



CONSENT FOR HEMODIALYSIS

I hereby authorize the performance of the procedure of Hemodialysis upon _____, under the direction of Dr. _____
Name of Patient

I have been fully informed by Dr. _____, M.D., of the surgical and medical procedures involved, and the problems and risks attendant thereto necessary to maintain my life in the treatment of my condition, which is chronic kidney failure. I recognize that as with most medical treatment, there are alternative methods of treatment, but I understand that hemodialysis is the most likely to be beneficial in the present circumstances.

This consent is for regular and repeated hemodialysis treatments and for all additional services deemed reasonable and necessary by my physician(s), for the optimal management of my kidney failure or any complications of the hemodialysis procedures.

I understand that the hemodialysis treatment may involve administration of local anesthetic, insertion of needles into the vascular access, administration of medications and intravenous fluids, which includes by-products of blood. The complications from such procedures may include blood loss, infection, sensitivity reaction and heart failure.

Print Name

Signature of Patient
Or, Parent/Legal Guardian

Witness

Date Signed

LIST OF PATIENT RIGHTS

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The dialysis unit has adopted the following list of patient rights and in accordance with Federal Law CFR (494.70).

1. The patient has the right to be treated with respect, dignity, and recognition of his or her individuality and personal needs, and sensitivity to his or her psychological needs and ability to cope with ESRD.
2. The patient has the right to receive all information in a way that he or she can understand.
3. The patient has the right to privacy and confidentiality in all aspects of treatment.
4. The patient has the right to privacy and confidentiality in personal medical records.
5. The patient has the right to be informed about and participate, if desired, in all aspects of his or her care, and be informed of the right to refuse treatment, to discontinue treatment, and to refuse to participate in experimental treatment.
6. The patient has the right to be informed about his or her right to execute advance directives, and the facility's policy regarding advance directives.
7. The patient has the right to be informed about all treatment modalities and settings, including but not limited to, transplantation, home dialysis modalities (home hemodialysis, intermittent peritoneal dialysis, continuous ambulatory peritoneal dialysis, continuous cycling peritoneal), and in-facility hemodialysis. The patient has the right to receive resource information for modalities not offered by the facility, including information about alternative scheduling options for working patients.
8. The patient has the right to be informed of facility policies regarding patient care, including, but not limited to, isolation of patients.
9. The patient has the right to be informed of facility policies regarding the reuse of dialysis supplies, including hemodialyzers.
10. The patient has the right to be informed by the physician, nurse practitioner, clinic nurse specialist, or physician's assistant treating the patient for ESRD of his or her own medical status as documented in the patient's medical record, unless the medical record contains a documented contraindication.



LIST OF PATIENT RIGHTS

- 11. The patient has the right to be informed of services available in the facility and charges for services not covered under Medicare.
- 12. The patient has the right to receive the necessary service outlined in the patient plan of care.
- 13. The patient has the right to be informed of the rules and expectations of the facility regarding patient conduct and responsibilities.
- 14. The patient has the right to be informed of the facility’s internal grievance process.
- 15. The patient has the right to be informed of external grievance mechanisms and processes, including how to contact the ESRD Network and the State survey agency.
- 16. The patient has the right to be informed of his or her right to file internal grievances or external grievances or both without reprisal or denial of services.
- 17. The patient has the right to be informed that she or he may file internal or external grievances, personally, anonymously or through a representative or the patient’s choosing.
- 18. The patient has the right to be informed regarding the facility’s policies for transfer, routine or involuntary discharge, and discontinuation of services to patients.
- 19. The patient has the right to receive a written notice 30 days in advance of an involuntary discharge except in the case of a patient who makes severe and immediate threats to the health and safety of others.

Print Name

Signature of Patient
Or, Parent /Legal Guardian

Date Signed



PATIENT GRIEVANCE PROCEDURE

All patients of this facility have the right to have their grievances handled promptly and courteously.

A grievance is a request for an investigation of a complaint about a possible risk to the health, safety, or well-being of a patient; or a situation where the patient is unnecessarily at high risk. The grievance is to provide an opportunity for discussion and possible resolution of problem(s) between patients and providers of care.

There is a "Suggestion/Grievance Box" located on the counter in the lobby, with forms available. These may be signed or filed anonymously. All suggestions/grievances will be handled promptly and with a goal of resolution.

