St. Joseph's Health

St. Joseph's University Medical Center
St. Joseph's Wayne Medical Center

GENERAL CONSENT PACKET

- ☐ General Consent and Conditions of Treatment
- ☐ Important Message from Medicare
- ☐ An important message from Tricare
- ☐ Utilization Management to Appeal
- ☐ Acknowledgement of Request for In and Out of Network Facility Services
- ☐ Acknowledgement of Request for Professional Out of Network Services
- ☐ New Jersey Immunization Information System (NJIIS) Consent To Participate
- ☐ Notice of Privacy Practices
- ☐ Patient Notice Regarding Physician Services
- ☐ Your Responsibilities as a Patient
- ☐ Patient Bill of Rights
- ☐ What you Need to know about Advance Directive
- ☐ Hand Hygiene
- ☐ Medication Safety Guidelines for Patients
- ☐ How Can I Quit Smoking
- ☐ Patient Portal

FREE
Guest Network (WiFi) Services

For your convenience, St. Joseph's Health is pleased to provide you with free Guest Network (WiFi) services while you are at St. Joseph's University Medical Center and St. Joseph's Wayne Medical Center.

- **For the Guest Network ACCESS Code, please dial Extension 8000.**

Para su conveniencia, St. Joseph's Health se complace en proveerle con servicios de Guest Network (WiFi/Conexión Inalábrica) gratis durante su estadía en St. Joseph's University Medical Center o St. Joseph's Wayne Medical Center

- **Para el código de acceso al Guest Network, favor de llamar a la Extensión 8000.**

St. Joseph's Health

St. Joseph's Health
St. Joseph's University Medical Center
St. Joseph's Wayne Medical Center

GENERAL CONSENT AND CONDITIONS OF TREATMENT AND ASSIGNMENTS OF BENEFITS

I hereby agree and give my consent for the admission to and/or treatment by St Joseph's Health at any of its sites or locations (collectively the "Facility") and its employees, contractors and staff, including care and/or treatment by any physicians and assistants or designees. This treatment may include the inpatient and outpatient services that my physicians, his or her associates, partners, assistants or designees may deem necessary or advisable, including but not limited to, routine diagnostic procedures such as x-ray, laboratory tests, including HIV, hepatitis C, hepatitis B antibody testing, anesthesia, emergency room services, nursing and/or medical treatment/ surgical treatment. I realize that the Facility is involved in medical education programs for medical, nursing and other health care personnel who may be involved with my care as a part of their education. I understand that medicine is not an exact science and that diagnosis or treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made to me as to the results of exams or treatments. I authorize the Facility to dispose of, or keep for scientific, teaching or other purposes any specimen or tissue that may be removed from my body. I permit the facility to photograph, film, record or video tape me for patient observation pursuant to Facility's policy and procedures, for telemedicine, medical, surgical, scientific and education purposes provided my identity is not revealed beyond those directly involved in my care. This consent shall also apply to the admission and medical treatment of a newborn infant(s) who I may deliver during my hospital stay. I also understand by signing below I am consenting to all future outpatient care given to me unless I revoke this consent in writing. I hereby agree and consent to the following conditions:

1. **I understand that many of the physicians at the Facility are neither employees nor agents of the Facility. Many physicians are either independent contractors or independent practitioners who have been granted the privilege of using the Facility for the care and treatment of their patients. These physicians are providing professional physician services as private practitioners and not on behalf of the Facility. I understand that some physicians participating in my care may be employed by other academic institutions.**

2. **I acknowledge that I have received a copy of the following either on today's visit or within the past year:**
   - The Facility's Notice of Privacy Practices
   - Information on Advanced Directives
   - Information on Smoking Cessation
   - A copy of "Patient's Bill of Right's" and "Your Responsibilities as a Patient"

3. **ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT AGREEMENT.** Because I have received medical and/or physician services from the Facility, I hereby assign to the Facility (and/or any physician(s) participating in my care, if applicable) any and all of my rights and interests in any health insurance benefits to which I am entitled to receive, under any plan or policy of insurance or otherwise, in connection with the services rendered by Facility (and treating physician(s), if applicable), from whatever applicable source, including, but not limited to, Medicare, Medicaid, a commercial insurance plan, the benefit plan of an employer, worker's compensation, auto insurance or other third-party payer (the "Insurance Benefits"). THIS IS A DIRECT ASSIGNMENT TO THE FACILITY (AND TO ANY TREATING PHYSICIAN(S), IF APPLICABLE) OF ANY AND ALL OF MY RIGHTS TO RECEIVE THE INSURANCE BENEFITS. This assignment of benefits fully and completely encompasses any legal claim I may have under the applicable plan or policy of insurance to receive the Insurance Benefits, including, but not limited to, my rights to appeal any denial of the Insurance Benefits on my behalf, to pursue legal action against the applicable third-party payer, and/or to file a complaint with the New Jersey Department of Banking and Insurance.

I authorize payment of health insurance benefits (including managed care, Medicare and Medicaid, when applicable) directly to the Facility and/or any physician participating in my care. I further agree that this assignment will not be withdrawn or voided at any time until accounts are paid in full. I authorize any holder of medical or other information about me to release to any third part including the Centers for Medicare and Medicaid and its agent, any information needed to determine the benefits for related services.

I agree to pay for charges not covered by the assignment of benefits described in this section, including, but not limited to, any applicable health insurance deductibles, copayments, and/or coinsurance amounts provided under any plan or policy of insurance; and charges not covered by a plan or policy of insurance. I agree that any patient or guarantor overpayment collected for inpatient or outpatient care and treatment by the Facility may be applied directly to any outstanding account for which the patient or guarantor is legally responsible. I agree that it is my responsibility to obtain a referral and/or precertification if it is required. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay collection agency fees, court costs and attorney's fees. I hereby grant permission and consent to the Facility, its assignees and third party collection agents, to contact me by telephone at any telephone number associated with me, including wireless numbers provided by me, to leave answering machine and voicemail messages for me, to send me text messages or emails using any email addresses I provided, and to use prerecorded/artificial voice messages and/or an automatic telephone dialing system, in connection with any communications made to me, including billing, payment, debt collection, and any other

St. Joseph's Health
St. Joseph's University Medical Center
St. Joseph's Wayne Medical Center

GENERAL CONSENT AND CONDITIONS OF TREATMENT AND ASSIGNMENTS OF BENEFITS

communications required by law. I understand that the Facility charges may not include the fees of my treating physician(s). I understand that I will receive a separate bill for these services and such bills may come directly from the physician(s), such as the emergency room physicians, the radiologists, pathologists, anesthesiologists, and other specialists. I also understand that some physician(s) may not participate in all of the same insurance plans as the Facility. It is my responsibility to determine if the physician providing care to me participates in my health insurance plan.

4. RELEASE OF INFORMATION. I authorize the Facility and or any physician providing my care to disclose and/or release copies of any records to any entity who is liable for payment. This may include release of information to insurance companies, workers' compensation carriers, welfare funds, the patient's employer, or a support person of the patient. The Facility may also disclose all or any part of my records as part of the discharge planning process, to any home care agency, health care facility, patient equipment or supply company or as needed. I realize that my authorization for release of information includes all information in the medical record, including HIV information, psychiatric diagnosis, evaluation or treatment, sexually transmitted diseases, and/or information related to drug or alcohol abuse. I am responsible for notifying the Facility if I don't want part of my medical record to be shared with my insurance company. If the insurance company denies payment because I limit my disclosure, I understand I will be responsible for payment.

5. MEDICARE PATIENT CERTIFICATION. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information or other information to be released to the Social Security Administration or its intermediaries or carriers of any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original and I request payment of authorized benefits be made on my behalf.

6. PERSONAL PROPERTY/VALUABLES. I understand that the Facility recommends all belongings and valuables should be sent home. I agree that the Facility will not pay for any loss or damages to my belongings.

7. HEALTHCARE EMPLOYEE BLOOD or BODY FLUIDS EXPOSURE. If somebody taking care of you is exposed to your blood or body fluids, the Facility will test you for Hepatitis B, Hepatitis C and HIV. You will not be charged for these tests. The test results will be kept confidential and will be used to guide treatment of the exposed person. Your doctor will be notified in the event the test results show that you need treatment.

FOR INPATIENTS ONLY:

8. PRIVATE ROOM DIFFERENCE. I agree and understand that if I request a private room, I am responsible to pay the amount not covered by my insurance.

9. CERTIFICATION OF INFORMATION RECEIVED.

I certify that I have received a copy of "An Important Message from Medicare" if applicable.
I certify that I have received a copy of "An Important Message from TRICARE" if applicable.

I have read and I understand this General Consent and Conditions of Treatment and Assignment of Benefits. I have signed this document voluntarily and of my own free will. I agree that my questions have been answered.

