



## SUMMARY NOTICE OF PRIVACY PRACTICES FOR PROTECTION OF INDIVIDUAL HEALTH INFORMATION

**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 a summary of your rights. The complete Notice of Privacy Practices is Available at the Registration or Admission Office*

### **RESPONSIBILITIES OF Roy Lester Schneider Hospital, Myrah Keating Smith Community Health Center and Charlotte Kimelman Cancer Institute**

Schneider Regional Medical Center is required by law to maintain the privacy of your protected health information and to give you notices of our duties and privacy practices. This Notice describes how we may use and disclose your individually identifiable health information. This Notice also describes your right to access and control your health information.

We must follow the terms of this Notice. We reserve the right to change this Notice consistent with the law. If we change this Notice, we will post a revised Notice and will make paper copies of the complete Notice available upon request. The terms of this Notice of Privacy Practices are consistent with the federal HIPAA Privacy Regulations.” Any term not defined in this Notice have the same meaning as it has in the HIPAA Privacy Regulations.

### **USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION**

We are legally permitted, without further notice to or consent from you, to use and/or disclose your protected health information in the following circumstances.

For treatment, Payment or Healthcare Operations or to Others Involved in Your Care	To Business Associates
To Other Covered entities or for Public Health Activities	For Abuse or Neglect Reporting or as Otherwise Required by Law
To the Food and Drug Administration (FDA)	Health-Related Benefit Information
For Workers’ Compensation or in Other Legal Proceedings	To Law Enforcement Personnel or for Inmates of Prison Facilities
To Coroners, Medical Examiners, Funeral Directors, Organ Donation	Military Activity and National Security, Protective Services
For Approved research	Prevention of a Serious Threat to health or Safety
For Disaster Relief Programs or health Oversight Activities	Limited Information for a facility Directory and to Clergy

We are required by law to disclose health information to the following people:

#### **To You or Your Personal Representative**

To the Secretary of the U.S. Department of Health and Human Services upon request

Other uses or disclosures of your health information may be made with your written authorization.



## **YOUR PRIVACY RIGHTS**

*The following is a summary of your rights with respect to your protected health information: (Please be aware that Schneider Regional Medical Center can deny your requests in certain circumstances.)*

*You may request a restriction on uses and disclosures of your health information.*

*You may request that our communications to you be confidential.*

*You may request to inspect and copy your protected health information (we may charge a fee for copying your record.)*

*You may request an accounting of disclosures of your health information.*

*You may request an amendment of your protected health information.*

*You have the right to receive a copy of the complete Notice of Privacy Practices.*

**You should also know that if you have greater protection under a specific U.S. Virgin Island statute or regulation, those protections will continue to apply to you.**

## **COMPLAINTS or ADDITIONAL INFORMATION**

*You may file a complaint to us to the Secretary of Health and Human Services if you believe that we have violated your privacy rights. You may also request additional information about the Notice of Privacy Practices.*

*Write to:*

**Roy Lester Schneider Hospital  
Attention: Delphine Olivacce  
Privacy Official  
9048 Sugar Estate  
St. Thomas, U.S.V.I. 00802**

### **Other Complaint Filing Information:**

**You may file a complaint with the  
USVI Department of Health**

*Write to:*

**Commissioner of Health  
9048 Sugar Estate, 5<sup>th</sup> Floor  
St. Thomas, U.S.V.I. 00802**

**You may file a complaint with the  
Peer Review Organization**

*Write to:*

**Peer Review Organization  
#1AD Estate Diamond Ruby  
PO Box 5989, Sunny Isle  
St. Croix, VI 00823**

## **EFFECTIVE DATE**

This notice is effective **February 22, 2007.**



## RECEIPT OF NOTICE OF PRIVACY PRACTICES

Medical Record Number \_\_\_\_\_

I, \_\_\_\_\_,

(Print your name)

Acknowledge that I have been informed of the *Notice of Privacy Practices* by Schneider Regional Medical Center (SRMC) and I am aware that I have the right to a printed copy of the Notice upon my request.

<b>Patient or Patient Representative</b>	<b>Received by SRMC:</b>
<b>Signature:</b>	<b>Signature:</b>
<b>Social Security #:</b>	<b>Department:</b>
<b>Date:</b>	<b>Date:</b>
<b>If signing as a Personal Representative Relationship to patient:</b>	

*For SRMC use only*

***Complete the section below is unable to obtain acknowledge of receipt from patient.***

Despite a good faith effort to do so, SRMC has been unable to obtain written acknowledgement of receipt of Notice of Privacy Practices from the following patient:

\_\_\_\_\_ for the following reason:

(Patient Name)

<b>SRMC:</b>
<b>Signature:</b>
<b>Department:</b>
<b>Date:</b>



Dear Patient of Schneider Regional Medical Center,

In accordance with Title 19, Chapters 10 and 20 Virgin Islands code, you have the legal right to say in advance what your wishes are for refusing or accepting treatment if you become unable to make your wishes known to your family and physician. An Advance Directive states your wishes at a time when you are able to thoroughly make a decision about your health care.

