Advanced Urology
Center for Robotic Surgery

For Office Use Only:
MRN#: _____

Legal Name: _____ **SSN:** _____ **Date:** _____ **DOB:** _____

Sex: M / F **Primary Care Provider:** _____ **Referred by:** _____

Home Address: _____
Address City ST Zip Code

Home Phone: _____ **Work Phone:** _____ **Mobile Phone:** _____

E-mail address: _____ **Insurance Name:** _____

Employer Name: _____

Employer Address: _____
Address City ST Zip Code

Emergency Contact:

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Responsible Party if Different:

Name: _____ SSN: _____ DOB: _____

Reason for Visit:

__Urinary Tract Infection
__Difficulty Urinating
__Prostate Problems
__Kidney Mass
__Elevated PSA
__Difficulty with Erections
__Blood in Urine
__Frequent Urination
__Strong Urge to Urinate
__Urine Leakage
__Weak Urine Stream
__Urinating at Night
__Low Sexual Desire
__Discharge
__Testicular Pain
When does it occur?_____
How long has this been going on?_____
Does anything make it better?_____
__Pain with Urination
__Elevated PSA
__Other:

Do you have any of the following?

Y or N	Fever or Chills	Y or N	Cough	Y or N	Back Pain
Y or N	Fatigue	Y or N	Shortness of Breath	Y or N	Nipple Discharge
Y or N	Headaches	Y or N	Nausea	Y or N	Bleeding Problems
Y or N	Weight Loss	Y or N	Vomiting	Y or N	Depression
Y or N	Changes in Vision	Y or N	Constipation	Y or N	Anxiety
Y or N	Sore Throat	Y or N	Diarrhea	Y or N	Pain During Sex
Y or N	Chest Pain	Y or N	Abdominal Pain		

Past Medical History/Illness: (Check all that apply)

__ Asthma
__ High Blood Pressure
__ Liver Disease (Hepatitis)
__ Rheumatoid Arthritis
__ Blood Clots
__ Kidney Disease
__ Vascular Disease
__ Thyroid Disorder
__ Heart Attack
__ Stroke
__ Seizures
__ Diabetes
__ Gout
__ Heart Failure
__ HIV/AIDS
__ Cancer, Type/Stage: _____
__ Blood/Bleeding Problems
__ High Cholesterol
__Stomach Ulcers

Past Surgery: (Check all that apply)

__ Heart Bypass
__ Prostate
__ Tendon/Ligament Repair
__ Tubal Ligation
__ Joint Replacement
__ Other: _____
__ Hernia
__ Fractures
__ Bowel Surgery
__ Gallbladder Removal
__ Appendectomy
__ Hysterectomy

Turn Page Over

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Social History: (Circle Y or N)

Do you smoke? **Y / N** How much: _____ Have you ever smoked? **Y / N** How much: _____
Do you consume alcohol? **Y / N** How much: _____ Employment Status: **working, retired, disabled** Job: _____
Relationship Status: **single, married, divorced, widowed** Have Kids: **Y / N**

Circle Below:

Mother: Deceased (Yes or No) Age of death _____ Cause of death _____
Father: Deceased (Yes or No) Age of death _____ Cause of death _____

Family History: Who in your family has the following? (Please write M for Mother, F for Father)

____ Asthma	____ Diabetes	____ Heart Attack	____ High Cholesterol	____ Glaucoma
____ COPD	____ Kidney Failure	____ Stroke	____ High Blood Pressure	____ Vascular Disease
____ Bladder Cancer	____ Kidney Cancer	____ Prostate Cancer		

What pharmacy do you use? _____

Please list your medications and doses below: (Include any nonprescription medications)

_____

_____

Are you allergic to any medications? Yes or No

Please list medication allergies and your reaction: Nausea / itching / hives / difficulty breathing / other

_____

_____

Any allergy to: Iodine **Y / N** Metal **Y / N** Latex **Y / N**

Authorization, Assignment of Benefits, and Referral Medical Release:

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution. I authorize payment directly o Columbus Regional Health Network for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this authorization shall be considered as effective and as valid as the original.

Signed: _____ Date: _____

Request for Treatment:

The Group maintains personnel and facilities to assist my physicians in providing my medical care, and I authorize the Group personnel to perform the care ordered by my physicians. I understand that I have the right to be informed by the physicians of the nature and purpose of an proposed procedure and any available alternative methods of treatment, together with an explanation of the risk associated with each procedure. This form is not a substitute for such explanations, which are the responsibility of my physicians to provide according to recognized standards of medical practice, and I acknowledge that the Group and its personnel are responsible for providing this information.