The staff member to whom the patient's complaint is verbalized will report the grievance to the Charge Nurse. If a solution to the grievance is not reached through this discussion, the Charge Nurse will notify the Clinical Manager, who will discuss the grievance with the patient and take appropriate action toward the solution, if possible. The Social Worker will be utilized as appropriate.

If the patient's grievance cannot be resolved by the Clinical Manager, the Medical Director will be alerted. He, will meet with the patient and discuss the grievance with the patient and take appropriate action toward resolution, if possible.

If any patient or family members are not satisfied with the outcome or do not wish to use the facility procedure, the patient can contact ESRD Network 18 or the California Department of Health Service for assistance at the addresses below. Both organizations monitor care

Every patient has the right to file a grievance without restraint or interference, and without fear of discrimination or reprisal.

Southern CA Renal Disease Council
ESRD Network 18
6255 Sunset Blvd., Suite 2211
Los Angeles, CA 90028
(323) 962-2020
(800) 637-4767

Department of Health Services
Licensing and Certification Division
Riverside District Office
625 East Carnegie Dr., Suite 280
San Bernardino, CA 92408
(909) 388-7170
(888) 354-9203

Print Name

Signature of Patient

Date Signed

Or, Parent/Legal Guardian

DIALYSIS CENTER RULES & PATIENT RESPONSIBILITIES

Page 1 of 2

Welcome to the Dialysis Center. In an attempt to provide safe and good quality care to all patients equally, we have established the following dialysis center rules and patient responsibilities:

1. The dialysis center schedules patients for treatment within certain hours. We request patients arrive for their scheduled treatment 15 minutes prior to their scheduled time. Patients will remain in the lobby until they are called-in to the clinic by a staff member. Please refrain from walking into the clinic until called as staff members are caring for others who require their attention. The staff makes every effort to have all patients receive their treatments as scheduled, however please be respectful of staff and other patients when treatment times are delayed due to unforeseen circumstances.
2. It is the patient's responsibility to be on time for their scheduled treatment. If the patient is late for dialysis, their dialysis treatment may be shortened, as it may interfere with the other patients scheduled treatments. Patients need to inform the clinic if they will not be arriving for their scheduled treatment or need to make schedule changes.
3. Patients who request to travel to other units on a temporary basis are required to provide advance notice to the Social Worker allowing time for arrangements to be made. We recommend 30-day notice as many units request updated vaccinations, lab work, etc., prior to placement. In addition, we must know the return date to this facility. If there is to be a delay or change in your scheduled return, please notify the unit as soon as possible. If appropriate notice is not given, your regular scheduled treatment time may not be available.
4. An attempt will be made to have patients be seated at the same chair and pod on a regular basis, however due to staffing issues and various individual treatment schedules, your chair may be changed from treatment-to-treatment.
5. An attempt will be made to schedule patients at their preferred shift and time. If the preferred time is not available you will be placed on a waiting list for that time slot. Scheduling must take into consideration the needs of all the patients in the unit, therefore, the patient might not always receive the dialysis schedule of their choice.
6. Eating within the dialysis center is not recommended and should be at the discretion of your physician. Visitors are not allowed to eat in the treatment area.
7. This is a no-smoking facility, which includes the outside premises of the facility.

DIALYSIS CENTER RULES & PATIENT RESPONSIBILITIES

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8. Disruptive or unruly behavior in the dialysis center, on the part of a patient or visitor is unacceptable. Any patient who demonstrates this type of behavior may have their dialysis treatment terminated at that time and requested to leave the unit. Patients who continue to disrupt the proper functioning of the unit may be involuntarily discharged according to the facility policy. Visitors will be requested to leave the facility and may be requested to not return.
9. Visitors will not be allowed in the unit while patients are being placed-on or taken-off dialysis. Visitors are expected to remain with the patient and not wander throughout the clinic, respecting the privacy of other patients. Visitation is controlled by the Charge Nurse on duty. Children under the age of 14 will not be permitted in the dialysis unit.
10. Patients will apply for Medicare, Medi-Cal or other insurance programs when appropriate and to maintain coverage to the best of their ability.
11. To achieve maximum well-being, patients will notify their physician and medical staff of their medical history and any medical changes, including changes in medication.
12. Patients will acknowledge that failure to comply with the Nephrologists' prescribed treatment times and schedule, medications, diet, and fluid restrictions and other physician's orders may result in declining health, hospitalization and possibly death.