Advance Directives enable patients to make their feelings known about the following types of treatment:

1. **Cardiopulmonary Resuscitation (CPR)** - used to restore stopped breathing and/or heartbeat.
2. **Intravenous (IV) Therapy**- used to provide food, water and/or medication through a tube placed in a vein.
3. **Feeding tubes**- inserted through the nose, throat, etc., to provide nutrition
4. **Dialysis**- a method of cleaning patient's body by machine, when kidneys no longer work properly.
5. **Anatomical Gift**- donation of one's organ for transplant, therapy, medical and dental education, research or the advancement of medical or dental science or for uses by a designated individual for transplantation or therapy needed by that individual.

We will provide any assistance about your Advance Directive by your indication of the following:

I need more information about the preparation of an Advance Directive  Yes  No  
I have already prepared an Advance Directive and will provide SRMC with a copy

Patient or Legal Guardian \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_



**Interim Advance Directive**

I, \_\_\_\_\_ do not have a "Durable Power of Attorney for Health Care" or other Advance Directives

- I don't want one at this time.
- I would like more information about Advance Directives.

\_\_\_\_\_  
Name Printed    Name Signed    Date

I, \_\_\_\_\_, have a "**Durable Power of Attorney for Healthcare**" (**DPA**) or other advance directive, but is not physically present at any time of my admission. During this admission, until my directive is available, I would like the following to be considered as an Interim Care Directive. The following, as indicated by an initialed box and my signature, reflects my wishes.

I, \_\_\_\_\_, do not have a "**Durable Power of Attorney for Healthcare**" (**DPA**) or other advance directive, at the time of my admission. During this admission, I would like the following to be considered as an **Interim Care Directive**. The following, as indicated by an initialed box and my signature, reflects my wishes.

- I do not want life sustaining treatment to be provided or continued if I in an irreversible coma or persistent vegetative state, and/or if I am terminally ill and the application of life sustaining procedures would serve only to artificially delay the moment of my death. I want the hospital and my **Health Care Agent** to provide comfort and pain relief measures should such measures be indicated.*
- I want life sustaining treatment to be provided even if I am in an irreversible coma or persistent vegetative state and/or I am terminally ill and the application of life sustaining procedures would serve only to artificially delay the moment of my death.*
- Other:* \_\_\_\_\_

My designated **Health Care Agent** is \_\_\_\_\_

Telephone Number(s) (\_\_\_\_) \_\_\_\_\_

Physical Address: \_\_\_\_\_

This *Interim Care Directive* **does not** replace, modify or cancel my existing DPA or other advance directive. This interim directive is only applicable until such time as my DPA or other directive becomes available to hospital personnel. I know that I may change or update this interim care directive or my DPA or other Advance Directive at any time.

\_\_\_\_\_  
Name (Printed)    Signature    Date

\_\_\_\_\_  
Witness Name (Printed)    Signature    Date



**CONSENT FOR ADMISSION/REGISTRATION TO HOSPITAL, MEDICAL TREATMENT INCLUDING  
EMERGENCY TREATMENT, RELEASE OF RECORDS AND RESPONSIBILITY**