Signed: _____ Date: _____

Thank you!

Advanced Urology
Center for Robotic Surgery

I, the undersigned, do hereby consent and request that Advanced Urology communicate with or release health information concerning me if said communication is in my best interest and is only information that is directly relevant to designated individuals' involvement with my healthcare and treatment decisions.

Patient's name: x_____

Date of birth: x_____

-If you do not wish for anyone aside from healthcare professionals to have access to your treatment information, please check here: ☐

-I do not grant consent for anyone to be given information regarding my care or treatment except required by law-

1. Name and address of person who I want to have health information as outlined above

Name _____ Relationship to Patient _____

Address: _____

_____

Phone: _____

2. Name and address of person who I want to have health information as outlined above

Name _____ Relationship to Patient _____

Address: _____

_____

Phone: _____

3. Name and address of person who I want to have health information as outlined above

Name _____ Relationship to Patient _____

Address: _____

_____

Phone: _____

_____ _____

Signature Date Printed Name

Columbus Regional
HEALTH NETWORK

PAYMENT POLICY & PATIENT STATEMENT OF RESPOBSIBILITY

TO OUR VALUED PATIENTS:

THANK YOU for choosing Columbus Regional Health Network for your healthcare services. We strive to provide the highest quality of care yet keep your healthcare costs as low as possible. These policies reflect our efforts to reduce healthcare costs. We appreciated your full cooperation.

FOR YOUR CONVENIENCE we accept any debit or credit card with the MasterCard, Visa, Discover, or American Express logo, as well as your personal check or cash.

PAYMENT (such as co pays, deductibles & co-insurance) is required at the time of service. We request that you do not ask to be billed. Patients repeatedly asking for exceptions will be directed to a supervisor or practice manager.

INSURANCE CARDS must be presented at each visit. You may feel this is unnecessary, but insurance plans are becoming more complicated, and cards, policy numbers, and renewal dates are constantly changing. In order for us to file your claims with the appropriate plan, we must have the most recent card presented. **If you arrive without your card,** you will be responsible for all charges until the billing office has received completed, current, and accurate insurance information. Most plans require we file your claim within 90 days from date of service. If we have not received your information within that time, you will remain responsible for all charges incurred up to the date you provide us with you insurance information and we receive payment from the insurance plan. Any balances you owe should be paid within thirty days.

MEDICARE PLANS are numerous and complicated. Columbus Regional Health Network participates with **Traditional Medicare (Part A & Part B)** and a limited number of Private Fee-for-Service (PFFS) Medicare Advantage Plans. We do not accept any Non-Private Fee-for-Service Plans except for in emergency situations. Please notify the front office immediately if you have recently changed Medicare Plans. Medicare deductibles and co-insurances are expected at the time of service. As a participating provider with Medicare and a limited number of PFFS, we will file your claim to Medicare and, if applicable, to you secondary insurance carrier.

MANAGED CARE PLANS have a network of participating providers. We participate with most major plans, but please contact your plan or check their website or call our office for confirmation before your visit. Applicable co pays, co-insurance, and deductibles are expected at time of service. You will also be billed for any non-covered services for which you are liable after your insurance pays their share. If you have a managed care plan that we do not participate with, you will be expected to pay the bill in full at time of service.

OTHER INSURANCE are those plans we do not participate in. You may be responsible for payment in full at the time of service. As a courtesy, we will file your claim.

WORKER'S COMPENSATION may or may not be accepted by your provider. Please check with your provider before making an appointment. If you provider accepts Worker's Compensation, you will be seen upon approval and authorization by your employer with the proper documentation.

MEDICAID may not be accepted by your provider. Please check with your provider's office before making an appointment. If you provider does accept Medicaid, **you will need to bring your current Medicaid Identification Card to each visit.** Failure to bring the current card may result in your appointment being rescheduled. If there is a co-pay with your plan you will be expected to pay it at time of service.

Columbus Regional
HEALTH NETWORK

HEALTH SAVINGS ACCOUNT/HEALTH REIMBURSEMENT ACCOUNTS are being promoted so that patients can have more control over managing their health care spending. These accounts will be patient specific so it is important you are aware of all benefits, deductibles, and co-payments. The deductible and co-payment will be expected at the time of service.

SELF-PAY PATIENTS are those patients who **do not have insurance coverage**. Self-Pay patients will be given a 30% discount off the charges for services provided and are expected to pay a minimum of $50.00 at time of service. This discount also does not apply to those patients who may have insurance, but we do not participate with their plan.

