PATIENT PARTICIPATION PLAN

(Disease/Health Condition Management)

To: _____ From: _____ _____
Doctor Name Patient Name HMO Name / Patient ID #

Disease/Condition (Check all that apply)

___	Arthritis	___	Asthma	___	Cancer	___	Depression
___	Diabetes	___	Heart Disease	___	Lung Disease	___	MS/Parkinson's
___	Osteoporosis	___	Pain Control	___	Pregnancy/Childbirth	___	Stroke

Other_____

Patient Rights Statement

Patients have the right to participate in their healthcare. This includes the right to receive information so that they can accept, refuse or request diagnoses & treatments that may or may not be recommended.

Patient Responsibility Statement

I am taking responsibility with my physician partner to participate in diagnosis and treatment decision-making and request his/her advocacy in the following areas:

--Access to All Medical Records
--Diagnostic Plans & Procedures
--Treatment Plans & Procedures
--Benefits/Risks of Diagnosis/Treatment Options
--Treatment Protocols (inc. experimental)
--Provider Qualifications inc. Disciplinary Actions
--Consulting Providers (Plan and Non-Plan)
--Disclosure of Body Donation & Parts Disposition
--Timing/Location of Subsequent Appointments
--Drug Therapy inc. Risk Disclosure
--Access to Disease Management Guidance
--Informed Consent Agreement(s)
--Disclosure of Experimental Protocols & Studies
--Emergency/Urgent Care Access
--Disclosure of Medical Errors
--Disclosure of Genetic Risk Profiling
--Protection of Human Research Subjects
--Patient Advocacy – Patient Rights Enforcement

By taking responsibility, I require that my physician partner, and any other person or entity that affects my health care, recognize my rights and act to fully inform and assist me in their enforcement through my or my agent's active participation in every medical decision.

Patient Satisfaction Statement

My HMO says that high quality service to patients is an important goal for doctors and other health care providers. The diagnosis and treatment that I choose will have an effect on my life. Therefore, the best medicine for me combines my doctor's medical expertise with my personal values.

Patient Rights Enforcement

I have the right to know and use patient satisfaction resources including but not limited to patient assistance, grievance and appeals procedures, etc., that can help me answer questions and resolve problems. I can make complaints **without fear of retaliation or threats** that my care will be adversely affected. I have the right to dispute resolution methods including but not limited to internal and external review, arbitration and/or lawsuits.

INSTRUCTION TO DOCTOR: PLEASE INCLUDE THIS DOCUMENT AS PART OF MY OFFICIAL MEDICAL RECORD.

_____ _____ _____ _____
Patient or Agent Signature Date Address Telephone