JUSTIN H. PIASECKI, MD
DBA: HARBOR PLASTIC SURGERY CENTER
11511 CANTERWOOD BLVD NW, SUITE 310
GIG HARBOR, WA 98332
(253) 858-5040

PATIENT'S RIGHTS & RESPONSIBILITIES

As our patient we would like to make you aware of your rights and responsibilities. You may exercise your rights without being subject to discrimination or reprisal.

Personal Privacy: Your personal privacy and safety are very important. It is your right by virtue of your physical surrounding and respect of dignity by all healthcare workers and business office employees that your privacy and safety be maintained. It is the patient's responsibility to indicate to our Facility's Management Team if at any time you feel your privacy or safety is being violated.

Receive care in a safe setting: By virtue of trained, professional healthcare workers and adherence to State, Local and Federal safety standards, Harbor Plastic Surgery Center strives to maintain the highest standards. It is the patient's responsibility to indicate to our facility's management if at any time you feel your safety is being violated.

Be free from all forms of abuse or harassment: As our patient it is your responsibility to file a grievance with our facility's management and to be assured our ASC will respond and take your grievances seriously.

Unanticipated Outcomes: You and, when appropriate, your family have the right to be informed about the outcomes of care, treatment, and services, including unanticipated outcomes.

Seclusion and/or Restraints: You have the right to be free from seclusion and/or restraints of any form that are not medically necessary or are used as a means of coercion or discipline.

Information Disclosure: You have the right to accurate and easily understood information about your health plan, healthcare professionals and your health care facilities. If you speak another language, have a physical or mental disability, or just don't understand something, help will be provided so you can make informed health care decisions. If you are in need of a translator; a translator will be provided to you upon request.

Choice of Providers: You have the right to choose health care providers. The successful outcome of any patient/doctor relationship requires the patient to be comfortable with their physician and his staff. Therefore, if you wish not to see any physician at Harbor Plastic Surgery Center, please notify our staff immediately. Seeing your physician of choice may not be possible in an emergent situation.

Access to Emergency Services: If you feel your emergent condition is life threatening please call 911 before contacting our office. If you have severe pain, an injury or sudden illness that makes you believe that your health is in serious danger, you have the right to be screened and stabilized using emergency services. Harbor Plastic Surgery Center has a physician on call 24 hours per day/Seven days per week. In case of emergency please contact us at (253) 509-4438.

Participation in Decisions: You have the right to know your treatment options and expected outcomes and take part in decisions about your care. Parents, guardians, family members or others that you select can represent you if you cannot make your own decisions.

Respect and Non-Discrimination: You have a right to considerate, respectful care from your doctors and his health care staff. All medical decisions will be based on current medical standards and knowledge.

Confidentiality of Health Information: You have the right to talk privately with your health care provider and to have your health care information protected. You also have the right to read and receive a copy of your own medical record. You have the right to ask the doctor to change his medical record if it is not correct, relevant or complete.

Health Insurance Problems: If you have concerns about your insurance, it is sometimes helpful to start with customer service at your insurance company. Harbor Plastic Surgery Center will provide any required assistance deemed necessary by your insurance carrier in order to process your claims correctly.

Billing and Claim Concerns: Harbor Plastic Surgery Center utilizes a separate outside facility to handle all of their claim submission. However, any billing related questions should be directed to the Harbor Plastic Surgery Center.

Advance Directives: It is the policy of Harbor Plastic Surgery Center that in the event a patient goes into cardiac or respiratory distress or any other medical emergency, all emergency care will be provided, including the calling of paramedics and transfer to a local hospital when indicated. Harbor Plastic Surgery Center policy is to make every effort to resuscitate all patients. If a patient wishes are not to be resuscitated (DNR) the patient must bring a copy of his/her POLST (Physicians Orders of Life Sustaining Treatment) to have on our records. This POLST form must be completed by your primary care physician and cannot be completed by Harbor Plastic Surgery Center Physician.

Ownership: Harbor Plastic Surgery Center is a privately owned Corporation by Justin H. Piasecki, MD.

Complaints and Appeals: You have the right to a fair, fast and objective review and when possible resolution of any complaint you have against your physician, their staff or the facility without affecting care or treatment. This includes complaints about waiting times, operating hours, the actions of health care personnel, and the adequacy of the health care facilities.

If you have complaints or concerns you have the right to file them with the following:

Harbor Plastic Surgery Center
Jill Piasecki, Administrator
11511 Canterwood Blvd NW, Suite 310
Gig Harbor, WA 98332
Email: jill@drpiasecki.com

Washington State Department of Health
Health Systems Quality Assurance
Complaint Intake
PO BOX 47850
Olympia, Washington 98504-7850
(800) 633-633-6828

Medicare Ombudsman
1-800-Medicare (1-800-633-4227)
http://www.medicare.gov/Ombudsman/resources.asp

Patient Responsibilities – As a patient it is your responsibility to:

Medical History: You are required to provide a complete and accurate history to the best of your ability. This includes, but is not limited to all medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.

Follow Treatment Plan: Your prescribed treatment plan was designed for the best outcomes. If you have any questions or concerns with the treatment plan, you have 24X7 access to your physician. It is your responsibility to contact him if you are confused or do not agree with the plan. Otherwise, we expect that you are following your treatment plan.

Transportation: Depending on the treatment performed, you may be required to have a responsible adult to transport you home and remain with you for 24 hours following your procedure. This will be discussed with your doctor.

Advance Directives: It is your responsibility to inform us of your Advance Directive, Living Will or any medical power of attorney.

Respectful Behavior: We expect that our patients will treat our physicians and staff in a courteous, professional and respectful manner.

Financial Responsibility: You are required to accept personal financial responsibility for any charges not covered by your insurance plan.

Termination: We believe that you have an important role in your care. Failure to comply with the patient responsibilities may result in your termination as a patient. If this happens, we will refer you to another provider to continue your care.

PATIENT NAME: _____ DOB: _____

I HAVE RECEIVED INFORMATION FROM MY SURGEON: JUSTIN H. PIASECKI, MD

I understand that the information received contains the following:

My Patient Rights and Responsibilities (Including Grievance Process, Advance Directives and Physician Ownership)
A Surgical Preparation Time Line
Post Operative Instructions
Financial & Insurance Information
Medications to Avoid List
Copy of Consent form that I will be signing the day of surgery

I understand that it is my right to have this information translated into my primary language-for my better understanding.

I will not require any assistance for translation regarding my medical care. Patient Initial _____

I will be able to provide a responsible adult as my own translator Patient Initial _____

I will need Harbor Plastic Surgery Center to provide me with a translator in the Following language/Dialect: _____ Patient Initial _____

I understand that I will have a pre operative conference with my surgeon's clinical staff to review the above information. I understand that it is my responsibility to have reviewed this information prior to that appointed conference.

Patient Signature: _____ Date: _____

Witness to Patient Signature Only: _____ Date: _____