MEDICAL FORMS/MEDICAL LEAVE/DISABILITY FORMS will be completed within 7 to 10 business days upon receiving the form in the office. Please make sure you allow plenty of time for completion of these forms. Emergencies will be handled on a case by case basis. There may also be a fee for completion of these forms.

We thank you for taking time to read and understand our policies. Please let us know if you have any questions. Again, our office should be notified immediately of any changes in insurance coverage or primary care assignment.

I understand my responsibilities as outlined above and will abide by them.

Patient/Guardian Name_____

Patient/Guardian Signature_____ Date_____

Patient Request for Access

Did you know you can view most of your medical record online via IQ Health? Go to www.crhealthcare.org and click on My Physicians Records. If you would like a copy of your medical record, please complete the form below.

I am a patient of Columbus Regional Health Network and my information is listed below:

Patient Name: _____ Date of Birth: _____

Street Address: _____ Last 4 numbers of SSN: _____

City, State, Zip: _____ Telephone: _____

I would like for _____ **to (choose one):**
(list facility or practice)

☐ **give me a copy of my health information**

☐ **send my records to:**

Advanced Urology **509 Olde Waterford Way Unit 102, Leland, NC 28451**
(Name of Facility, Person, Company) (Street Address or PO Box, City, State, Zip Code)

(910) 641-8650 **(910) 640-2829**
(Phone Number) (Fax Number)

I would like these dates of service to be released: _____

I want these parts of my record:

Hospital (check all that may apply):	**Office/Clinic (check all that may apply):**	**Behavioral Health/Sub. Abuse (check all that may apply):**
☐ Hospital Summary ☐ Discharge Summary ☐ Emergency Record ☐ History and Physical ☐ Operative Reports ☐ Laboratory reports ☐ Radiology/X-Ray Reports ☐ Other _____ ☐ Entire record ☐ Itemized Bill	☐ Office/Clinic Summary ☐ Office Visits ☐ Physical Exam ☐ Laboratory Reports ☐ Radiology Reports ☐ Other _____ ☐ Entire record ☐ Itemized Bill	☐ Hospital/Discharge Summary ☐ Assessments ☐ Progress notes ☐ Medications ☐ Lab reports ☐ Other _____ ☐ Entire record (Not including psychotherapy notes) ☐ Itemized Bill

I want these records as a (choose one):

☐ **Paper copy**
☐ **Other:** _____

Please send medical records to:

Direct Email – mrulapaugh@crhn.cernerdirect.com
or
Fax to: (910) 640-2829

As an alternative, you may schedule an appointment with your healthcare provider's office to see your record in person. Please note it may take up to 30 days to schedule the appointment or provide copies.

Signature: _____ **Print Name:** _____

Relationship to Patient: _____ **Date:** _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this for the patient. (Written Proof May be Requested)

905

Columbus Regional
HEALTH NETWORK

ACKNOWLEDGEMENT FORM

Medical Records #: _____

Patient's Name: _____ Date of Birth: ____/____/____
Day Month Year

We are required by law to provide you with our Notice of Privacy Practices which explains how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you.

Signature: _____ Date: _____
(Patient or Authorized Representative)

Relationship to patient: _____ Self _____ Spouse _____ Other: _____

Reason Patient Unable/ Unwilling to Sign: _____

ACKNOWLEDGEMENT FORM

DOCUMENTO DE RECONOCIMIENTO DE COLUMBUS REGIONAL HEALTH NETWORK

Numero de Registro Medico: _____

Nombre del Paciente: _____ Fecha de Nacimiento: ____/____/____
Dia Mes Ano

La ley nos requiere que nosotros le proveamos a usted con nuestro Aviso de Practicas de Privacidad las cuales explican como podemos usar y divulgar su imformacion medica. La ley tambien nos requiere que obtengamos su firma, reconociendo que este aviso lo hemos hecho disponible para usted.

Firma: _____ Fecha: _____
(Paciente o Representate Authorizado)

Relacion al Paciente: _____ Mismo _____ Esposo (a) _____ Otro: _____

Razon Por la Cual El Paciente No Desea Firmar: _____

PATIENT RIGHTS

1. A patient has the right to respectful care given by competent personnel.

2. A patient has the right, upon request, to be given the name of his attending physician, the names of all other physicians directly participating in his care, and the names and functions of other health care persons having direct contact with the patient.

3. A patient has the right to every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination, and treatment are considered confidential and shall be conducted discreetly.

4. A patient has the right to have all records pertaining to his medical care treated as confidential except as otherwise provided by law or third party contractual arrangements.

5. A patient has the right to know what facility rules and regulations apply to his conduct as a patient.

6. The patient has the right to expect emergency procedures to be implemented without unnecessary delay.

7. The patient has the right to good quality care and high professional standards that are continually maintained and reviewed.

