HEALTH CARE ACCESS
100 First Avenue, 1st Floor, P.O. Box 591, Phoenixville PA 19460

PATIENT RESPONSIBILITIES FOR PROGRAM PARTICIPATION

~ I will inform Program staff of any changes to my personal information i.e., change in insurance coverage, phone number, change in household size, change in income or any other circumstances change that may affect my eligibility.

~ I will make Program staff aware of any medical history information that may be pertinent to the care I'm receiving, including change in medications.

~ I have been made aware of HCA "Confidentiality Policy" and how my personal information is protected.

~ I will be prompt for appointments or call if I need to reschedule.

~ I will ask questions if I don't understand any aspect of my Program services.

~ I will report any problem or concern I may have during my participation with the Health Care Access Program. (I can also refer to the Grievance Policy.)

~ I will provide clear and accurate information regarding my needs and circumstance.

~ I agree to treat the Program staff and providers with the same professional respect I deserve. This includes not showing up for appointments under the influence of drugs or alcohol, refraining from vulgar or threatening language and not making sexual or harassing remarks.

The purpose of these patient responsibilities is to optimize my benefit in receiving services from the Health Care Access Programs.

I understand failure to comply with these responsibilities could result in me being discharged from the Health Care Access Programs.

_____ _____

Patient Signature Date

Staff Initials _____

5/07