_____ OR _____ **Date/Time:** _____
Signature of Patient — Agent or Representative

_____ OR _____ **Date/Time:** _____
Signature of Witness — Relationship of Agent or Representative

TO EMERGENCY DEPARTMENT REGISTRATION STAFF: If a Patient or Agent/Representative is unable to sign indicate the reason.

☐ Patient non-responsive (patient unconscious restrained, reduced mental status, trauma patient or cardiac arrest status).

☐ Patient left without treatment or against medical advice.

☐ Patient transferred to another Facility, unable to sign due to emergency transfer.

☐ Patient refused to sign after being given a copy of General Consent for Treatment, Patient Bill of Rights, Notice of Privacy Practices, Important Message from Medicare, and Important Message from Tricare.

Staff Member: _____ Date/Time: _____

Nurse notified: _____ Date/Time: _____

St. Joseph's Health
St. Joseph's University Medical Center
St. Joseph's Wayne Medical Center

703 Main Street
Paterson, NJ 07503
973-754-3155

IMPORTANT MESSAGE FROM MEDICARE

Patient name: **Patient number:**

Your Rights as a Hospital Inpatient:

- You can receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
- You can be involved in any decisions about your hospital stay.
- You can report any concerns you have about the quality of care you receive to your QIO at: **Livanta BFCC-QIO, 1-866-815-5440 or TTY 1-866-868-2289**. The QIO is the independent reviewer authorized by Medicare to review the decision to discharge you.
- You can work with the hospital to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.
- You can speak with your doctor or other hospital staff if you have concerns about being discharged.

Your Right to Appeal Your Hospital Discharge:

- You have the right to an immediate, independent medical review (appeal) of the decision to discharge you from the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the reviewer will each receive a copy of a detailed explanation about why your covered hospital stay should not continue. You will receive this detailed notice only after you request an appeal.
- If the QIO finds that you are not ready to be discharged from the hospital, Medicare will continue to cover your hospital services.
- If the QIO agrees services should no longer be covered after the discharge date, neither Medicare nor your Medicare health plan will pay for your hospital stay after noon of the day after the QIO notifies you of its decision. If you stop services no later than that time, you will avoid financial liability.
- If you do not appeal, you may have to pay for any services you receive after your discharge date.

See page 2 of this notice for more information.

St. Joseph's Health
St. Joseph's University Medical Center
St. Joseph's Wayne Medical Center

703 Main Street
Paterson, NJ 07503
973-754-3155

IMPORTANT MESSAGE FROM MEDICARE

How to Ask For an Appeal of your Hospital Discharge

- You must make your request to the QIO listed above.
- Your request for an appeal should be made as soon as possible, but no later than your planned discharge date and before you leave the hospital.
- The QIO will notify you of its decision as soon as possible, generally no later than 1 day after it receives all necessary information.
- Call the QIO **Livanta BFCC-QIO, 1-866-815-5440 or TTY 1-866-868-2289** to appeal, or if you have questions.

If You Miss The Deadline to Request An Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO **Livanta BFCC-QIO, 1-866-815-5440 or TTY 1-866-868-2289**.
- If you belong to a Medicare health plan:
  Call your plan at _____

Additional Information (Optional):

Please sign below to indicate you received and understood this notice.

I have been notified of my rights as a hospital inpatient and that I may appeal my discharge by contacting my QIO.

_____ _____ _____

Signature of Patient or Representative | Date | Time

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1019. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Form CMS 10065-IM (Exp. 12/31/2025) OMB approval 0938-1019

January 2018

An Important Message From **TRICARE®**

YOUR RIGHTS WHILE A TRICARE HOSPITAL PATIENT

You have the right to receive all the hospital care that is necessary for the proper diagnosis and treatment of your illness or injury. According to Federal law, your discharge date must be determined solely by your medical needs, not by "Diagnostic Related Groups (DRGs)" or by TRICARE payments.

You have the right to be fully informed about decisions affecting your TRICARE coverage and payment of your hospital stay and any post-hospital services.

You have the right to request a review by a TRICARE Regional Review Authority (RRA) of any written notice of noncoverage that you may receive from the hospital stating that TRICARE will no longer pay for your hospital care. RRAs employ groups of doctors under contract by the Federal Government to review medical necessity, appropriateness and quality of hospital treatment furnished to TRICARE patients. The phone number and address of the RRA for your area are:

E

East Region

Humana Military
Utilization Management
P.O. Box 740044
Louisville, KY 40201-7444

1-800-334-5612

W

West Region

Health Net Federal Services, LLC
P.O. Box 9108
Virginia Beach, VA 23450-9108

1-844-866-WEST (1-844-866-9378)

TALK TO YOUR DOCTOR ABOUT YOUR STAY IN THE HOSPITAL

You and your doctor know more about your condition and your health needs than anyone else. Decisions about your medical treatment should be made between you and your doctor. If you have any questions about your medical treatment, your need for continued hospital care, your discharge or your need for possible post-hospital care, don't hesitate to ask your doctor. The hospital's patient representative or social worker will also help you with your questions and concerns about hospital services.

IF YOU THINK YOU ARE BEING ASKED TO LEAVE THE HOSPITAL TOO SOON

Ask a hospital representative for a written notice of explanation immediately, if you have not already received one. This notice is called a "notice of noncoverage." You must have this notice of noncoverage if you wish to exercise your right to request a review by the RRA.

The notice of noncoverage will state whether your doctor or the RRA agrees with the hospital's decision that TRICARE should no longer pay for your hospital care.

- If the hospital and your doctor agree, the RRA does not review your case before a notice of noncoverage is issued. But the RRA will respond to your request for a review of your notice of noncoverage and seek your opinion. You cannot be made to pay for your hospital care until the RRA makes its decision if you request the review by noon of the first work day after you receive the notice of noncoverage.
- If the hospital and your doctor disagree, the hospital may request the RRA to review your case. If it does make such a request, the hospital is required to send you a notice to that effect. In this situation, the RRA must agree with the hospital or the hospital cannot issue a notice of noncoverage. You may request that the RRA reconsider your case after you receive a notice of noncoverage, but since the RRA has already reviewed your case once, you may have to pay for at least one day of hospital care before the RRA completes this reconsideration.

! IF YOU DO NOT REQUEST A REVIEW, THE HOSPITAL MAY BILL YOU FOR ALL THE COSTS OF YOUR STAY BEGINNING WITH THE THIRD DAY AFTER YOU RECEIVE THE NOTICE OF NONCOVERAGE. THE HOSPITAL, HOWEVER, CANNOT CHARGE YOU FOR CARE UNLESS IT PROVIDES YOU WITH A NOTICE OF NONCOVERAGE.

HOW TO REQUEST A REVIEW OF THE NOTICE OF NONCOVERAGE

If the notice of noncoverage states that your physician agrees with the hospital's decision:

- You must make your request for review to the RRA by noon of the first work day after you receive the notice of noncoverage by contacting the RRA by phone or in writing.
- The RRA must ask for your views about your case before making its decision. The RRA will inform you by phone and in writing of its decision on the review.
- If the RRA agrees with the notice of noncoverage, you may be billed for all costs of your stay beginning at noon of the day after you receive the RRA's decision.
- Thus, you will not be responsible for the cost of hospital care before you receive the RRA decision.

If the notice of noncoverage states that the RRA agrees with the hospital's decision:

- You should make your request for reconsideration to the RRA immediately upon receipt of the notice of noncoverage by contacting the RRA in writing.
- The RRA can take up to three working days from receipt of your request to complete a review. The RRA will inform you in writing of its decision on the review.
- Since the RRA has already reviewed your case once prior to the issuance of the notice of noncoverage, the hospital is permitted to begin billing you for the cost of your stay beginning with the third calendar day after you receive your notice of noncoverage, even if the RRA has not completed its review.
- Thus, if the RRA continues to agree with the notice of noncoverage, you may have to pay for at least one day of hospital care.

Note: The process described above is called "immediate review." If you miss the deadline for this immediate review while you are in the hospital, you may still request a review of the TRICARE decision to no longer pay for your care at any point during your hospital stay or after you have left the hospital. The notice of noncoverage will tell you how to request this review.

POST-HOSPITAL CARE

When your doctor determines that you no longer need all the specialized services provided in a hospital, but you still require medical care, he or she may discharge you to a skilled nursing facility or to home care. The discharge planner at the hospital will help arrange for the services you may need after your discharge. TRICARE and supplemental insurance policies have limited coverage for skilled nursing facility care and home health care. Therefore, you should find out which services will or will not be covered and how payment will be made. Consult with your doctor, hospital discharge planner, Beneficiary Counseling and Assistance Coordinator (BCAC), patient representative and your family in making preparations for care after you leave the hospital. Don't hesitate to ask questions.