8. The patient has the right to full information in laymen's terms, concerning his diagnosis, treatment and prognosis, including information about alternative treatments and possible complications. When it is not possible or medically advisable to give such information to the patient, the information shall be given on his behalf to the patient's designee.

9. Except for emergencies, the physician must obtain the necessary informed consent prior to the start of any procedure or treatment, or both.

10. A patient has the right to be advised when a physician is considering the patient as a part of a medical care research program or donor program. Informed consent must be obtained prior to actual participation in such program and the patient or legally responsible party, may, at any time, refuse to continue in any such program to which he has previously given informed consent. An Institutional Review Board (IRB) may waive or alter the informed consent requirement if it reviews and approves a research study in accord with federal regulations for the protection of human research subjects including U.S. Department of Health and Human Services (HHS) regulations under 45 CFR Part 46 and U.S. Food and Drug Administration (FDA) regulations under 21 CFR Parts 50 and 56. For any research study proposed for conduct under a FDA "Exception from Informed Consent Requirements for Emergency Research" or a HHS "Emergency Research Consent Waiver" in which informed consent is waived but community consultation and public disclosure about the research are required, any facility proposing to be engaged in the research study also must verify that the proposed research study has been registered with the North Carolina Medical Care Commission. When the IRB reviewing the research study has authorized the start of the community consultation process required by the federal regulations for emergency research, but before the beginning of that process, notice of the proposed research study by the facility shall be provided to the North Carolina Medical Care Commission. The notice shall include:
- the title of the research study;
- a description of the research study, including a description of the population to be enrolled;
- a description of the planned community consultation process, including currently proposed meeting dates and times;
- an explanation of the way that people choosing not to participate in the research study may opt out; and
- contact information including mailing address and phone number for the IRB and the principal investigator. The Medical Care Commission may publish all or part of the above information in North Carolina Register, and may require the institution proposing to conduct the research study to attend a public meeting convened by a Medical Care Commission member in the community where the proposed research study is to take place to present and discuss the study or the community consultation process proposed.

11. A patient has the right to refuse any drugs, treatment or procedure offered by the facility, to the extent permitted by law, and a physician shall inform the patient of his right to refuse any drugs, treatment or procedures and of the medical consequences of the patient's refusal of any drugs, treatment or procedure.

12. A patient has the right to assistance in obtaining consultation with another physician at the patient's request and expense.

13. A patient has the right to medical and nursing services without discrimination based upon race, color, religion, sex, sexual orientation, gender identity, national origin or source of payment.

14. A patient who does not speak English or is hearing impaired shall have access, when possible, to a qualified medical interpreter (for foreign language or hearing impairment) at no cost, when necessary and possible.

15. The facility shall provide a patient, or patient designee, upon request, access to all information contained in the patient's medical records. A patient's access to medical records may be restricted by the patient's attending physician. If the physician restricts the patient's access to information in the patient's medical record, the physician shall record the reasons on the patient's medical record. Access shall be restricted only for sound medical reason. A patient's designee may have access to the information in the patient's medical records even if the attending physician restricts the patient's access to those records.

16. A patient has the right not to be awakened by hospital staff unless it is medically necessary.

17. The patient has the right to be free from needless duplication of medical and nursing procedures.

18. The patient has the right to medical and nursing treatment that avoids unnecessary physical and mental discomfort.

19. When medically permissible, a patient may be transferred to another facility only after he or his next of kin or other legally responsible representative has received complete information and an explanation concerning the needs for and alternatives to such a transfer. The facility to which the patient is to be transferred must first have accepted the patient for transfer.

20. The patient has the right to examine and receive a detailed explanation of his bill.

21. The patient has a right to full information and counseling on the availability of known financial resources for his health care.

22. A patient has the right to expect that the facility will provide a mechanism whereby he is informed upon discharge of his continuing health care requirements following discharge and the means for meeting them.

23. A patient shall not be denied the right of access to an individual or agency who is authorized to act on his behalf to assert or protect the rights set out in this Section.

24. A patient, or when appropriate, the patient's representative has the right to be informed of his rights at the earliest possible time in the course of his hospitalization.