Name: \_\_\_\_\_ Date: \_\_/\_\_/\_\_\_\_ Time: \_\_\_\_\_

1. I/We the undersigned, knowing that \_\_\_\_\_ is suffering from a condition requiring diagnosis and medical, surgical, emergency treatment or newborn care hereby voluntarily consent to such diagnostic procedures and hospital care by or under the supervision of Dr. \_\_\_\_\_.
2. I/We are aware that the practice of medicine or surgery is not an exact science and I/We acknowledge that no guarantees or assurances have been made to me/us with regard to the results that may be obtained from treatments or examinations in the hospital.
3. I/We acknowledge that the Roy L Schneider Hospital does not assume responsibility for loss or damage to personal property kept in the patient's room. I/We further acknowledge that while the safe is available for the keeping of money and valuables of the patient, the Roy L Schneider Hospital assumes no responsibility for any possessions deposited therein.
4. I/We consent to allow students from formal education programs for health care professions to participate in my/the patient's care, under the supervision of appropriately licensed and/or credentialed members of such disciplines.
5. I/We acknowledge that I/We have received a written document regarding my/the patient's rights under Virgin Islands law to make decisions about my/the patient's medical care, and specifically about advance directive, (i.e. living wills, etc.) NOTE: Included in this document is information about the Roy L Schneider Hospital's policies as regards advance directives.
6. If applicable, I/We authorize the Roy L Schneider Hospital's pathologist to use discretion in the disposal of any specimen or tissue obtained from the patient in the course of diagnosis or treatment.
7. If applicable, I/We consent to the administration of such anesthetics as are necessary and applied by or under the direction of the medical anesthesia department. Note exceptions if any \_\_\_\_\_.
8. I/We understand that some insurance companies require authorization for inpatient admissions or specific procedures, and that maximum reimbursement may not be received if authorization is required and I/We do not have it. I/We assume the responsibility of obtaining such authorization if necessary and understand that Roy L Schneider Hospital cannot obtain such authorization for me/us.
9. I/We authorize Roy L Schneider Hospital and/or any doctor involved with my/the patient's care including those performing x-ray services, anesthesia services, pathology services, emergency services, delivery and care of newborns, or other similar services to release any information from my/the patient's medical record as requested by the patient's insurance company for payment of the hospital's or physician's accounts.
10. I/We agree that the information provided here is true and accurate. I/We understand failure to provide accurate information may preclude ability to file insurance benefits thereby reverting to self-pay.
11. I/We assign all insurance benefits due to or received by me/us to Roy L Schneider Hospital, and/ or the doctors involved with my/the patient's care including those performing x-ray services, anesthesia services, pathology services, emergency services, delivery and care of newborns, or other similar services as total or partial payment for services provided. I/We understand that this assignment may not constitute full payment of my/the patient's bill, and does not relieve me/us from liability for the unpaid balance. If insurance benefits to which I/the patients are entitled are paid directly to me/us, such benefits will be immediately delivered to Roy L Schneider Hospital (or the appropriate physician) by me/us until the full amount of all charges incurred are paid in full. I/We agree to pay directly to Roy L Schneider Hospital and/or such doctors the charges incurred for services received, at their established rates. I/We will pay all attorney fees and court costs incurred by Roy L Schneider Hospital or such doctors in collecting any unpaid balances for services I/the patient received.

**DO NOT SIGN THIS FORM UNTIL YOU READ IT AND UNDERSTAND ITS CONTENTS**

\_\_\_\_\_  
(Witness)

\_\_\_\_\_  
(Signature of patient)

(If patient is unable to consent or is a minor, complete the following :)

Patient is a minor \_\_\_\_\_ years of age (or is unable to consent because: \_\_\_\_\_)

\_\_\_\_\_  
(Witness)

\_\_\_\_\_  
(Signature of closest relative or legal guardian)



## Schneider Regional Medical Center Patient Relations Department/Patient Advocacy Program

The Patient Relations Department here at the Schneider Regional Medical Center is here to serve as the Patients' Advocate. Our Mission is to address questions or concerns you or your family members may have about care, hospital policies and procedures, or the quality of hospital services. Patient relations representative are also happy to receive *compliments*, suggestions, and other recommendations that might improve the services provided by this facility.

### Compliments

If you would like to thank a special staff member or volunteer who made your hospital stay especially comfortable, a Patient Relations Representative can assist you. Staff is also happy to receive suggestions or recommendation for future improvements. A word of thanks from the patients we come in contact with helps to lift staff spirits and boost morale!

### Grievances and Concerns

If you have a complaint, you may register it verbally or in writing with a Patient Relations Representative. Your particular concern will be investigated and a resolution will be provided as soon as possible.

All patients have the right to file external grievances with the Department of Health & Human Services (Centers for Medicare & Medicaid Services) Division of Survey Certification & Enforcement at **212-616-2480**.

As a Medicare patient, you also have the right to have grievance regarding quality of care and premature discharge referred to and independently reviewed by the Virgin Islands Medical Institute Peer Review Organization (PRO) at **(340) 712-2400 or (340) 712-2449**, independently review your case, please advise the Patient Advocacy Program. We will refer your concern accordingly, though the Office of the Medical Director.

If you have a complaint regarding a HIPAA privacy violation, you may direct it to Ms. Patricia Lake-Blyden, RHIA, Chief Compliance Officer, 9048 Sugar Estate, St. Thomas, USVI 00802, or at 776-8311 x2136.

In the event that you or your family would like to file your grievance outside of the internal grievance process and with the Hospital's regulatory agency, you may forward your written grievance to:

*Commissioner of Health, or Designee  
USVI Department of Health  
#9048 Sugar Estate, 5<sup>th</sup> Floor  
St. Thomas, USVI 00802  
Tel: 340-774-0117*

When sharing your compliments and concerns with our department, please be sure to include your name, date of stay, the unit, the nature of the issue, the names of any individuals whom you feel are important to the issue at hand, and how you would like to see the matter resolved.