Questions involving billing or specific benefit coverage issues should be addressed to your TRICARE claims processor which is:

E

East Region

TRICARE East Claims
P.O. Box 7981
Madison, WI 53707-7981

1-800-444-5445

W

West Region

Health Net Federal Services, LLC
c/o PGBA, LLC/TRICARE
P.O. Box 202100
Florence, SC 29502-2100

1-844-866-WEST (1-844-866-9378)

ACKNOWLEDGMENT OF RECEIPT

My signature only acknowledges my receipt of this message from

_____ (Name of Hospital) on _____ (Date)

and does not waive any of my rights to request a review or make me liable for any payment.

_____ _____ _____

Signature Of Beneficiary Or Person Acting On Behalf Of The Beneficiary | Date Signed | Time

TRICARE is a registered trademark of the Department of Defense, Defense Health Agency. All rights reserved.

St. Joseph's Health
St. Joseph's University Medical Center
St. Joseph's Wayne Medical Center

CONSENT TO REPRESENTATION

New Jersey Department of Banking and Insurance

CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary.* This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY, does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS

I, [PRINT NAME], by marking [√] (or [x]) and signing below, agree to:

☐ representation by [St. Joseph's Health] in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.

☐ release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program or the Chapter 32 Independent Arbitration System, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: _____ Ins. ID#:_____ Date: _____

Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative (provide contact information on back)

* If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

CO0100

St. Joseph's Health
St. Joseph's University Medical Center
St. Joseph's Wayne Medical Center

CONSENT TO REPRESENTATION

New Jersey Department of Banking and Insurance

NOTICE OF REVOCATION OF CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND OF AUTHORIZATION TO RELEASE OF MEDICAL RECORDS

You may, at any time, revoke the consent you gave allowing a health care provider to represent you in an appeal of a UM determination and allowing the release of your medical records to the DOBI, the IURO and medical professionals that contract with the IURO. You may use this form to revoke your consent, or you may submit some other written evidence of your intent to revoke consent, if you prefer. Either way, if you have not yet received a Stage 2 UM determination from the carrier, send the written and signed revocation to the carrier at the address indicated in the carrier's written notice to you regarding the carrier's initial UM determination. If you have received a Stage 2 UM determination, then your revocation should be sent to:

New Jersey Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care – Attn: IHCAP
P.O. Box 329
Trenton, NJ 08625-0329
OR for courier service to: 20 West State Street OR by fax to: (609) 633-0807

You may also want to send a copy of your notice of revocation to the health care provider.

ONLY COMPLETE AND SEND THIS IN WHEN AND IF YOU WISH TO REVOKE YOUR CONSENT!

REVOCATION OF CONSENT TO REPRESENTATION AND RELEASE OF MEDICAL RECORDS IN UM DETERMINATION APPEALS

☐ I hereby revoke my consent to representation by [St. Joseph's Health] and my authorization to the release of medical information in an appeal of an adverse UM determination. I understand that by revoking consent, the UM appeal may not be pursued further by my health care provider. I understand that this revocation may occur after my personal and medical information has already been shared with the DOBI, the IUROs and medical professionals with whom the IUROs contract, but that no further distribution of records in this matter will occur based on my authorization, and that all of my medical and personal information is required to be maintained as confidential by all parties.

Signature: _____ Ins. ID#_____ Date:_____
Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative

Contact Information of Personal Representative

Please provide the following contact information IF it is different from the patient's contact information:

PRINT NAME: _____

ADDRESS:_____

_____

PHONE: _____ FAX: _____ EMAIL: _____

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

St. Joseph's Health
St. Joseph's University Medical Center
St. Joseph's Wayne Medical Center

ACKNOWLEDGEMENT OF REQUEST FOR IN AND OUT OF NETWORK FACILITY SERVICES

Primary Insurance Plan: _____

❑ I have been notified that this facility is **OUT OF NETWORK** with my health insurance plan. I was also informed:

- *I should contact my insurance company regarding out of network benefits, AND identify the specific estimated out of pocket expenses as they will be more than the in−network copayment, coinsurance or deductible.*
- *I will be responsible for any excess amount above the allowed amount my insurance plan pays or reimburses for the services*

❑ I have been notified that this facility is **IN NETWORK** with my health insurance plan. I was also informed that:

- *I will not pay more than my in−network copayment, deductible or coinsurance for covered services unless I specifically select an out−of−network healthcare professional, which may lead to higher out−of−pocket costs.*
- *I should notify my health insurance plan and/or the Department of Health if I receive any in−network medical bills for more than my copayment, deductible or coinsurance and I did not knowingly and voluntarily select an out−of−network provider.*

Although we are in Network, there may be services provided during this visit by providers such as consulting specialists, anesthesiologists, radiologists, or pathologists, who are out of network with your insurance plan.

You should contact the physician ordering the healthcare services to determine whether that physician is in network or out of network.

Information on the insurance plans in which the hospital's employed and contracted physicians participate is posted on the facility's website at https://www.stjosephshealth.org

By signing below, you acknowledge receiving a copy of this disclosure.

_____	_____	_____	_____
Patient Signature (or authorized representative)	Relationship (if not the patient)	Date	Time

_____
Print Name

This notice is only required for scheduled non−emergent or elective service.

CO0100

St. Joseph's Health
St. Joseph's University Medical Center
St. Joseph's Wayne Medical Center

ACKNOWLEDGEMENT OF REQUEST FOR PROFESSIONAL OUT OF NETWORK SERVICES

Primary Insurance Plan: _____

I have been notified that the healthcare professional that my appointment is scheduled with is **Out Of Network** with my health insurance plan, I was also informed:

- *I should contact insurance company regarding out of network benefits, AND identify the specific estimated out of pocket expenses as they will be more than the in−network copayment, coinsurance or deductible.*
- *I will be responsible for any excess amount above the allowed amount my insurance plan pays or reimburses for the services*

Information on the insurance plans that the hospital's employed and contracted physicians participates with are on the facility's website at https://www.stjosephshealth.org

By signing below, you acknowledge receiving a copy of this disclosure.

_____	_____	_____	_____
Patient Signature	Relationship	Date	Time
(or authorized representative)	(if not the patient)		

_____
Print Name

This notice is only required for scheduled non−emergent or elective service.

CO0100

St. Joseph's Health
St. Joseph's University Medical Center
St. Joseph's Wayne Medical Center

New Jersey Department of Health
Vaccine Preventable Disease Program
P.O. Box 369, Trenton, NJ 08625-0369
609-826-4860 (Fax 609-826-4866)
www.njiis.nj.gov

NEW JERSEY IMMUNIZATION INFORMATION SYSTEM (NJIIS)
CONSENT TO PARTICIPATE

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -

REGISTRANT INFORMATION	***PARENT/GUARDIAN INFORMATION (if NJIIS Registrant is a minor)***
Registrant Name *(Print)*	Name *(Print)*
Date of Birth	Address
Country of Birth	City, State, Zip Code
Name of Primary Health Care Provider	Relationship to Registrant

I have received information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me when my/my child's immunizations are due and to keep a central record of my/my child's immunization history.

I understand that the medical information in the NJIIS may be shared with authorized health care providers, schools, licensed child care centers, colleges, public health agencies, health insurance companies, and others as permitted by New Jersey Law at N.J.S.A. 26:4-131 et seq. and rules at N.J.A.C. 8:57-3.

I understand that I can get a copy of my/my child's record from my primary health care provider, my local health department, or the New Jersey Department of Health (NJDOH). The NJDOH may be contacted at the website or telephone number listed above.

There is no cost to participate in this program.

☐ Yes, I would like to participate in this program.

☐ No, I do not want to participate in this program.

Signature of Registrant (or Parent/Guardian, IF Registrant under 18 Years of Age)	Date

Name of NJIIS Enrollment Site	Registry ID Number	Medical Record Number

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -

CO0100

St. Joseph's Health

NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2013

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.

This Notice is provided to you pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH"). It is designed to tell you how we may, under federal law, use or disclose your Protected Health Information ("PHI").

We are required by law to provide you with this Notice of our legal duties and privacy practices with respect to your PHI that we maintain. HIPAA, as amended by HITECH, places certain obligations upon us with regard to your PHI and requires that we keep confidential any medical information that identifies you. We take this obligation seriously and when we need to use or disclose your PHI, we will comply with the full terms of this Notice. Anytime we are permitted to or required to share your PHI with others, we only provide the minimum amount of data necessary to respond to the need or request unless otherwise permitted by law.

I. USES AND DISCLOSURES OF YOUR PHI THAT DO NOT REQUIRE YOUR AUTHORIZATION.

We are permitted by law to use and disclose your PHI without your written or other form of authorization under certain circumstances as described below. This means that we do not have to ask you before we use or disclose your PHI for purposes such as to provide you with treatment, seek payment for our services, or for health care operations. We may also use or disclose your PHI without asking you for other activities or to state and/or federal officials.