PATIENT RIGHTS

25. A patient, and when appropriate, the patient's representative has the right to have any concerns, complaints and grievances addressed. Sharing concerns, complaints and grievances will not compromise a patient's care, treatment or services.
• If a patient has a concern, complaint, or grievance, he may contact his nurse, the nursing supervisor, or call the Patient Advocate at 910-642-1741.
• If the patient issues are not satisfactorily addressed while the patient remains hospitalized, the investigation will continue. The intent is to provide the patient a letter outlining the findings within seven days.
• If a patient chooses to identify a concern, complaint, or grievance after discharge, he may call the Patient Advocate at 910-642-1741 or write a letter to the CRHS Administration, 500 Jefferson St, Whiteville, NC 28472.
• The patient has the right to directly contact the North Carolina Department of Health and Human Services (State Survey Agency) or the DNV GL Healthcare.
• NC Division of Health Services Regulation Complaint Intake Unit 2711 Mail Service Center Raleigh, NC 27699-2711 www.2.ncdhhs.gov/dhsr/ciu/complaintintake. html 1-800-624-3004
• DNV GL Healthcare
Email: hospitalcomplaint@dnvgl.com
1-866-496-9647

26. The patient has the right to participate in the development and implementation of his plan of care, including his inpatient treatment/care plan, outpatient treatment/care plan, discharge care plan, and pain management plan.

27. The patient, or when appropriate, the patient's representative has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. Making informed decisions includes the development of their plan of care, medical and surgical interventions (e.g. deciding whether to sign a surgical consent), pain management, patient care issues and discharge planning.

28. The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives.

29. The patient has the right to have a family member or representative of his or her choice and his own physician notified promptly of his admission to the hospital.

30. The patient has the right to personal privacy. Privacy includes a right to respect, dignity, and comfort as well as privacy during personal hygiene activities (e.g. toileting, bathing, dressing), during medical/nursing treatments, and when requested as appropriate. It also includes limiting release or disclosure of patient information such as patient's presence in facility, location in hospital, or personal information.

31. The patient has the right to receive care in a safe setting. A safe setting includes environmental safety, infection control, security, protection of emotional health and safety, including respect, dignity, and comfort, as well as physical safety.

32. The patient has the right to be free from all forms of abuse or harassment. This includes abuse, neglect, or harassment from staff, other patients, and visitors.

33. The patient has the right to be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff.

34. The patient has the right to be free from seclusion and restraints, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff.

35. A patient has the right to designate visitors who shall receive the same visitation privileges as the patient's immediate family members, regardless of whether the visitors are legally related to the patient by blood or by marriage.

PATIENT RESPONSIBILITIES

1. Patients, and their families when appropriate, are responsible for providing correct and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to their health.

2. Patients and their families are responsible for reporting unexpected changes in their condition or concerns about their care to the doctor or nurse who is treating them.

3. Patients and their families are responsible for asking questions when they do not understand their care, treatment, and service or what they are expected to do.

4. Patients and their families are responsible for following the care,treatment, and service plans that have been developed by the healthcare team and agreed to by the patient.

5. Patients and their families are responsible for the outcomes if they do not follow the care, treatment, and service plan.

6. Patients and their families are responsible for following the hospital's rules and regulations.

7. Patients and their families are responsible for being considerate of the hospital's staff and property, as well as other patients and their property.

8. Patients and their families are responsible to promptly meet any financial obligation agreed to with the hospital.

Columbus Regional
HEALTHCARE SYSTEM

February 2019

DERECHOS DEL PACIENTE

1. Un paciente tiene derechos a recibir cuidados respetuosos por parte de personal competente.

2. Un paciente tiene derecho, si lo solicita, a que se le provea el nombre del médico a cargo de su caso, los nombres de todos los demás médicos que participan directamente en su cuidado, y los nombres y funciones del resto de personal de cuidado de salud que tiene contacto directo con usted.

3. Un paciente tiene derecho a toda consideración sobre su privacidad con respecto a su propio programa de cuidados médicos. La discusión del caso, consultas, exámenes y tratamiento se consideran confidenciales y se llevarán a cabo con discreción.

4. Un paciente tiene derecho a que todos los documentos relacionados a su cuidado médico sean considerados confidencial, excepto cuando la ley especifique lo contrario o los acuerdos contractuales con terceros.

5. Un paciente tiene derecho a saber qué reglas y regulaciones de la instalación aplican a su conducta como paciente.

6. El paciente tiene derecho a esperar que los procedimientos de emergencia sean puestos en práctica sin demoras innecesarias.

7. El paciente tiene derecho a buena calidad en el cuidado y altos estándares profesionales, que continuamente son mantenidos y revisados.

8. El paciente tiene derecho a que se le dé la información completa en lenguaje sencillo acerca de su diagnóstico, tratamiento y pronóstico, incluyendo información sobre tratamientos alternativos y posibles complicaciones. Cuando no sea posible o no resulte médicamente aconsejable darle tal información, ésta le será dada en su nombre a quien usted haya designado.

