____
Relationship or status if signed by anyone other than the patient (parent, legal guardian, etc.)

Notice of Privacy Practices
Gonzaba Medical Group

Effective: November 1, 2014

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.

INTRODUCTION

Protecting the privacy of patients medical information is an aspect of our doctor's Hippocratic Oath and has always been an important part of our doctor-patient relationship. Please read this Notice carefully, as we may ask for your acknowledgement that you have read and understood it. If you have questions, please do not hesitate to ask. We have Privacy Officers in our office who will answer any questions you may have about this Notice or our privacy practices. Our office follows the policies that are described in the Notice.

ABOUT THIS NOTICE

We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights and we have certain legal obligations regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

WHO WILL FOLLOW THIS NOTICE

This notice describes the privacy practices followed by our employees, staff and other personnel.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about you, your health, health status, and the health care and services you receive from Gonzaba Medical Group (). Your health information may include information created and received by Gonzaba Medical Group, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information.

We are required by law to make this Notice available to you. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

There are several circumstances in which we are allowed to use or disclose your health data without your authorization. We will disclose your protected health information for reasons relating to Treatment, Payment and Health Care Operations. We will only use and/or disclose your protected health information when the law allows us to do so. Any other use and disclosures will be made only with your authorization, and in those instances; you have the right to revoke that authorization. Any revocation will not apply to disclosures or uses already made or disclosure or uses made in reliance on your prior authorization.

We may use and disclose your protected health information for the following purposes:

Treatment. We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, staff or other personnel who are involved in taking care of you and your health. For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you. Different personnel in our organization may share information about you and disclose information to people who do not work for Gonzaba Medical Group in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have. We will request your permission before sharing health information with your family or friends unless you are unable to give permission to such disclosures due to your health condition.

Payment. We may use and disclose health information about you so that the treatment and services you receive at Gonzaba Medical Group may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will pay for the treatment.

Health Care Operations. We may use and disclose health information about you in order to run Gonzaba Medical Group and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective. We may also disclose your health information to health plans that provide you insurance coverage and other health care providers that care for you. Our disclosures of your health information to plans and other providers may be for the purpose of helping these plans and providers provide or improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.

SPECIAL SITUATIONS

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

As Required By Law. We will disclose health information about you when required to do so by federal, state, local or international law.

Appointment Reminders. We may use or disclose Health Information to contact you to remind you that you have an appointment with us.

Treatment Alternatives and Health Related Benefits and Services.

We may also use or disclose your Health Information as necessary to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also send you information about products or services that we believe may be beneficial to you. You may contact one of our Privacy Officers in writing to request that these materials not be sent to you.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security and Intelligence. If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

Information Not Personally Identifiable. We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Family and Friends. We may disclose health information about you to your family members or friends if we obtain your verbal or written agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection.

We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room or the hospital during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care.
For example, we may inform the person who accompanied you to the clinic that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.
Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:
1. Uses and disclosures of Protected Health Information for **marketing purposes**; and
2. Disclosures that constitute a **sale** of your Protected Health Information
3. **Any disclosure of your psychotherapy notes.** These are the notes that your behavioral health provider maintains that record your appointments with your provider and are not stored with your medical record.
4. **Other uses and disclosures** of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.
Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:
Right to Inspect and Copy. You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to our Privacy Officer in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. A modified request may include requesting a summary of your medical record.
If you request to view a copy of your health information, we will not charge you for inspecting your health information. If you wish to inspect your health information, please submit your request in writing to our Privacy Officer. You have the right to request a copy of your health information in electronic form if we store your health information electronically. An e-copy will be provided to you within 15 days from your request. We may deny your request to inspect and/or copy your record or parts of your record in certain limited circumstances. If you are denied copies of or access to, health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.
Right to Amend. If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by Gonzaba Medical Group. To request an amendment, complete and submit a medical record amendment/correction form to our Privacy Officer. We may deny your request for an amendment if your request is not in writing or does not include a reason to support the request.
In addition, we may deny or partially deny your request if you ask us to amend information that:
• We did not create, unless the person or entity that created the information is no longer available to make the amendment
• Is not part of the health information that we keep
• You would not be permitted to inspect and copy
• Is accurate and complete
If we deny or partially deny your request for amendment, you have the right to submit a rebuttal and request the rebuttal be made a part of your medical record. Your rebuttal needs to be 1-2 pages in length or less and we have the right to file a rebuttal responding to yours in your medical record. You also have the right to request that all documents associated with the amendment request (including rebuttal) be transmitted to any other party any time that portion of the medical record is disclosed.
Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, health care operations, when specifically authorized by you and a limited number of special circumstances involving national security, correctional institutions and law enforcement. To obtain this list, you must submit your request in writing to our Privacy Officer. It must state a time period, which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose

about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. **We are not required to agree to your request.**
If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or we are required by law to use or disclose the information. **We are required to agree to your request** if you pay for treatment, services, supplies and prescriptions "out of pocket" and you request the information not be communicated to your health plan for payment or health care operations purposes. There may be instances where we are required to release this information if required by law. To request restrictions, you may complete and submit the Request for Restriction on Use/Disclosure of Medical Information to our privacy officer.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you may complete and submit the Request for Restriction on Use/Disclosure of Medical Information and/or Confidential Communication to our Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact our Privacy Officer(s).

BREACH OF HEALTH INFORMATION

We will inform you if there is a breach of your unsecured health information.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post the current notice at our location(s) with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect. We will inform you of any significant changes to this Notice. This may be through our newsletter, a sign prominently posted at our location(s), a notice posted on our website or other means of communication.