- **Treatment, Payment and Health Care Operations.**
  - We may use and disclose your PHI in order to provide you with treatment and related services. We may disclose your PHI to our health care professionals – including doctors, nurses and technicians – for purposes of assisting them with providing treatment to you, as well as to residents, interns and other trainees who may be assisting with the provision of your care.
  - We may use your information – and send relevant parts to your insurance companies – in order to determine your eligibility and benefits for services you receive and obtain payment for the services we have provided to you.
  - You may privately pay for care without a bill being submitted to insurance.
  - We may access or send your information to our attorneys or accountants in the event we need the information in order to address one of our own business functions or to our other business partners in order to conduct our operations.
- **To Other Healthcare Providers.** We may disclose your PHI to other health care professionals where it may be required by them to treat you, to obtain payment for the services they provided you with or for their own health care operations.
- **Disclosures to Relatives, Close Friends, Caregivers.** We may disclose your PHI to family members and relatives, close friends, caregivers or other individuals that you may identify so long as we:
  - Obtain your agreement;
  - Provide you with the opportunity to object to the disclosure and you do not object; or
  - We reasonably infer that you would not object to the disclosure.
  - If you are not present or, due to your incapacity or an emergency, you are unable to agree or object to a use or disclosure, we may exercise our professional judgment in order to determine whether such use or disclosure would be in your best interests. Where we would disclose information to a family member, other relatives, or a close friend, we would disclose only that information we believe is directly relevant to his or her involvement with your care or payment related to your care. We will also disclose your PHI in order to notify or assist with notifying such persons of your location, general condition or death. You may at any time request that we do NOT disclose your PHI to any of these individuals.
- **Public Health Activities.** We may disclose your PHI for certain public health activities as required by law, including:
  - to report PHI to public health authorities for the purpose of preventing or controlling disease, injury or disability;
  - to report certain immunization information where required by law, such as to the state immunization registry or to your child's school;
  - to report births and deaths;
  - to report child abuse to public health authorities or other government authorities authorized by law to receive such reports;
  - to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration, such as reactions to medications;
  - to notify you and other patients of any product or medication recalls that may affect you;
  - to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and
  - to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.
- **Health Oversight Activities.** We may disclose your PHI to a health oversight agency such as Medicaid or Medicare that oversees health care systems and delivery, to assist with audits or investigations designed for ensuring compliance with such government health care programs.
- **Health Information Exchange.** We, along with other health care providers in New Jersey participate in Jersey Health Connect, a Health Information Exchange ("HIE") which allows patient information to be shared electronically through a secured network that is accessible to the providers treating you. We may disclose your PHI to the HIE unless you opt out of participating. To opt out, please contact Jersey Health Connect at (855) 624-6542 or visit www.jerseyhealthconnect.org to print out the form which you can mail or fax in.
- **Victims of Abuse, Neglect, Domestic Violence.** Where we have reason to believe that you are or may be a victim of abuse, neglect or domestic violence, we may disclose your PHI to the proper governmental authority, including social or protective service agencies, who are authorized by law to receive such reports.
- **Judicial and Administrative Proceedings.** We may disclose your PHI pursuant to a court order, subpoena or other lawful process in the course of a judicial or administrative proceeding. For example, we may disclose your PHI in the course of a lawsuit you have initiated against another party for compensation or damage for personal injuries you received to that person or his/her insurance carrier.
- **Law Enforcement Officials.** We may disclose your PHI to police or other law enforcement officials as may be required or permitted by law or pursuant to a court order, subpoena or other lawful process. For example, we may disclose your PHI to police in order to identify a suspect, fugitive, material witness or missing person. We may also disclose your PHI to police where it may concern a death we believe is a result of criminal conduct or due to criminal conduct within our premises. We may also disclose your PHI where it would be necessary in an emergency to report a crime, identify a victim of a crime, or identify or locate the person who may have committed a crime.
- **Decedents.** We may disclose your PHI to medical coroners for

purposes of identifying or determining cause of death or to funeral directors in order for them to carry out their duties as permitted or required by law.

- **Workers Compensation.** We may use or disclose your PHI to the extent necessary to comply with state law for workers' compensation or other similar programs, for example, regarding a work-related injury you received.
- **Research.** Although generally we will ask for your written authorization for any use or disclosure of your PHI for research purposes, we may use or disclose your PHI under certain circumstances without your written authorization where our research committee has waived the authorization requirement.
- **Fundraising Communications.** From time to time, we may contact you by phone, email or in writing to solicit tax-deductible contributions to support our activities. In doing so, we may disclose to our fundraising staff certain demographic information about you, such as your name, address and phone number, as well as certain other limited information. You have a right to opt-out of receiving these communications and may do so at any time by calling us at 973-754-4483, emailing us at optoutsj@sjhmc.org, or by writing to us at The Foundations of St. Joseph's Health, Annual Giving Manager, 703 Main Street, Paterson, NJ 07503.
- **Health or Safety.** We may use or disclose your PHI where necessary to prevent or lessen threat of imminent, serious physical violence against you or another identifiable individual, or a threat to the general public.
- **Military and Veterans.** For members of the armed forces and veterans, we may disclose your PHI as may be required by military command authorities. If you are a foreign military personnel member, your PHI may also be released to appropriate foreign military authority.
- **Specialized Government Functions.** We may disclose your PHI to governmental units with special functions under certain circumstances. For example, your PHI may be disclosed to any of the U.S. Armed Forces or the U.S. Department of State.
- **National Security and Intelligence Activities.** We may disclose your PHI to authorized federal officials for purpose of intelligence, counter-intelligence and other national security activities that may be authorized by law.
- **Protective Services for the President and Others.** We may disclose your PHI to authorized federal officials for purposes of providing protection to the President of the United States, other authorized persons or foreign heads of state or for purposes of conducting special investigations.
- **Inmates.** If you are an inmate in a correctional institution or otherwise in the custody of law enforcement, we may disclose PHI about you to the correctional institution or law enforcement official(s) where necessary:
  - For the institution to provide health care;
  - To protect your health and safety or the health and safety of others; or
  - For the safety and security of the correctional institution.
- **Organ and Tissue Procurement.** Where you are an organ donor, we may disclose your PHI to organizations that facilitate or procure organs, tissue or eye donations or transplantation.
- **As Required by Law.** We may use or disclose your PHI in any other circumstances other than those listed above where we would be required by state or federal law or regulation to do so.

II. USES AND DISCLOSURES OF YOUR PHI THAT REQUIRE YOUR WRITTEN AUTHORIZATION.

In general, we will need your **specific written authorization** on our HIPAA Authorization Form to use or disclose your PHI for any purpose other than those listed above in Section I. For example, in order for us to send your information to your life insurance company, you would need to sign our HIPAA Authorization Form and tell us what information you would like sent.

We will seek your **specific written authorization** for *at least* the following information unless the use or disclosure would be otherwise permitted or required by law as described above:

- **HIV/AIDS Information.** In most cases, we will NOT release any of your HIV/AIDS related information unless your authorization expressly states that we may do so. There are certain purposes, however, for which we may be permitted to release your HIV/AIDS information without obtaining your express authorization. Under New Jersey law, all cases of HIV Infection are reported to the New Jersey State Department of Health.
- **Sexually Transmitted Disease Information.** We must obtain your specific written authorization prior to disclosing any information that would identify you as having or being suspected of having a sexually transmitted disease. However, we may use and disclose information related to sexually transmitted diseases without obtaining your authorization only where permitted by law.
- **Tuberculosis Information.** We must obtain your specific written authorization prior to disclosing any information that would identify you as having or being suspected of having tuberculosis (TB). We may use and disclose information related to TB without obtaining your authorization where authorized by law. For example, under New Jersey State law, we are required to report your diagnosis of tuberculosis to the Department of Health, even if you do not consent.
- **Psychotherapy Notes.** We must obtain your specific written authorization prior to disclosing any psychotherapy notes unless otherwise permitted by law. However, there are certain purposes for which we may disclose psychotherapy notes, without obtaining your written authorization, including the following: (1) to carry out certain treatment, payment or healthcare operations, (2) to the Secretary of the Department of Health and Human Services to determine our compliance with the law, (3) as required by law, (4) for health oversight activities authorized by law, (5) to medical examiners or coroners as permitted by state law, or (6) for the purposes of preventing or lessening a serious or imminent threat to the health or safety of a person or the public.
- **Mental Health.** We must obtain your specific written authorization prior to disclosing certain mental health PHI or information that would identify you as having a mental health condition. We may use and disclose information related to mental health without obtaining your authorization only where permitted by law. For example, if we reasonably believe that you are threatening imminent harm to yourself or others, we will disclose information about you to protect yourself or others, even if you do not consent.
- **Drug and Alcohol Information.** We must obtain your specific written authorization prior to disclosing information related to drug and alcohol treatment or rehabilitation under certain circumstances such as where you received drug or alcohol treatment at a federally funded treatment facility or program.
- **Genetic Information.** We must obtain your specific written authorization prior to using or disclosing your genetic information for treatment, payment or health care operations purposes. We may use or disclose your genetic information, or the genetic information of your child, without your written authorization only where it would be permitted by law. For example, under New Jersey State law, we may disclose your genetic information for purposes of identifying bodies.
- **Information Related to Emancipated Treatment of a Minor.** If you are a minor who sought emancipated treatment from us, such as treatment related to your pregnancy or treatment related to your child, or a sexually transmitted disease, we must obtain your specific written authorization prior to disclosing any of your PHI related to such treatment to another person, including your parent(s) or guardian(s), unless otherwise permitted or required by law.

