



# Patient Rights

## Kansas

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# Welcome to Freeman Health System

As a patient, you have many options for your health care needs, and we sincerely thank you for choosing Freeman Health System. We are dedicated to respecting your dignity and honoring your preferences regarding medical care while upholding the highest standards of treatment.

Our team is committed to providing exceptional care to every patient. If there's anything we can do to assist you during your stay, please don't hesitate to reach out. In Joplin, call 417.347.4940, in Neosho, call 417.347.4300, and in Ft Scott, call 620.768.0388.

Kind regards,



Matthew W. Fry  
President and Chief Executive Officer

*Our mission is to improve the health of the communities we serve through contemporary, innovative, quality healthcare solutions.*

## **FREEMAN WEST**

Full-Service General Acute Care  
1102 W. 32nd St.  
Joplin, MO 64804  
417.347.1111

## **FREEMAN NEOSHO**

General Acute Care  
113 W. Hickory St.  
Neosho, MO 64850  
417.451.1234

## **OZARK CENTER**

Behavioral Health Services  
1105 E. 32nd St.  
Joplin, MO 64804  
417.347.7600

## **FREEMAN EAST**

Outpatient and Post-Acute  
Care Behavioral Health Services  
932 E. 34th St.  
Joplin, MO 64804  
417.347.1111

## **FREEMAN FORT SCOTT**

General Acute Care  
401 Woodland Hills Blvd  
Fort Scott, KS 66701  
620.768.0388



Health System

[freemanhealth.com](http://freemanhealth.com)

# *Exercise of Patient Rights*

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Per CMS Condition of Participation (42 CFR §482.13) and Kansas Administrative Regulation §28-52, patients receiving care at Freeman Health System have the following rights:

## **Non-Discrimination and Respect**

- Right to receive hospital services without discrimination based on race, color, religion, sex, national origin, or source of payment.
- Right to respectful and dignified care provided by competent personnel.

## **Safety and Protection**

- Right to receive care in a safe and secure environment.
- Right to be free from all forms of abuse, neglect, or harassment.
- Right to be free from restraint or seclusion unless necessary to ensure immediate physical safety. Such measures must never be used for coercion, discipline, convenience, or retaliation and must be discontinued as soon as possible.

## **Privacy and Confidentiality**

- Right to personal privacy during all aspects of care.
- Right to confidentiality of clinical records.
- Right to access information in clinical records within a reasonable time frame.
- Right for the patient or legally designated representative to access medical records, in accordance with state law.
  - Areas within the facility may be under video surveillance for security purposes.

## **Communication and Language Access**

- Right to receive communication in a language understood by the patient.
- Right to free access to translation and interpretation services, telecommunications devices, and other tools to facilitate communication with health care personnel.

## **Participation in Care**

- Right to participate in the development and implementation of the plan of care.
- Right for a representative/support person (as permitted by state law) to make informed decisions regarding care.
- Right to be informed of health status, involved in care planning and treatment decisions, and to request or refuse treatment.
- Right to give or withhold consent for treatment.
- Right to be fully informed of and to consent or refuse participation in experimental or research activities without compromising access to care.
- Right to be informed of the right to have pain managed effectively.
- Right to formulate advance directives and have them honored by hospital staff and practitioners.

## **Admission and Visitation**

- Right to have a family member, representative of choice, and personal physician notified promptly upon admission.
- Right to be informed of visitation rights and to designate visitors of their choosing, regardless of relationship status.
- Right to withdraw visitation consent at any time.
- Right to have a support person identified to make visitation decisions for incapacitated patients

## Discharge and Transfer

- Right to request, or have a representative request, a discharge planning evaluation.
- Except in emergencies, right to be transferred to another facility only after receiving a full explanation, arrangements for continued care, and acceptance by the receiving institution.

## Financial Transparency

- Right to examine and receive a detailed explanation of the bill.
- Right to access the cost of services rendered, itemized, when possible, within a reasonable time frame.
- Right to be informed of the source of the hospital's reimbursement and any limitations that may affect care.

## Provider Information & Grievances

- Right to know the professional status and names of individuals responsible for and providing care.
- Right to be informed of any proposed changes in the professional staff responsible for care.
- Right to assistance in obtaining a consultation with another physician or practitioner at the patient's request and expense.
- Right to be informed of the process for filing a grievance and who to contact.

