



Elevated Community Health

PATIENT RIGHTS AND RESPONSIBILITIES

As our valued partner, Elevated Community Health's (ECH) responsibility to you will be:

- ❖ Provide considerate, respectful and culturally competent, quality care while preserving the dignity and confidentiality of everyone we serve.
- ❖ Partnering with you in your healthcare decisions is important to us, we will share detailed information about illness, treatment options, or procedures needed for informed consent or refusal of care.
- ❖ We will share the names, professional status, and experience of the care team involved in your care.
- ❖ We will protect your privacy and explain how we share your personal health information.
- ❖ We will make reasonable effort to provide care in the language of choice.
- ❖ Provide information on how to access care after-hours, weekend, and emergency care.
- ❖ Provide assistance to access medical records in preferred format for services provided at ECH within a reasonable time frame.
- ❖ Explanation of services available and an estimate of related costs, upon request. (Actual cost may differ from estimate in the event there are unanticipated complications or changes based on insurance)
- ❖ Notification of our sliding fee scale (SFS)
- ❖ Provide Information regarding advanced directives.
- ❖ ECH will abide by all laws and regulations.
- ❖ To help meet your needs, we invite you to share your feedback, recommendations, and voice your complaints freely.
 - You can speak to an employee, supervisor, Manager, or director regarding your feedback or concern.
 - If your concern is still unresolved, you may contact our **Quality and Compliance Department at (970)452-8508.**

As our partner, we ask of you:

- ❖ Provide us with complete, honest, and accurate information about your current and past healthcare needs, medications, illnesses, and hospitalizations.
- ❖ Participate in health care decisions and management, follow the plan of care agreed upon, to include taking medication as prescribed and goal setting.
- ❖ Feel empowered to ask questions regarding any aspect of your care or required signatures when you do not understand.
- ❖ Be considerate and respectful of other patients, staff and facility.
- ❖ Please keep your appointments and be on time. If you must miss your appointment, please call 24 hours in advance to reschedule.
- ❖ Bring your insurance, Medicaid, CHP, or Medicare card to each appointment.
- ❖ Pay your co-pay or self-pay fee at time of check-in for each visit.
- ❖ Arrange to consult with another provider for a second opinion, or to change providers, clinics, or hospitals.
- ❖ Have the right to refuse treatment and/or leave the facility against the provider's advice with a full understanding of the risk involved with the refusal of recommended treatment or procedure.

ECH is a Federally Qualified Health Center (FQHC). As an FQHC, ECH is eligible for Federal Torts Claims Act (FTCA) medical malpractice liability protection. As such, this health center receives Health and Human Services (HHS) funding and has Federal Public Health Service (PSH) deemed status, with respect to certain health or health-related claims, including medical malpractice claims, for itself and its covered individuals.



Anyone may use our services without regard to gender identity, race, age, religion, color, nationality, sexual orientation, or financial status. ECH serves all patients regardless of inability to pay. Discounted services are offered on a Sliding Fee Scale. Qualifications are based on household income, family size, and the federal poverty level.

ECH is a non-profit, 501(c)3 organization supported in part by funding from the Health Resources and Services Administration (HRSA). Your donations are greatly appreciated and are tax deductible. Thank you.

Patient's Name: _____ Patient's Date of Birth: _____
Patients Legal Name

I, _____ understand my rights and responsibilities as a patient of ECH.
Patient/legal Guardian Printed full Name

Signature: _____ Date: _____
Patient/Legal Guardian

Office Use Only

ECH staff printed name: _____ Signature: _____ Date: _____

☐ Valid ID of Patient/Legal Guardian verified.