- **Marketing Activities.** We must obtain your specific written authorization in order to use any of your PHI to provide you with marketing materials by mail, email or telephone. However, we may provide you with marketing materials face-to-face without obtaining authorization, in addition to communicating with you about services or products that relate to your treatment, case management, care coordination, alternative treatments, therapies, providers or care settings. If you do provide us with your written authorization to send you marketing materials, you have a right to revoke your authorization at any time. If you wish to revoke your authorization, please contact the Privacy Officer.
- **Activities Where We Receive Money for Giving Your PHI to a Third Party.** For certain activities in which we would receive remuneration, directly or indirectly, from a third party in exchange for your PHI, we must obtain your specific written authorization prior to doing so. However, we would not require your authorization for activities such as for treatment, public health or research purposes. If you do provide us with your written authorization, you have a right to revoke your authorization at any time. If you wish to revoke your authorization, please contact the Privacy Officer.

III. YOUR RIGHTS.

1. **Right to Request Additional Restrictions.** You have the right to request restrictions on the uses and disclosures of your PHI, such as:
   - For treatment, payment and health care operations;
   - To individuals involved in your care or payment related to your care;
   - To notify or assist individuals to locate you or obtain information about your condition;
   - Your right to privately pay for care without a bill being submitted to insurance.

   Although we will carefully consider all requests for additional restrictions on how we will use or disclose your PHI, we are not required to grant your request **unless** your request relates *solely* to disclosure of your PHI to a health plan or other payor for the *sole purpose of payment or health care operations for a health care item or service that you or your representative have paid us for in full.* Requests for restrictions must be in writing. Please contact the Privacy Officer if you wish to request a restriction.
2. **Right to Confidential Communications.** You have the right to make a reasonable written request to receive your PHI by alternative and reasonable means of communication or at alternative reasonable locations.
3. **Right to Inspect/Copy PHI.** You have the right to inspect and request copies of your PHI that we maintain. For PHI that we maintain in any electronic designated record set, you may request a copy of such PHI in a reasonable electronic format, if readily producible. However, under limited circumstances, you may be denied access to a portion of your records. For example, if your doctor believes that certain information contained within your medical record could be harmful to you, we would not release that information to you. Please contact the Health Information Management Department if you would like to inspect or request copies of your PHI from us. We may charge you a reasonable fee for paper copies of your PHI or the amount of our reasonable labor costs for a copy of your PHI in an electronic format.
4. **Right to Notice of Breach.** We take very seriously the confidentiality of our patients' information, and we are required by law to protect the privacy and security of your PHI through appropriate safeguards. We will notify you in the event a breach occurs involving your unsecured PHI and inform you of what steps you may need to take to protect yourself.
5. **Right to Paper Copy of Notice of Privacy Practices.** You may at any time request a paper copy of this Notice, even if you previously agreed to receive this Notice by email or other electronic format. Please contact the Privacy Officer to obtain a paper copy of this Notice.
6. **Right to Revoke Authorization.** You may at any time revoke your authorization, whether it was given verbally or in writing. You will generally be required to revoke your authorization **in writing** by contacting our Privacy Officer. Any revocation will be granted except to the extent we may have taken action in reliance upon your authorization.
7. **Right to Request Amendment.** You may request in writing that we amend, or change, your PHI that we maintain by contacting the Director of Health Information Management. We will comply with your request unless:
   - We believe the information is accurate and complete;
   - We maintain the information you have asked us to change but we did not create or author it; for example, your medical records from another doctor were brought to us and incorporated into your medical records with our doctors;
   - The information is not part of the designated record set or otherwise unavailable for inspection.

   Requests for amendments must be in writing.
8. **Right to an Accounting.** You may request an accounting of certain disclosures we have made of your PHI within the period of six (6) years from the date of your request for the accounting. The first accounting you request within a period of twelve (12) months is free. Any subsequently requested accountings may result in a reasonable charge for the accounting statement. Please contact the Privacy Officer if you wish to request an accounting of disclosures. We will generally respond to your request in writing within thirty (30) days from receipt of the request.

IV. OUR DUTIES.

We are required by law to maintain the privacy of your PHI and to provide you with a copy of this Notice. We are also required to abide by the terms of this Notice. We reserve the right to amend this Notice at any time in the future and to make the new Notice provisions applicable to all your PHI – even if it was created prior to the change in the Notice. However, if we do change this Notice, we will only make changes to the extent permitted by law. We will also make the revised Notice available to you by posting it in a place where all individuals seeking services from us will be able to read the Notice. You may obtain the Notice in hard copy from our Privacy Officer.

V. COMPLAINTS TO THE GOVERNMENT.

If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services or the Privacy Officer for St. Joseph's Health. To file a complaint with St. Joseph's Health, contact the Privacy Officer at the address below. We will not retaliate against you for any complaint you make to the government about our privacy practices.

VI. CONTACT INFORMATION.

If you have any questions or would like additional information about this Notice, please contact the Privacy Officer at:

St. Joseph's University Medical Center
703 Main Street
Paterson, New Jersey 07503
Phone: 973-754-2859

VII. ELECTRONIC NOTICE.

This Notice of Privacy Practices is also available on our web page at www.StJosephsHealth.org

ST. JOSEPH'S HEALTH HOSPITALS

- St. Joseph's University Medical Center
- St. Joseph's Children's Hospital
- St. Joseph's Wayne Medical Center
- St. Joseph's Healthcare & Rehab Center

Formerly St. Vincent's Healthcare & Rehab Center

FOR HOSPITAL OR OTHER FACILITY PATIENTS

YOU MAY RECEIVE TWO OR MORE BILLS FOR SERVICES PROVIDED

TOTAL DIAGNOSTIC OR TREATMENT COST

PHYSICIAN OR PROVIDER'S FEE

HOSPITAL CHARGES OR OTHER FACILITY

Receiving two bills is not the result of a duplicate charge, but a separation of the facility and physician or provider's fees. These services were provided while you were under our care, or at the request of your physicians or providers.

Your bill from the facility may include a separate charge for use of equipment, supplies, and technical services. You may also receive bills from other physicians or providers who were involved with your care if you were a patient in a hospital or other facility.

PARA LOS PACIENTES DEL HOSPITAL U OTROS ESTABLECIMIENTOS

USTED PODRÍA RECIBIR DOS O MÁS FACTURAS POR LOS SERVICIOS PRESTADOS

COSTO TOTAL DE LOS SERVICIOS DE DIAGNÓSTICO O TRATAMIENTO

HONORARIOS DE MÉDICOS O PROVEEDORES

CARGOS DEL HOSPITAL U OTRO ESTABLEC

Recibir dos cuentas no implica un cargo duplicado, sino una separación de los cargos del establecimiento y los honorarios de los médicos o proveedores. Usted recibió estos servicios como parte de su atención, o a pedido de sus otros médicos o proveedores.

La factura del establecimiento podría incluir un cargo aparte por el uso de sus equipos, suministros y servicios técnico. Es posible que también reciba facturas de otros médicos o proveedores que hayan participado en su atención si usted fue paciente en un hospital u otro establecimiento.