9. Un paciente tiene derecho a dar consentimiento informado, excepto en emergencias, antes del inicio de cualquier procedimiento, tratamiento, o ambos.

10. Un paciente tiene derecho a ser advertido cuando un médico lo esté incluyendo dentro de un programa de investigación de cuidado médico o de un programa de donantes. Se debe obtener consentimiento informado antes de la participación efectiva en dicho programa, y en cualquier momento usted o su representante legal podrán negarse a continuar en cualquier programa de este tipo, aun si hubiera dado previamente su consentimiento informado. Una Junta de Revisión Institucional (IRB) podrá no aplicar o modificar el requisito del consentimiento informado si se revisa y aprueba un estudio de investigación, de acuerdo con las regulaciones federales, para la protección de personas en investigación entre ellos el Departamento de Salud y Servicios Humanos (HHS, por sus siglas en inglés) de los Estados Unidos, según regulaciones previstas por 45 CFR Parte 46 y las regulaciones de la Administración de Alimentos y Fármacos (FDA, por sus siglas en inglés) bajo 21 CFR Partes 50 y 56. Para cualquier estudio de investigación propuesto a ser realizado bajo la "Excepción de requisitos de consentimiento informado para la investigación de emergencia" de la FDA, o para una "Excepción de Consentimiento para Investigación de Emergencia" de la HHS, en las cuales se otorgue una excepción al consentimiento informado pero se requiera de una consulta a la comunidad y la divulgación pública de la investigación, cualquier entidad propuesta para participar de esta investigación también deberá verificar que el estudio de investigación propuesto haya sido registrado en la Comisión de Cuidados Médicos de Carolina del Norte. Cuando el IRB encargado de controlar la investigación hubiera autorizado el inicio del proceso de consulta a la comunidad requerido por las regulaciones federales para la investigación de emergencia, pero antes de comenzar dicho proceso, la entidad deberá informar a la Comisión de Cuidados Médicos de Carolina acerca del estudio propuesto. La notificación deberá incluir:

- el título de la investigación;
- descripción de proceso planificación de consulta comunitaria, incluyendo fechas actualizadas y horarios de las reuniones propuestas;
- explicación del proceso de exclusión de las personas que decidan no participar en el estudio de investigación;
- información de contacto incluyendo dirección postal y número de teléfono para el IRB y el investigador principal.

La Comisión de Cuidados Médicos puede publicar todo o parte de la información anterior en el Registro de Carolina del Norte, y puede requerir la asistencia de la institución que propone realizar el estudio de investigación a una reunión pública convocada por un miembro de la Comisión de Cuidados Médicos dentro de la comunidad donde la propuesta del estudio de investigación se llevará a cabo para presentar y consultar sobre el estudio o el proceso de consulta comunitaria propuesto

11. Un paciente tiene derecho a rechazar cualquier medicamento, tratamiento o procedimiento ofrecido por la institución, en la medida de lo permitido por la ley. Un médico le informará acerca del derecho del paciente a rechazar cualquier medicamento, tratamiento o procedimiento y de las consecuencias médicas de su rechazo.

12. Un paciente tiene derecho a recibir ayuda para acceder una consultar con otro médico cuando lo solicite y a su cargo.

13. Un paciente tiene derecho a servicios medicos y de enfermria sin discriminacion en base a su raza, color, religion, sexo, orientacion sexual, identidad de genero, origen nacional o fuente de pago.

14. Un paciente que no habla el inglés o con discapacidad auditiva tendrá acceso, cuando sea posible, a un intérprete médico calificado (de idioma extranjero o por discapacidad auditiva) sin costo, cuando sea posible y necesario.

15. Una instalación deberá proporcionarle al paciente, o a la persona designada por el paciente, al ser solicitado, acceso a toda información contenida en su historial médico. Tal acceso podrá ser restringido por el médico que lo atiende. En tal caso, el médico deberá hacer constar las razones en su historial médico. Dicha restricción sólo se podrá fundamentar por motivos médicos razonables. Aún en el caso de que su médico resolviera restringir el acceso, la persona designada por el paciente sí podrá acceder a tal información.

16. Un paciente tiene derecho a no ser despertado por el personal del hospital, a menos que sea médicamente necesario.

17. El paciente tiene derecho a no ser sometido a duplicaciones innecesarias de procedimientos médicos y de enfermería.

18. El paciente tiene derecho a recibir tratamiento médico y de enfermería que evite incomodidades físicas y mentales innecesarias.

