SCHOOL OF MEDICINE WICHITA
MEDICAL PRACTICE ASSOCIATION
The University of Kansas

ACKNOWLEDGEMENT OF PATIENT RIGHTS AND RESPONSIBILITIES

PATIENT RIGHTS

As a patient of UKSM-W Medical Practice Association (MPA), you have the right:

- To be treated with respect, dignity, consideration, and compassion.
- To receive services free of discrimination on the basis of race, color, sex/gender, ethnicity, national origin, religion, age, class, sexual orientation, physical or mental ability.
- To participate in creating a care plan and in making decisions that affects your care.
- To be informed about services and options available to you, including the cost.
- To have your personal information and medical records be treated confidentially.
- To communicate in a language you can understand.
- To consent or refuse to participate in any proposed research study without retribution or difference in the quality of your care.
- To file a grievance about services you are receiving or denial of services.
- To not be subjected to physical, sexual, verbal and/or emotional abuse or threats.

PATIENT RESPONSIBILITIES

As a patient of UKSM-W MPA, you have the responsibility:

- To treat other patients and staff of this clinic with respect and courtesy.
- To protect the confidentiality of other patients you encounter in this clinic.
- To participate as much as you are able in creating a care plan, asking questions until you fully understand your care plan, and participating in decision-making that affects your care.
- To let your physician and provider/care team know any concerns you may have about your care plan or changes in your needs.
- To make and keep appointments to the best of your ability, or if possible, to call to cancel or change an appointment time.
- To keep clinic informed of changes in your personal information, including address, phone number, or insurance to ensure timely processing of bills and to promptly meet your financial obligations.
- To provide accurate information to your physician and provider/care team about your symptoms, past illnesses, hospitalizations, medications, and behaviors that may affect your health.
- To follow your care plan and tell physicians and nurses about any obstacles you may encounter in continuing your care plan.
- To consent to a blood test if any healthcare worker should come in contact with your blood.
- To follow clinic rules, such as our no-smoking policy and clinic expectations for patient and visitor behavior, which includes refraining from the use of profanity; verbally abusive, offensive, and/or sexually suggestive language; threatening statements or any act or threat of inappropriate behavior.

I acknowledge that I have reviewed and understand these rights and responsibilities, and I understand that my signature below means that I am agreeing to do my part to respect the clinic's policies and to help create a safe, healing environment. I understand that failure to comply with the terms of this Agreement may prevent me from continuing to receive care from the clinic.

Patient Name ***(Print)***	**Date of Birth (MM/DD/YYYY)**
Patient Signature	**Date**

If the patient lacks capacity or is a minor, signature of the parent, guardian, or authorized legal representative is required:

Representative Name ***(Print)***	**Relationship/Authority to Sign**
Representative Signature	**Date**