St. Joseph's Health | StJosephsHealth.org
Sponsored by the Sisters of Charity of Saint Elizabeth

HBG 50130HS (10/18)

St. Joseph's Health
St. Joseph's University Medical Center
St. Joseph's Wayne Medical Center

YOUR RESPONSIBILITIES AS A PATIENT

Patients and families play a vital role through verbal and written communication. The effectiveness of care, patient safety, and patient satisfaction depends, in part, on the patient fulfilling certain responsibilities.
As a patient, you are responsible for:

- ☑ Ensuring the Facility has a copy of your written Advance Directive, if you have one.
- ☑ Designating a surrogate or proxy decision maker who will exercise your rights on your behalf if you lack decision−making capacity, are legally incompetent, or are a minor.
- ☑ Providing your doctor and other health care providers, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, and other matters pertaining to your health.
- ☑ Asking your doctor or nurse what to expect regarding pain and pain management. Discuss pain relief options with your doctor and nurse to develop a pain management plan, ask for pain relief when pain first begins, help your doctor and nurse assess your pain, tell your doctor or nurse if your pain is not relieved, and tell your doctor or nurse about any worries you have about taking pain medication.
- ☑ Reporting unexpected changes in your condition to the doctor and nursing staff.
- ☑ Reporting to your doctor or nurse whether you understand the treatment plan and what you are expected to do.
- ☑ Following the treatment plan agreed upon by you and the health care provider and informing your caregivers if you anticipate problems in following the prescribed treatment.
- ☑ Your actions and their consequences if you refuse treatment or do not follow the health care provider's instruc−tions.
- ☑ Asking for information on your medications in terms you can understand.
- ☑ Keeping appointments and, when you are unable to do so for any reason, notifying the doctor or Facility.
- ☑ Respecting the rights and privacy of other patients and their families, and for assisting in the control of noise and number of visitors.
- ☑ Treating the staff with respect and dignity and following the Facility's rules and regulations affecting patient care conduct.
- ☑ Understanding that your signature on an insurance form and/or on the Facility admission form gives permission to the appropriate Facility personnel to release information regarding your hospitalization.
- ☑ Assuring that financial obligations of your health care are fulfilled as promptly as possible and for providing the facility with accurate and timely information concerning your sources of payment and ability to meet financial obligations.
- ☑ Recognizing the impact of your lifestyle on personal health. Your health depends on much more than health care services.
- ☑ Speaking up and asking questions stating any concerns you may have.

St. Joseph's Health
St. Joseph's University Medical Center
St. Joseph's Wayne Medical Center

Patient Bill of Rights

St. Joseph's University Medical Center
703 Main Street
Paterson, New Jersey 07503
973-754-2000

St. Joseph's Wayne Medical Center
224 Hamburg Turnpike
Wayne, New Jersey 07470
973-942-6900

www.stjosephshealth.org

Sponsored by the Sisters of Charity of Saint Elizabeth

HBG 108101HS (5/17/23) 1.4

St. Joseph's Health
St. Joseph's University Medical Center
St. Joseph's Wayne Medical Center

PATIENT BILL OF RIGHTS

The Patient Bill of Rights is available in Spanish and Arabic. If you would like a copy of the Patient Bill of Rights in Spanish or in Arabic, please call 973-754-3147.

Every effort will be made to make the Patient Bill of Rights available to you in a language that you can understand.

Si usted prefiere recibir una copia de los Derechos del Paciente en español, por favor llame al 973-754-3147.

وثيقة حقوق المريض ومسؤولياتك كمريض متوفرة باللغة العربية. إذا رغبت في الحصول على نسخة منها يمكنك الإتصال
٩٧٣-٧٥٤-٣١٤٧

AS A PATIENT IN ST. JOSEPH'S HEALTH, YOU HAVE THE FOLLOWING RIGHTS UNDER STATE LAW AND REGULATIONS:

MEDICAL CARE – To expect that within the Facility's capacity and in accordance with the moral teaching of the Roman Catholic Church, to receive the care and health services as required by law.

To be fully informed in advance of care or treatment and to actively participate in the planning of your care and treatment.

To receive an understandable explanation from your physician of your complete medical condition, recommended treatment, expected results, risks involved, and reasonable medical alternatives. If your physician believes that some of this information would be detrimental to your health, or beyond your ability to understand, the explanation must be given to your next of kin or guardian.

To give informed, written consent prior to the start of specified, non-emergency medical procedures or treatments. Your physician should explain to you – in words you understand – specific details about the recommended procedure or treatment, any risks involved, time required for recovery, and any reasonable medical alternatives. If you are incapable of giving informed consent, your physician will seek consent from your next of kin or guardian.

To refuse medication and treatment after possible consequences of this decision have been explained clearly to you, unless the situation is life-threatening or the procedure is required by law.

To be included in experimental research only if you give informed, written consent. You have the right to refuse to participate in experimental research including the investigations of new drugs and medical devices.

To be advised of the outcomes of care, including unanticipated outcomes.

The patient's family has the right of informed consent of donation of organs and tissues.

To have a family member or representative of your choice be involved in decisions regarding your care, treatment, services or discharge planning.

COMMUNICATION AND INFORMATION – To be informed of the names and functions of all health care professionals providing you with personal care. These people should identify themselves by introduction or by wearing a name tag.

To receive, as soon as possible, the services of a translator or interpreter to facilitate communication between the patient and Hospital's Healthcare Personnel.

St. Joseph's Health
St. Joseph's University Medical Center
St. Joseph's Wayne Medical Center

PATIENT BILL OF RIGHTS

To be informed of the names and functions of any outside health care and educational institutions involved in your treatment. You may refuse to allow their participation.

To receive (or have your next of kin or guardian receive), upon request, the Facility's written policies and procedures regarding life saving methods and the use or withdrawal of life support mechanisms.

To be advised in writing of the Facility's rules regarding the conduct of patients and visitors.

To receive a summary of your patient rights that includes the name and phone number of the Facility Staff member to whom you can ask questions or complain about any possible violation of your rights.

To freely voice complaints without being subject to coercion, discrimination, reprisal or unreasonable interruption of care, treatment and services.

To know the relationship(s) of the Facility to other persons or organizations participating in the provision of your care.

PAIN MANAGEMENT – As a patient at this Facility, you can expect information about pain and pain relief measures, a concerned staff committed to pain prevention and management, health professionals who respond quickly to reports of pain, state-of-the-art pain management, dedicated pain relief specialists, and that your reports of pain will be believed.

MEDICAL RECORDS – To have prompt access to the information in your medical record. If your physician feels that this access is detrimental to your health, your next of kin or guardian has a right to see your record.

To obtain a copy of your medical record, at a reasonable fee, within 30 days after a written request to the Facility.

COST OF YOUR CARE – To receive a copy of the Facility payment rates. If you request an itemized bill, the Facility must provide one, and answer any questions you may have. You have a right to appeal any charges.

To be informed by the Facility if part or your entire bill will not be covered by insurance. The Facility is required to help you obtain any public assistance and private health care benefits to which you may be entitled.

DISCHARGE PLANNING – To receive information and assistance from your attending physician and other health care providers if you need to arrange for continuing health care after your discharge from the Facility.

To receive sufficient time before discharge to arrange for continuing health care needs.

To be informed by the Facility about any appeal process to which you are entitled by law if you disagree with the Facility's discharge plans.

TRANSFER – To be transferred to another Facility only when you or your family has made the request, or in instances where the transferring Facility is unable to provide you with the care you need.

To receive an advance explanation from a physician of the reasons for your transfer and possible alternatives.

PERSONAL NEEDS – To be treated with courtesy, consideration, and respect for your dignity and individuality.

St. Joseph's Health
St. Joseph's University Medical Center
St. Joseph's Wayne Medical Center

PATIENT BILL OF RIGHTS

To have your cultural, psychosocial, spiritual, and personal values, beliefs, and preferences respected.

To an environment that preserves dignity and contributes to a positive self-image.

To have access to storage space in your room for private use. The Hospital must also have a system to safeguard your personal property.

FREEDOM FROM ABUSE AND RESTRAINTS – To freedom from all forms of abuse and harassment.

To freedom from restraints, unless they are authorized by a physician for a limited period of time to protect the safety of you or others.

To freedom from unnecessary use of physical or chemical restraint and/or seclusion as a means of coercion, convenience or retaliation.

To access protective and advocacy services in cases of abuse or neglect.

PRIVACY AND CONFIDENTIALITY – To have physical privacy during medical treatment and personal hygiene functions, such as bathing and using the toilet, unless the patient needs assistance for his or her own safety. The patient's privacy shall also be respected during other health care procedures and when hospital personnel are discussing the patient.

To confidential treatment of information about you. Information in your records will not be released to anyone outside the Facility without your approval, unless it is required by law.

LEGAL RIGHTS – To treatment and medical services without discrimination based on race, age, religion, national origin, sex, sexual preferences, gender identity or expression, marital, domestic partnership, or civil union status, handicap, diagnosis, ability to pay, or source of payment.

The right to execute an Advance Directive regarding decisions at the end of life in accordance with Federal and State Patient Self-Determination Act(s).

To exercise all your constitutional, civil and legal rights.

PRIVATE DUTY NURSING – To contract directly with a New Jersey licensed registered professional nurse of the patient's choosing for private professional nursing care during his or her hospitalization. A registered professional nurse so contracted shall adhere to Facility policies and procedures in regard to treatment protocols, so long as these requirements are the same for private duty and regularly employed nurses. The Facility upon request, shall provide the patient or designee with a list of local non-profit professional nurses association registries that refer nurses for private professional nursing care.