19. Cuando sea médicamente aceptable, el paciente puede ser trasladado a otro centro únicamente después de que usted o su pariente más cercano u otro representante legalmente responsable recibiera completa información y una explicación de las necesidades y las alternativas a dicho traslado. La instalación a la que usted va a ser trasladado debe primero haberlo aceptado para el traslado.

20. El paciente tiene derecho a recibir una explicación detallada de su factura y analizarla.

21. El paciente tiene derecho a toda información y asesoramiento sobre la disponibilidad de recursos financieros conocidos para su cuidado médico.

22. Un paciente tiene derecho a esperar a que en el momento del alta, la instalación, le informen de los requisitos de cuidado médico continuo después del alta y la manera de cómo obtenerlos.

23. A un paciente no se le negará el derecho a tener acceso a una persona o una agencia autorizada para actuar en su nombre y hacer valer o proteger los derechos enunciados en esta sección.

24. Un paciente, o cuando sea apropiado, el representante del paciente tiene derecho a ser informado de sus derechos lo antes posible durante el transcurso de su hospitalización.

Columbus Regional
HEALTHCARE SYSTEM

febreo 2019

DERECHOS DEL PACIENTE

25. Un paciente, o cuando sea apropiado, elrepresentante del paciente tiene derecho a que se atiendan cualquier inquietud, reclamo o motivo de queja. Esto no perjudicará el cuidado, tratamiento o servicios del paciente.
• Si un paciente tiene una inquietud, reclamo, o motivo de queja, él puede ponerse en contacto con su enfermero, el supervisor de enfermería o llamar a la Línea de Atención al Cliente al 910-642-1741.
• Si los problemas del paciente no se han atendido de forma satisfactoria mientras el paciente se encuentra hospitalizado, la investigación continuará. La intención es proporcionarle al paciente una carta, dentro de siete días, que describa los resultados.
• Si un paciente elige identificar una inquietud, reclamo o motivo de queja después de ser dado de alta, él puede llamar a la Línea de Atención al Cliente al 910-642-1741 o escribir una carta al CRHS Administration, 500 Jefferson St, Whiteville, NC 28472.
• El paciente tiene derecho a ponerse en contacto directamente con el Departamento de Salud y Servicios Humanos de Carolina del Norte (Agencia de Encuestas del Estado) ("North Carolina Department of Health and Human Services", en inglés [State Survey Agency]") o a la: DNV GL Healthcare
Email: hospitalcomplaint@dnvgl.com
1-866-496-9647.
• NC Division of Health Services Regulation Complaint Intake Unit 2711 Mail Service Center Raleigh, NC 27699-2711.
www..2.ncdhhs.gov/dhsr/ciu/complaintintake. html 1-800-624-3004
• DNV GL Healthcare
Email: hospitalcomplaint@dnvgl.com
1-866-496-9647

26. El paciente tiene derecho a participar en el desarrollo e implementación de su plan de cuidado, incluyendo su plan de tratamiento/cuidado como paciente interno, plan de tratamiento/cuidado como paciente ambulatorio, plan de cuidado después del alta y el plan de control y manejo del dolor

27. El paciente, o cuando sea apropiado, el representante del paciente, tiene derecho a tomar decisiones informadas con respecto a su cuidado. Los derechos del paciente incluyen estar informado de su estado de salud, estar involucrado en la planificación del cuidado y tratamiento y tener la capacidad de solicitar o rechazar tratamiento. Este derecho no debe ser interpretado como un mecanismo para demandar la provisión de tratamiento o servicios que se considere médicamente innecesarios o inapropiados. Tomar decisiones informadas incluye el desarrollo del plan de cuidado, intervenciones médicas y quirúrgicas (ej. decidir si firmar un consentimiento quirúrgico), control del dolor, asuntos del cuidado del paciente y la planificación de la dada de alta.

28. El paciente tienen derecho a formular instrucciones anticipadas, y que el personal hospitalario y los médicos que brindan cuidados en el hospital cumplan con esas instrucciones.

29. El paciente tiene derecho a que un miembro de su familia o representante designados de su elección al igual que sus propios médicos sean notificados con prontitud acerca de su ingreso al hospital.

30. El paciente tiene derecho a la privacidad personal. La privacidad incluye el derecho a respeto, dignidad y comodidad, así como privacidad durante sus actividades de aseo personal (ej. usando el inodoro, bañándose, vistiéndose), durante tratamientos médicos o de enfermería, y cuando lo solicite como sea apropiado. Además incluye limitar la entrega o revelación de información del paciente, tal como la presencia del paciente en las instalaciones, ubicación en el hospital o información personal.

31. El paciente tiene derecho a recibir cuidado en un ambiente seguro. Un ambiente seguro incluye seguridad del entorno, control de infección, seguridad, protección de seguridad y salud emocional, incluyendo respeto, dignidad y comodidad, así como también seguridad física.