Feel free to call, write, or visit the Patient Relations Department. A representative will be available to assist you.

**Director:** Ms. Laverne Moorhead  
**Hours:** Monday through Friday, 8 a.m. to 5p.m.  
**Location:** Schneider Regional Medical Center  
9048 Sugar Estate  
St. Thomas, USVI 00802  
**Telephone:** (340) 776-8311, Extension 2302, 2201  
**E-mail:** [lvmoorhead@srmedicalcenter.org](mailto:lvmoorhead@srmedicalcenter.org)

After hours and on weekends, in non-urgent situations, please leave a message. If you have an emergency, please contact the nursing supervisor of duty.

***Please let us know how you feel! We're here to offer a helping hand!***

# PATIENT RIGHTS & RESPONSIBILITIES

Schneider Regional Medical Center is dedicated to serving the whole patient regardless of race, creed, social or economic status, believing that the rights and dignity of every patient must be protected and promoted with care. The hospital, health center and institute endeavor to protect the patient's rights to privacy and keep patient records and communications confidential, in accordance with professional ethics and the law. Schneider Regional Medical Center is committed to safeguarding the right of each patient to information about and participation in decisions regarding medical care, and to promoting respect and dignity for all individuals. In the case of a minor, the following rights and responsibilities are afforded the patient's parent or guardian.

## You Have the Right To:

- Considerate and respectful care, which optimizes your comfort and dignity throughout your treatment.
- Access to treatment regardless of gender, age, disability, ethnicity, religion, or source of payment. This includes the right to supportive social and pastoral services that respect your personal value and belief system.
- Expect that every attempt will be made to provide an interpreter, if your spoken language is not English, or if you are deaf or hearing impaired.
- Receive aggressive, timely and appropriate pain management when indicated.
- Participate in the consideration of ethical issues that arise in the course of your care.
- Personal privacy and confidentiality. Be free from all forms of abuse or harassment, including the right to access protective services, if needed.
- Receive information about, and an explanation of, your hospital bill.
- Request a copy of your completed medical record and obtain the copy within a reasonable timeframe.
- To know if this hospital/health center has relationships with outside parties that may influence your treatment and care. These relationships may be with educational institutions, other health care providers, or insurers.

- Be treated by skilled, compassionate, caring physicians, nurses, and hospital staff.

- Know the names and roles of the providers caring for you.

- Be well informed about your illness, possible treatments, likely and unanticipated outcomes, and to discuss this information with your healthcare provider.

- Be advised if the hospital/health center proposes to engage in research projects affecting your care or treatment, and the right to refuse to participate in such studies without compromising the quality of care you receive.

- Receive a high standard of patient care and safety while in the hospital setting. The hospital/health center, your doctor, and health care professionals will protect your safety and security as much as possible.

- Be free from chemical or physical restraint except as authorized by a physician or in an emergency when necessary to protect you or others from injury.

- Receive appropriate discharge teaching and instruction for self-care, including awareness of community resources available to provide supportive care.

- Act in partnership with your health care providers to make decisions regarding your care.

- "Advance Directives": you have the right to formulate an Advance Directive or to appoint a surrogate to make health care decisions on your behalf.

- Informed consent, including the right to have treatment options explained so that you understand the benefits, risks, and treatment choices.

- Refuse treatment to the extent permitted by ethics and law, and to be informed of the medical consequences of your action.

- To obtain pertinent information as to any relationship of this hospital/health center and other health care institutions which may affect your care.

## It Is Your Responsibility To:

### Be Part of Your Care

- Be as accurate and complete as possible when providing medical history and treatment information.

- Inform your health care provider if you have any questions regarding care and treatment.

- Partner with the health care providers to develop an appropriate plan of care.

- Participate in the designated plan of care.

- Notify your health care providers if the designated plan of care cannot be followed.

- Provide a copy of your "Advance Directive" to the hospital/health center.

- Notify your health care providers or the Patient Representative at 776-8311x2302,2201 if you are not satisfied with the care you received.

## Respect and Consider the Rights of Others

- Be considerate of the rights of other patients and their families.

- Be considerate of the physicians and hospital/health center personnel.

- Provide the hospital/health center with accurate and timely information concerning the sources of payment and ability to meet financial obligations associated with care.

## Ensuring a Safe Hospital Stay

- The single most important way you, as a patient, can help to prevent errors is to be an active member of your health care team. *Speak up!* if you have any questions or concerns.

• Discuss your concerns with your nurse, physician, or if you have a commendation or complaint about the quality of your care, you may call the Hospital Operator to page the Patient Representative or after hours, page the Nursing Supervisor. At Myrah Keating, contact the Administrator. At Charlotte Kimelman Cancer Institute, contact the Administrative Director.