

PATIENT STATEMENT OF RESPONSIBILITIES

I will provide accurate information about present and past illnesses, hospitalizations, medications, allergies, and food or drink.

I will make every attempt to understand the implications of my procedure, including risks of refusing treatment, and I will ask for clarification when needed.

I will be respectful of the rights of other patients and staff, and property.

I will immediately inform my physician of change in condition or adverse reaction.

I will be responsible for assuring that the financial obligations of my health care are fulfilled as promptly as possible.

I understand what my responsibilities are at the Medical Center at Elizabeth Place and I will comply.

Patient Signature

Date

Facility Representative Signature

Date