COMPLAINTS

If you have any questions about this Notice, if you need more information or if you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services at (**You will not be penalized for filing a complaint**):

Secretary of DHHS: U.S. Department of Health and Human Services
HIPAA Complaint
7500 Security Blvd. C5-24-04
Baltimore, MD 21244

Contact Privacy Officers:

Pamela Setufe, MHA, CPCS Mary Unger, RN, CMCO Maria McDonald, CPC, CCS-P
Chief Compliance Officer/Privacy Officer Co-Privacy Officer Deputy Compliance Officer
720 Pleasanton Road 720 Pleasanton Road 720 Pleasanton Road
San Antonio, TX 78214 San Antonio, TX 78214 San Antonio, TX 78214
Tel: 210-921-3800 Tel: 210-921-3800 Tel: 210-921-3800
Email: pamelasetufe@gonzaba.com maryunger@gonzaba.com mariamcdonald@gonzaba.com

You may request a copy at any time.

GONZABA™
MEDICAL GROUP
Como Familia | Like Family®

PATIENT RIGHTS AND RESPOSSIBIITIES

Gonzaba Medical Group is committed to upholding patient rights at all times. All team members must abide by the set of patients' rights when performing patient care activities. Patients of Gonzaba Medical Group also have responsibilities that have been established to assist patients to takin ownership of their care.

Patient Rights

- Be considered for service(s) without harassment or abuse, and without regard to race, color, age, sex, sexual orientation, religion, marital status, disability, national origin, or sponsor.
- Receive considerate and dignified care with respect for cultural, psychological, spiritual, personal beliefs and preferences.
- Full consideration of privacy concerning his or her medical care program. Examination and treatment are confidential and should be conducted discreetly to include privacy throughout the provision of care, treatment, and services.
- Knowledge of the name of the provider who has primary responsibility for coordinating his or her care when being see at the Gonzaba Medical Group and the names and professional relationships of other providers who will see him or her.
- Receive information from his or her provider about his or her illness, health status, diagnosis, course of treatment, outcomes of care (including unanticipated outcomes), and recovery in terms that he or she or the patient's representative can understand. When it is not medically advisable to give such information to them, the information is made available to a person designated by the patient or to a legally authorized person to include the surrogate decision maker.
- An appropriate and timely response to reports of pain.
- The opportunity to participate in decision involving their health care except when such participation is contraindicated for medical reasons.
- The opportunity to communicate in the language primarily used and/or make available resources tailored to the patient's age, language, and cognitive ability to understand to include vision, speech, or hearing impairments.
- Be free from neglect; exploitation; and verbal, mental, physical, and sexual abuse.
- A secure and safe environment for self and property.
- Appropriate and timely referrals for follow-up with findings and test as a result of their visit to the Gonzaba Medical Group.
- Receive information on formulation of Advance directives, as required by state or Federal laws or regulations when requested.
- Receive information about any proposed treatment or procedure he or she may need in order to participate in the development of the plan of care, give informed consent, alternatives for medical care or treatment, and the name of the person responsible for the procedures and/or treatment.
- To refuse the course of treatment; information and consequences of not complying with therapy even if against the advice of the provider.
- To have the right to have complaints reviewed by the organization on behalf of the patient, his/her family and how to present grievances, complaints, or suggestions to the facility or externally without fear of reprisal, as required by state and federal laws and regulations.

- The right to honor the patients right to give or withhold informed consent to produce, or use recordings, films, or other images for internal or external use to include obtaining signed confidentiality statements to protect the patients identity and confidential information.

- Confidential treatment of all communications and records pertaining to his or her care. His or her written permission will be obtained before his or her medical records can be made available to anyone not directly involved with his or her care.

- The right to allow the patient/legal guardian access, request amendment to, and obtain information on disclosures of their protected health information in accordance with law and regulation.

- Be informed by his or her provider or a delegate of his or her provider of the continuing healthcare requirement's following his or her discharge and to participate in planning for care after discharge.

- Examine and receive and explanation of his or her bill regardless of source of payment including fees for services and payment policies.

Patient Responsibilities

- Providing accurate and complete information concerning his or her present complaints, past, illness, hospitalizations, medications and other matters relating to his or her health. If the patient is a minor, his or her legal guardian has the same responsibility.

- Asking questions about their condition, diagnostic test results or when they do not understand their care, treatment or services or what they are expected to do.

- Following instructions related to their plan of care, treatment or services and expresses any concerns about their ability to follow the proposed plan of care, treatment or services.

- Accepting consequences for their share of responsibility for the outcomes of care, treatment or services; or if they do not follow plan of care.

- Reporting unexpected changes in his or her condition to the responsible practitioner.

- Reporting any concerns or errors they may observe that make them feel unsafe.

- Following the treatment plan established by his or her provider, including the instructions of medical assistants and other health professionals as they carry out the providers orders.

- Being responsible for his or her actions should her or she refuse treatment or not follow the providers order or being complaint with discharge instructions.

- Assuring that the financial obligations of his or her care are met as agreed upon by the facility. IF the patient is a minor, the patient's legal guardian is responsible for satisfying all financial obligations.

- Following policies and procedures of the Gonzaba Medical Group.

- Showing respect and consideration of the facility's staff and property, as well as other patients and their property.

Patient Concerns

- If, at any time, a patient has a concern regarding the quality of care or the safety practices at the facility, the Clinic Coordinator and/or the Practice manager can be contacted. They are happy to discuss any concerns with patients.

Both the clinic Coordinator and Practice manager can be reached at 210-921-6600. If requested, patients are advised of the grievance process, should he or she wish to communicate this in writing. Notification of the grievance process includes: whom to contact to file a grievance, and that he or she will be provided with a written notice of the grievance determination that contains the name of the facility contact person, their steps taken on his or her behalf to investigate the grievance, the results of the grievance and the result of the grievance.