32. El paciente tiene derecho a ser libre de toda forma de abuso, negligencia o acoso ya sea por parte del personal, de otros pacientes y visitantes.

33. El paciente tiene derecho a ser libre de cualquier tipo de restricción física que no sea médicamente necesaria o se use como medio de coacción, disciplina, conveniencia o represalia por parte del personal.

34. El paciente tiene derecho a ser libre de aislamiento y restricciones, de cualquier tipo, impuestos como un medio de coacción, disciplina, conveniencia o represalia por parte del personal.

35. El paciente tiene derecho a designar los visitantes quienes recibirán los mismos privilegios de visitas que los miembros de familia inmediata del paciente, sin importar si los visitantes son parientes legales, consanguíneos o matrimonio con el paciente.

RESPONSABILIDADES DEL PACIENTE

1. Los pacientes, y sus familias cuando sea apropiado, son responsables de proporcionar información correcta y completa sobre quejas actuales, enfermedades anteriores, hospitalizaciones, medicamentos y otros asuntos relacionados a su salud.

2. Los pacientes y sus familias son responsables de reportar cambios inesperados en su condición o inquietudes sobre su cuidado al médico o enfermero que los está atendiendo.

3. Los pacientes y sus familias son responsables de hacer preguntas cuando ellos no entiendan su cuidado, tratamiento y servicio o lo que se espera que ellos hagan.

4. Los pacientes y sus familias son responsables de seguir los planes de cuidado, tratamiento y planes de servicio que han sido desarrollados por el equipo de cuidado de salud y acordados por el paciente.

5. Los pacientes y sus familias son responsables por los resultados si ellos no siguen los planes de cuidado, tratamiento y servicio.

6. Los pacientes y sus familias son responsables de seguir las reglas y regulaciones del hospital.

7. Los pacientes y sus familias son responsables de ser considerados con el personal y propiedad del hospital, así como también con otros pacientes y sus pertenencias.

8. Los pacientes y sus familias son responsables de cumplir con prontitud cualquier obligación financiera que han acordado con el hospital.

AUA SYMPTOM SCORE (AUASS)

PATIENT NAME: _____ **TODAY'S DATE:** _____

(Circle One Number on Each Line)	Not at All	Less Than 1 Time in 5	LessThan Half the Time	About Half the Time	More Than Half the Time	Almost Always
Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
During the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
During the past month or so, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
During the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
During the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
During the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
	None	**1 Time**	**2 Times**	**3 Times**	**4 Times**	**5 or More Times**
Over the past month, how many times per night did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5

Add the score for each number above and write the total in the space to the right. **TOTAL:** _____

SYMPTOM SCORE: 1-7 (Mild) 8-19 (Moderate) 20-35 (Severe)

QUALITY OF LIFE (QOL)

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	0	1	2	3	4	5	6

SEXUAL HEALTH INVENTORY FOR MEN (SHIM)

PATIENT NAME: _____ **TODAY'S DATE:** _____

PATIENT INSTRUCTIONS

Sexual health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help you and your doctor identify if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with your doctor.

Each question has several possible responses. Circle the number of the response that **best describes** your own situation. Please be sure that you select one and only one response for **each question**.

OVER THE PAST 6 MONTHS:

1. How do you rate your confidence that you could get and keep an erection?		Very Low	Low	Moderate	High	Very High
		1	2	3	4	5
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?	No Sexual Activity	Almost Never or Never	A Few Times (much less than half the time)	Sometimes (about half the time)	Most Times (much more than, half the time)	Almost Always or Always
	0	1	2	3	4	5
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	Did Not Attempt Intercourse	Almost Never or Never	A Few Times (much less than half the time)	Sometimes (about half the time)	Most Times (much more than, half the time)	Almost Always or Always
	0	1	2	3	4	5
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	Did Not Attempt Intercourse	Extremely Difficult	Very Difficult	Difficult	Slightly Difficult	Not Difficult
	0	1	2	3	4	5
5. When you attempted sexual intercourse, how often was it satisfactory for you?	Did Not Attempt Intercourse	Almost Never or Never	A Few Times (much less than half the time)	Sometimes (about half the time)	Most Times (much more than, half the time)	Almost Always or Always
	0	1	2	3	4	5

Add the numbers corresponding to questions 1-5. **TOTAL:** _____

The Sexual Health Inventory for Men further classifies ED severity with the following breakpoints:

1-7 Severe ED **8-11 Moderate ED** **12-16 Mild to Moderate ED** **17-21 Mild ED**