I have read and agree to comply with the above dialysis center rules and regulations.

Print Name

Signature of Patient
Or, Parent/Legal Guardian

Date Signed

PATIENT STANDARD OF CONDUCT AGREEMENT

Upon entering the unit, each patient shall have the Patient Standards of Conduct explained to him/her. A statement signed by the patient stating that he/she has read, or has had read to him/her, the Patient Standard of Conduct Agreement, and that he/she agrees to abide by these standards, shall be placed into the patient's chart. The standards are as follows:

1. Patients will treat other patients and staff members, with respect, dignity and consideration.
2. Patients will respect the rights of other patients to have a safe, clean, calm, adequate treatment and treatment environment.
3. Patients will assure that their activities or that of their visitor's activities do not interfere with facility operations.
4. Patients will use the facility's grievance procedure to voice concerns or complaints.
5. Patients will refrain from any form of verbal abuse, physical abuse, or sexual harassment of other patients, staff or visitors.
6. Patients will arrive on time for their scheduled treatment and remain on dialysis for the treatment time prescribed.
7. Patients will inform the facility if they are going to be late, or need to be rescheduled, with the understanding that being late, may cause a patient not to receive their full treatment.
8. Patients will cooperate with the staff member assigned to provide their care. Patients will understand that they cannot require specific staff members to care for them. If a patient is uncomfortable with a specific staff member assigned to their care, they will make the Charge Nurse aware of the concern(s).
9. Patients will refrain from operating the dialysis equipment, removing or manipulating their needles unless they have been trained and have permission to do so.
10. Patients will arrive at the unit free of the influence of illegal drugs, alcohol and without a weapon. Patients also agree to refrain from having them in their possession while on the premises of the unit.
11. Patients will agree to observe the law and understand that the consequences for breaking the law apply to their conduct at the facility.

As stated above, patients are expected to abide by these standards of conduct. If a patient behaves in a manner not consistent with the standards of the unit, the Facility Head Nurse, Social Worker, Physician, Administrator, as applicable, will discuss the negative behaviors and /or actions with the patient. Should the behavior continue and be detrimental to the proper functioning of the unit; the patient may be involuntarily discharged from the dialysis facility. The facility staff will follow the Involuntary Discharge regulations set forth by Federal law CFR §494.180 (f).



The Agreement reads as follows:

The Patient Standards of Conduct has been read and fully explained to me. I agree to abide by these standards at all times while registered as a patient at the clinic: _____.

Print Name

Signature of Patient
Or, Parent/Legal Guardian

Date Signed

Signature of Staff



Authorization To Release Medical Information and Payment Benefits

Patient Name: _____

____ I authorize the clinic _____ to release medical information which the insurance company may request concerning my illness or injury.

____ I authorize payment of medical benefits to be made directly to the clinic _____ for insurance claims submitted on my behalf. I further understand that I am financially responsible to clinic _____ for charges not covered by this assignment.

A copy of the authorization shall be considered as valid as the original.

Print Name

Signature of Patient
Or, Parent/Legal Guardian

Date Signed



Authorization To Release Information to Other Family

I, _____ authorize

___ Kidney Institute of the Desert
81-715 Dr. Carreon Blvd., Suite B-2, Indio, CA 92201

___ La Quinta Kidney Center
43576 Washington Street, Suite 101, La Quinta, CA 92253

___ Kidney Institute at Eisenhower Medical Center
39000 Bob Hope Dr., Probst Building, Suite 103, Rancho Mirage, CA 92270

___ Coachella Kidney Institute
1413 6th Street, Coachella, CA 92236

To release information to and to exchange information with
the following family member(s) or other(s):

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

I understand that purpose of the release/exchange of information is to
coordinate my dialysis treatment and to increase family/other
understanding of the dialysis treatment process.

Print Name

Signature of Patient
Or, Parent /Legal Guardian

Date Signed



Authorization To Release Medical Information

The undersigned does hereby authorize the release of information

To: _____

From: _____

For Patient: _____

Signature of Patient: _____

Date: _____ This authorization is good for up to one year.

Please send the following reports:

- History and Physical
- Discharge Summary
- EKG-reports
- All x-Ray Reports
- Operation Reports
- All Consults
- Most Recent Lab Results
- Social Worker Assessment
- Nutrition Assessment
- Other _____

THANK YOU
