JACKLIN POLADIAN, M.D., INC.
800 S. Fairmount Ave., Suite 420
Pasadena, CA 91105
(626) 200-4500 office
(626) 795-0704 Fax

PATIENT'S RIGHTS

We are dedicated to providing respectful and high quality medical care to our patients. In turn, we want our patients to understand their rights.

PATIENT RIGHTS

1. I have the right to receive informed consent in advance of any treatment being performed on me.
2. I have the right to privacy (as described in Privacy Notices of this practice)
3. I have the right to be seen in a timely manner. I have the right to reschedule without penalty if the office is given at least 24 hours notice.
4. I have the right to actively participate in my healthcare decisions.
5. I have the right to be properly informed of all my test results.
6. I have the right to speak to a physician in a timely manner if I have an urgent medical issue.
7. I have the right to receive a complete copy of my medical record upon my written request for a processing fee of $25 .

I have read and understand the patient's rights and I agree to be bound by its terms. I understand that failure to follow the practice's policies may cause dismissal from this practice.

(Please note that this policy may be amended by the practice from time to time. Prior to implementation of any amended terms, the revised policy will be provided to our patients.)

Patient or Guardian Signature Date

Please print the name of the patient

JACKLIN POLADIAN, M.D., INC.
800 S. Fairmount Ave., Suite 420
Pasadena, CA 91105
(626) 200-4500 office
(626) 795-0704 Fax

PATIENT'S RESPONSIBILITIES

We are dedicated to providing respectful and high quality medical care to our patients. In turn, we want our patients to understand their responsibilities.

PATIENT RESPONSIBILITIES

1. I have the responsibility to understand my insurance plan and benefits. I am responsible for all fees not paid by my insurance company as described below.
   (It is your responsibility to know and understand your insurance policy and benefits. We have arrangements with many insurance companies and health plans to accept an assignment of benefits. As a service to you, we file your insurance forms. ***You are responsible for all fees that are not covered by insurance or if your insurance company does not pay the practice within a reasonable period****. If you are insured by a health plan that we do not have a prior arrangement with, we will file your insurance forms on an assigned basis, and the insurer will send the payment directly to you. Therefore, our charges for your care are due at the time the services are rendered.)*
2. I have responsibility to keep my insurance and demographic information up to date with the office.
3. I have the responsibility to pay a thirty dollar ($30.00) charge for any check returned by my bank for any reason.
4. I understand that accounts that are not paid within sixty (60) days from the date of service may be assigned to collections. I have the responsibility to pay all of the costs of collections including reasonable attorney's fees.
5. I have a right to a copy of my medical records upon request. **I understand that I must place my request one (1) week in advance and will have a responsibility to pay a reasonable, cost-based fee**.
6. I have the responsibility to be on time for all scheduled appointments. I must notify the office at least 24 hours in advance when I need to cancel or reschedule an appointment. A failure to do so may result in a fifty dollar ($50) charge.
7. I am expected to provide the doctor with a copy of my advance directive, if I have one.
8. I am expected to provide complete and accurate information about my health and medical history, including present condition, past illnesses, hospital stays, medicines, vitamins, herbal products and any other matters that pertain to your health, including perceived safety risks.
9. I am expected to ask questions when I do not understand information or instructions. If I believe I cannot follow through with my treatment plan, I am responsible for telling my physician. I am responsible for the outcomes if I do not follow the care, treatment and service plan.
10. I am expected to actively participate in my pain management plan and to keep my physician informed of the effectiveness of my treatment. I might be asked to sign a pain management contract with my physician.
11. I am expected to treat all office staff, other patients and visitors with courtesy and respect; abide by all office rules and safety regulations including no-smoking; and be mindful of noise levels. I am expected to refrain from behavior that unreasonably places the health of others at risk.
12. I am expected to respect the property of other persons and that of the facility.
13. I must show respect to Dr. Poladian and her staff. I understand that any abusive or inappropriate behavior toward staff may lead to dismissal from the practice.
    (A certified letter of dismissal from our practice will be mailed to you. You will be given thirty (30) days to find a new doctor, and Dr. Poladian will see you within thirty (30) days if you have a medical emergency.)

I have read and understand the patient's responsibilities and I agree to be bound by its terms. I understand that failure to follow the practice's policies may cause dismissal from this practice.

(Please note that this policy may be amended by the practice from time to time. Prior to implementation of any amended terms, the revised policy will be provided to our patients.)

Patient or Guardian Signature Date

Please print the name of the patient