QUESTIONS AND COMPLAINTS – To present questions or grievances to the Department of Patient Relations at 973-754-3147 or email patientrelations@sjhmc.org to receive a response in a reasonable period of time. You may directly contact the N.J. Department of Health Complaint hotline at 1-800-792-9770. Or contact DNV at 866-496-9647; fax at 281-870-4818; email: hospitalcomplaint@dnv.com; or write to DNV Healthcare USA Inc., Attn: Hospital Complaints, 4435 Aicholtz Road, Suite 900, Cincinnati, OH 45245; or scan the QR code below to file a complaint online.

This list of Patient Rights is an abbreviated summary of the current New Jersey Law and Regulations governing the rights of hospital patients. For more complete information, consult N.J. Department of Health Regulations at N.J.A.C. 8:43G-4.1, or Public Law 1989-Chapter 170, or Centers for Medicare and Medicaid Services (CMS) at 482.13 Condition of Participation: Patient's Rights, available through the Patient Relations Department by calling 973-754-3147.

St. Joseph's Health
St. Joseph's University Medical Center
St. Joseph's Wayne Medical Center

"WHAT YOU NEED TO KNOW ABOUT ADVANCE DIRECTIVES"

You have the right to decide what medical treatment you wish to receive and the right to refuse treatment you do not want. Federal and State laws protect this right to accept or refuse medical treatment and to have treatment stopped once it has begun through the use of Advance Directives. Advance Directives allow you to appoint someone to make decisions for you and/or state your treatment preferences if you are unable to make decisions for yourself. When you enter a hospital, there is a specific Federal Law (The Patient Self-Determination Act) that requires you to be advised in writing about your right to have an Advance Directive, and to acknowledge an existing Advance Directive when you are admitted to the hospital.

Facts About Advance Directives

What is an Advance Directive?

An Advance Directive is a statement, preferably written, which lets your doctors and other health care providers know what type of medical treatments you would or would not want if you are unable to speak for yourself.

What types of Advance Directives are there?

The two most common forms of Advance Directives are:

Health care proxy – is anyone you choose and appoint to make medical decisions for you in case you are unable to communicate for yourself. Your health care proxy has decision-making power only when you are unable to make decisions for yourself. A health care proxy is sometimes referred to as a durable power of attorney for health care, medical power of attorney, health care agent or health care representative.

Living Will – is a statement expressing what types of treatment you would or would not want a health care provider or institution to provide, as well as any health care instructions you want known if you cannot speak or communicate for yourself.

Why should I have an Advance Directive?

By planning in advance, you can give specific instructions about treatment and/or appoint someone you trust to make medical decisions for you. Adults in New Jersey have a right to accept or refuse medical treatment and Advance Directives allow you to specifically express your preferences when you are unable to communicate.

I am healthy. Why should I prepare an Advance Directive now? Can it wait?

It is best to create an Advance Directive while you are well, can think clearly and are able to discuss your wishes with family members and friends. These decisions are best made without the stress and crisis of illness. However, you can fill out an Advance Directive at any time, as long as you have "capacity" to do so. Capacity is a determination made by a physician that the patient is or is not able to make decisions for himself/herself.

What should I do with my Advance Directive once I have one?

Always make it known that you have an Advance Directive, even if you are not asked! Ask that it become part of your medical record. You may also carry it with you or use a small wallet size health care proxy card. You should give copies of all Advance Directives to your doctors, health care proxy, health care facility and any friends or family that you would like to have it. If possible, you should bring it with you during any admission to a health care facility.

How long is my Advance Directive effective for?

An Advance Directive remains effective indefinitely unless you include an expiration date or change it.

Will my Advance Directive be followed in other states?

As long as it complies with the laws of the state you are in, it will be honored.

Are Advance Directives only for end of life decisions?

No. They are for guidance concerning your medical treatment at any time you may not be able to make decisions for yourself.

Do I have to fill out a new Advance Directive if I am admitted to a different hospital, transferred to a nursing home or going home?

No, the health care proxy and living will remain in effect until you change or cancel them.

Who can I appoint to be my health care proxy?

You may appoint anyone you trust to make decisions for you if you are unable to make them for yourself. Your health care proxy must be at least 18 years old and able to make medical decisions on your behalf.

Can I have more than one health care proxy?

No, you can have only one health care proxy. However, an alternate can also be named in case your health care proxy cannot be reached.

Does my proxy need to know I have appointed him or her?

Yes, although the law does not require you to notify your proxy, it is important to discuss your wishes with your health care proxy and let your proxy know that you have chosen him/her for this important task. It is important to give your proxy as much guidance as possible and try to be as detailed as possible about your preferences. You should also give your proxy a copy of the document.

Can I change my health care proxy once it has been signed?

Yes, the most recently dated Advance Directive is the one that is binding. However, it is a good idea to let your proxy, doctor, hospital and family know of these changes. It is advisable to make changes in writing. If you are too ill to write, you can verbally state your wishes or have another adult sign the Advance Directive on your behalf with at least two, preferably three, witnesses present who are not the proxy or the alternate proxy.

I have power of attorney. Is this the same as a power of attorney for health care or medical power of attorney?

No, a medical power of attorney (also called power of attorney for healthcare or health care proxy) is different from a power of attorney. A power of attorney is limited to financial matters only. These are two separate legal documents each requiring their own forms.

What if I do not have anyone I want to appoint as my health care proxy?

You can fill out a living will, which states the types of treatment that you would or would not want. You can be as specific as you like.

Can I have a living will and a health care proxy?

Yes, you can have both a living will and a health care proxy. A living will can help give guidance to your health care proxy.

Do I need a lawyer to create a health care proxy?

No.

How do I create a health care proxy or living will?

You need to appoint your proxy or write your wishes down on a piece of paper. In fact, you do not even need a special form, although you can easily obtain one from your hospital or doctor. You need to sign and date your Advance Directive and have it signed and witnessed by at least two, preferably three, people at least 18 years of age who are not the health care proxy or the alternate. The document does not need to be notarized.

Are there any treatment decisions my health care proxy cannot make?

If you do not limit the types of health care decisions your proxy can make, he/she can make the same treatment decisions that you could make for yourself.

Proxies can make end-of-life decisions for you including the limiting or terminating of life-sustaining treatments.

Why should I appoint a health care proxy if I have family members who will be asked to make decisions for me if I am unable?

Appointing a health care proxy gives that person legal decision-making power. A proxy can review your medical record and obtain confidential medical information that he/she might need to make decisions. The proxy can only use this privilege while he/she is making medical decisions for you because you are unable to make them yourself. Family members who are not legally appointed proxies may not be able to obtain this information. A proxy can also stop treatment he/she believes you would not have wanted or that is in your best interest not to have. You may want to choose someone other than a family member so that your family is not burdened with making health care decisions or to avoid family conflicts.

How does my health care proxy make decisions on my behalf?

Your health care proxy is there to carry out your instructions and act in your best interest when you cannot. The decisions your proxy makes should be based on what your wishes are and all he/she knows about you. This is why it is important to discuss your wishes with your proxy. If you have not left specific instructions, then your proxy must try to figure out what you would have wanted by taking into account your previous decisions and behaviors and what he/she knows about you, as well as what is in your best interest. Health care providers must provide your proxy with all the medical information necessary to make decisions, as well as access to medical records.

Information About the Psychiatric Advance Directive

What is a Psychiatric Advance Directive (PAD)?

The PAD is a legal document that allows you to give instructions for future mental health treatment or appoint an agent to make future decisions about mental health treatment. The document is used when you experience acute episodes of psychiatric illness and become unable to make or communicate decisions about treatment.

Why do I want to create a PAD?

There are two main reasons:

1. A PAD makes it possible for you to be treated according to your wishes.
2. Creating a PAD can facilitate a more informed and open dialogue with your treatment provider.

When would I be considered "incapable"?

Generally, incapacity means that, in the opinion of a physician or eligible psychologist, you currently lack sufficient understanding or capacity to make and communicate mental health treatment decisions.

Are there conditions when my PAD would not be followed?

Yes, your PAD would not be followed:

- If it conflicts with generally accepted community practice standards.
- If the treatments requested are not feasible or available.
- If it conflicts with emergency treatment.
- If it conflicts with applicable law.

If you require further information about Advance Directives or assistance in completing an Advance Directive form, please call the Pastoral Care Department at 973-754-3015.

For Your Good Health & Protection

Clean Hands Count
PLEASE ASK

Hand washing is one of the best ways to prevent the transmission of infectious diseases. If you're unsure that your healthcare provider has properly sanitized their hands, ask them!

St. Joseph's Health

Providing a safe environment for all your healthcare needs.

