



PATIENT RIGHTS & RESPONSIBILITIES

MANDATORY ALASKA STATE DISCLOSURE:

NOTICE: A DIRECT PRIMARY CARE AGREEMENT IS NOT INSURANCE. This Agreement is NOT health insurance. Patient is not entitled to the protections under Alaska Statute § 21.07 (Patient Protections Under Health Care Insurance Policies). It does not cover hospitalization, surgical procedures, specialist care, or emergency room visits. Patients are strongly encouraged to maintain comprehensive health insurance coverage for medical services not provided under the membership agreement.

Patient Rights

1. Respect, Dignity, and Non-Discrimination

- **Dignified Care:** You have the right to receive considerate, respectful care that recognizes your individuality, personal values, and cultural background.
- **Equal Treatment:** You have the right to receive care free from discrimination based on race, color, national origin, age, sex, religion, physical or mental disability, marital status, change in marital status, pregnancy, parenthood, or any other characteristic of a class of persons protected by a state or federal law that prohibits discrimination.
- **Safe Setting:** You have the right to be treated in a secure clinical environment free from all forms of abuse, neglect, harassment, or unnecessary restraint.



2. Information and Informed Consent

- **Provider Identity:** You have the right to know the names, professional titles, and specific credentials of all personnel involved in your care.
- **Informed Decisions:** You have the right to receive full, clear explanations of your health status, diagnoses, proposed treatments, associated risks, and alternative options before giving consent.
- **Refusal of Treatment:** You have the right to refuse any recommended medication, test, or procedure to the extent permitted by law, after being informed of the potential medical consequences.

3. Confidentiality and Medical Records

- **Privacy Protections:** You have the right to strict confidentiality regarding your medical evaluations, treatment plans, and all personal health information.
- **Record Access:** Under Alaska law, you have the right to inspect, review, and request copies of your health records, except where a provider exercises professional judgment that disclosure would be harmful to your health.
- **Disclosure Control:** You have the right to approve or refuse the release of your medical records to outside entities, except when mandated or authorized by law.

4. Communication and Grievances

- **Language Access:** You have the right to receive information in a clear format. The Practice will make reasonable efforts to accommodate communication needs or coordinate with patient-provided translators.



- **Voice Concerns:** You have the right to voice grievances regarding your care. We request that you first submit any complaints directly to the Practice Owner via our internal clinic grievance process so we can address your concerns immediately. If a resolution cannot be reached internally, you retain the right to file a formal complaint directly with the Alaska Board of Nursing or the Alaska State Medical Board without experiencing retaliation.

Patient Responsibilities

1. Accurate Information Sharing

- **Health History:** You are responsible for providing complete, honest, and accurate details regarding your past medical history, hospitalizations, surgeries, and current health status.
- **Medications and Allergies:** You must disclose all active medications, including prescription drugs, over-the-counter products, vitamins, herbal supplements, and known allergies.
- **Updates on Health:** You are responsible for promptly notifying your care provider of any unexpected changes, worsening symptoms, or new health conditions.

2. Participation in the Care Plan

- **Follow Agreed Plans:** You are responsible for working collaboratively with your provider and following the treatment instructions, lifestyle goals, and preventive care regimens you have mutually agreed upon.



- **Ask Questions:** You must speak up and ask for clarification immediately if you do not understand your diagnosis, treatment options, or wellness plan.
- **Accept Consequences:** You accept personal responsibility for the health outcomes if you choose to refuse recommended treatments or decline to follow the agreed-upon medical plan.

3. Clinic Etiquette and Professional Conduct

- **Mutual Respect:** You are responsible for treating all clinic providers, medical staff, administrative employees, and other patients with courtesy and respect.
- **Disruptive Behavior:** Disruptive, abusive, threatening, or discriminatory language or behavior toward staff or fellow patients will not be tolerated and may result in immediate dismissal from the practice in accordance with the Termination Section of this Agreement.
- **Keep Appointments:** You must arrive on time for scheduled appointments or provide notice at least 24 hours prior to cancellation or rescheduling, ensuring clinical slots remain available for others in need.
- **Communication Boundaries:** You are responsible for utilizing the clinic's designated secure communication channels appropriately and respecting standard office hours for non-emergency inquiries, such as routine medication refills.

4. Financial Obligations

- **Clear Arrangements:** You are responsible for understanding your clinic's billing structure, payment terms, or membership model prior to receiving services.
- **Membership Terms:** You are responsible for reviewing, understanding, and adhering to the terms outlined in your Direct Primary Care Membership Agreement.



- **Timely Payments:** You are responsible for maintaining a valid payment method on file and ensuring monthly membership fees or ancillary service costs (such as in-office labs) are settled promptly according to the agreement.

By signing below, I certify that I have read, fully understand, and agree to all the terms, and conditions, outlined in this Patient Rights and Responsibilities document.

Patient Name: _____ Date: _____

Signature: _____

Name of Legal Representative (if applicable): _____

Signature: _____ Date: _____

Provider Name: _____ Date: _____