Sponsored by the Sisters of Charity of Saint Elizabeth

St. Joseph's Health
St. Joseph's University Medical Center
St. Joseph's Wayne Medical Center

MEDICATION SAFETY GUIDELINES FOR PATIENTS

General Guidelines for Taking Medication

- Know the name of the medication you are taking − both generic and brand names
- Know the dose or how much medication you are taking
- Know when to take your medication
- Know how to store your medication
- Know what side effects you might expect
- Know what to do if you skip a dose *or* take too much
- Know what foods to avoid *or* to add to your diet
- Tell your healthcare provider and pharmacist about all non prescription drugs (vitamins, herbal remedies, teas, cold medicines, pain relievers, etc) that you take. These may interact with your prescription medication.

Questions to Ask Your Healthcare Provider

? Why am I taking this medication?
? How will I know if the medication is working?
? How long should it take the medication to work?
? What should I do if the medication does not appear to be working?
? How long should I take the medication?
? What if I feel better? Can I stop taking the medication?
? What if I feel worse? Can I stop taking the medication?
? Can I take over the counter or herbal medication?

Keep Records.

❍ Keep a list of the medications you take every−day with the name, purpose, dosage, and special directions.
❍ Keep a check off sheet every time you take your daily medication *or* use a pillbox with the days of the week.
❍ Share your list of medication (prescription and non prescription) information with every doctor you visit.
❍ Select one Pharmacy where you will have <u>*all*</u> your prescriptions filled.
❍ Remember to notify your physician and pharmacist of any medication or food allergies you may have.

DO NOT....

◆ Take more than the prescribed amount of medication without first consulting your healthcare provider.
◆ Borrow a friend's prescription medication.
◆ Mix alcohol with medication.
◆ Give your prescription medication to anyone else.

Avoid Drug Interactions

✷ *Food−Drug:* Know what foods to avoid or to add to your diet.
✷ *Drug−Drug:* Some drugs interact with each other to cause adverse effects or beneficial effects. Your healthcare provider and pharmacist need to know about <u>*all*</u> prescription and non prescription medications that you take to avoid drug interactions.

American Heart Association.
Healthy for Good™

Life's Essential 8™

HOW TO QUIT TOBACCO

EDUCATE YOURSELF

The first step to quitting smoking, vaping and using tobacco is to understand the risks and health effects for you and your family.

- Within 1 year after quitting, your risk of heart disease goes down by half.
- Smoking is the most preventable cause of death in the U.S. It's linked to about one third of all deaths from heart disease and 90% of lung cancers.
- Smoking damages your circulatory system and increases your risk of multiple diseases.
- Cigarettes, e-cigarettes and tobacco products contain many toxic chemicals, as do their smoke, vapor and liquids.
- Tobacco use and nicotine addiction is a growing crisis for teens and young adults. You can be one of the millions of people who successfully quit every year.
- Vaping and secondhand smoke
- About half of U.S. children ages 3-11 are exposed to secondhand smoke and vapor.

MAKE A PLAN TO QUIT

You're more likely to quit tobacco for good if you prepare by creating a plan that fits your lifestyle.

SET a quit date within the next 7 days.

CHOOSE a method: cold turkey or gradually.

DECIDE if you need help from a health care professional, nicotine replacement or medicine.

PREPARE for your quit day by planning how to deal with cravings and urges

QUIT on your quit day.

TIPS FOR SUCCESS

DEAL WITH URGES

Whether physical or mental, learn your triggers and make a plan to address them. Avoid situations that make you want to smoke or use tobacco until you're confident that you can handle them.

GET ACTIVE

Physical activity can help you manage the stress and cravings when quitting. You'll feel better, too.

HANDLE STRESS

Learn other healthy ways to manage the stress of quitting.

GET SUPPORT

A buddy system or support program can help you with some of the common struggles of quitting. 1-800-QuitNow

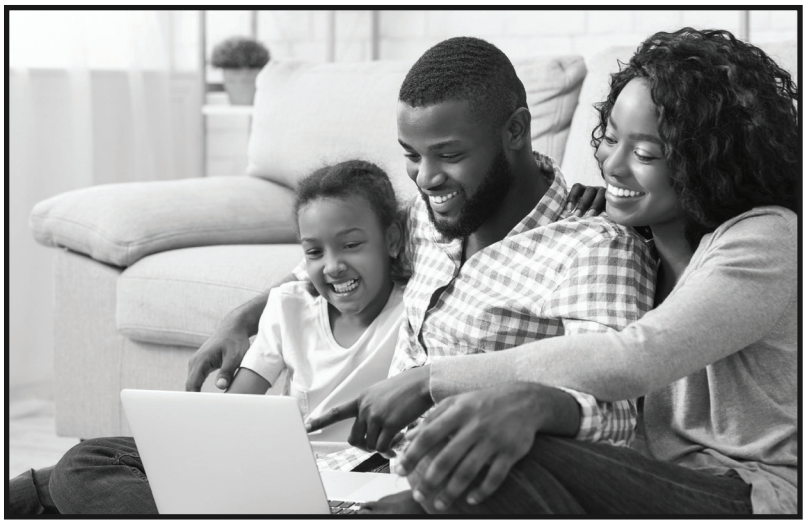
STICK WITH IT

Quitting tobacco takes a lot of willpower. Reward yourself when you reach milestones and forgive yourself if you take a step backward. Get back on course as soon as possible to stay on track and kick the habit for good.

Learn more at heart.org/lifes8

© 2022 American Heart Association, Inc., a 501(c)(3) not-for-profit. All rights reserved. Unauthorized use prohibited. Citations available upon request. 5/22 DS19388
50307HS

ST. JOSEPH'S HEALTH PATIENT PORTAL
My Health... My Results



What is MyStJosephsRecord?
MyStJosephsRecord is the St. Joseph's Health patient portal. A patient portal provides you with electronic access to your health records and information about your care. Once you are enrolled in MyStJosephsRecord, you can access it from your computer, tablet or phone. MyStJosephsRecord is convenient, free and secure.

MyStJosephsRecord is an easy way to view your medical records and information about your care including:
- Test results-Lab, Radiology (Diagnostic results available 36 hours after discharge)
- Medicine lists
- Allergies and immunizations
- Summaries of your care
- Health, wellness and education information

Manage your services including:
- View all appointments
- Schedule or reschedule an appointment
- Launch a scheduled telehealth visit
- Complete pre-visit questionnaires
- Message your healthcare providers
- Request a prescription refill or renewal
- Access online bill payments
- You can also fill out pre-visit forms in advance of your visit

What information can I access?
You can access information about:
- Discharge instructions
- Medicines
- Results available 36 hours after discharge

Who can use the St. Joseph's Health patient portal?
Patient portal access is available to almost all St. Joseph's Health patients, except minors, access is granted to parent or legal guardian.

How do I sign up?
For access to MyStJosephsRecord
- You can enroll during your next visit or hospital stay
- Assistance is available from a trained St. Joseph's staff member

St. Joseph's Health
MyStJosephsRecord

Sponsored by the Sisters of Charity of Saint Elizabeth

- When you provide a valid email address and accept access, you will receive an email invitation to finish the sign up process. After you complete those steps, you will be directed to log into the patient portal

You can enroll online at https://www.stjosephshealth.org/portal, self-enroll by completing the "self- enrollment" form. You can also simply scan the QR code below. To register, you must have a registered email address.

SCAN ME to Enroll Now

What if I do not have an email account?
An email account is needed to create a portal account. Visit an online web based service that offers a free webmail account.

Is my medical record information secure?
Yes. St. Joseph's Health patient portal uses the most effective security measures. This includes a secure connection and password to protect your medical information.

What do I need when a St. Joseph's staff member helps me set up a MyStJosephsRecord patient portal account?
You will be asked to show a valid photo ID and you must have a valid email account to register for MyStJosephsRecord.

How do I access my StJosephsRecord?
MyStJosephsRecord can now be accessed from your computer, tablet or phone. You can view and print your records by logging into your account on https://stjosephshealth.org/portal. You can download the St. Joseph's Health Portal app for Apple or Android devices from your mobile device App Store. Once you have signed up, log into your account using your username and password.

What if I forget my account log in information?
If you forget your MyStJosephsRecord patient portal password, go to the log on screen, click "Forgot Password?" link. Enter your email address or username, check the box "I'm not a robot," and click Next. Enter the answer to your security question and reset your password.

St. Joseph's Health is now offering you the ability to securely view your health information on participating health management apps. This new process better connects your health and wellness data, allowing you and your care team to make informed choices.

How to access:
If you are interested in this opportunity, please contact us at the number below. Once we receive your request and technical requirements are met, St. Joseph's Health will work to establish a secure connection to the mobile app(s) of your choice.

St. Joseph's Health Portal Support Team

1-888-580-5739

24 hours a day, 7 days a week.