## Concerns or Questions

It is the policy of Freeman Health System that our patients are informed of their rights and given the opportunity to present their concerns. If you have a concern, you may voice it to your care provider or nurse to help enhance your health care experience.

If you wish to file a grievance, you may contact any of the following by phone, fax, or in person:

For any Freeman patient seeking care at any Freeman facility:

### **Freeman Patient Relations**

1102 W 32nd Street, Joplin, MO 64804

Phone: 417.347.4940 Fax: 417.347.3610

Text Telephone (TTY) Number: 800.735.2966 Voice: 866.735.2460

For Freeman Fort Scott-affiliated patients:

### **Freeman Fort Scott Facility Administrator**

401 Woodland Hills Blvd, Fort Scott, KS 66701

Phone: 620.768.0389

Fax: 417.347.0370

For Freeman Pittsburg Surgery Center-affiliated patients:

### **Freeman Surgical Center of Pittsburg Facility Administrator**

100 N. Pine Street, Pittsburg, KS 66762

Phone: 620.231.9072

Fax: 417.347.1713

Grievances will be addressed by a Patient Relations member within seven (7) business days of receipt from the patient or hospital personnel.

Should you wish to file a complaint with the Department of Health or other quality improvement, accreditation or other certifying bodies, or if you have a concern about patient abuse, neglect, misappropriation of a patient's property in the facility, or other unresolved complaint, patient safety, or quality concern, you may lodge a grievance directly by contacting Kansas Department of Health and Environment (KDHE), Complaint Hotline at 800.842.0078 or for Medicare recipients, you may contact the Office of Medicare Beneficiary Ombudsman at 1.800.MEDICARE (800.633.4227).

## Code Of Conduct

In order to effectively provide medical treatment to you, Freeman Health System requires a commitment by staff, patients, and visitors alike. Mutual trust and respect can help us provide the right treatment plan, in a safe and respectful environment that promotes healing.

Below, we've outlined the code of conduct and expectations for all patients and visitors designed to help make your hospital stay, appointment, or visit successful:

- Patients, visitors, and staff will address each other in a respectful manner.
- Patients, visitors, and staff will respect patient privacy, and Protected Health Information (PHI) and comply with requirements of the Health Insurance Portability and Accountability Act (HIPAA).
- Patients, visitors, and staff will refrain from exhibiting threatening or abusive behavior towards each other. We have a zero tolerance for threatening or abusive behavior.
- Profanity, racial, or cultural slurs or other derogatory remarks toward others of any kind is not tolerated. This includes, but is not limited to; Slurs or remarks targeting another's age race, ethnicity, religion, culture, disability, language, sexuality, or sexual orientation, gender identity, socioeconomic states, marital status, or ancestry.
- Weapons, illegal or dangerous items, alcohol, marijuana, and illicit drug use, as well as possession of related paraphernalia, is forbidden in all areas and campus grounds.
- Patients and visitors are not allowed to record audio, video, or take photos in any clinical area, or in non-clinical areas where staff or patients may be captured, without their explicit consent.
- Patients are encouraged to speak with their providers about their therapeutic care plan.
- This is a smoke-free-campus. Tobacco use is forbidden on campus grounds.

### **The Following Expectations are Also Required of All Hospitalized or Clinic Patients:**

- Patients will remain on the unit for their safety and to facilitate timely care. Being on the unit allows for prompt testing, timely medication administration, and frequent assessment by health care providers. Leaving the unit may be considered leaving against medical advice and could result in your discharge.
- Patients are responsible for providing correct and complete information about their health and past medical history. Patients are responsible for reporting changes in their general health condition, symptoms, or allergies to the responsible caregiver.
- Patients are responsible for assisting in the control of noise in their rooms and complying with system visitation guidelines.
- Patients are expected to attend appointments as scheduled. If you are not able to attend an appointment, you or another person must give ample notice to the department or office in which the visit is scheduled. Freeman Health System may dismiss patients from a specific department or health care provider due to behaviors such as:
  - Repeated missed appointments without proper cancellation, in advance.
  - Failure to follow an agreement related to the use of controlled substance(s) or similar concerns.
  - Failure to follow the care team's treatment plan, a treatment plan is also called a care plan.

A safe and respectful environment is central to promoting a healing environment, therefore, if the above-mentioned expectations are not followed:

**Patients:** If you choose not to comply with your therapeutic care plan or the above expectations, we may discharge you from the hospital or your appointment. For subsequent appointments or admissions, we will follow our standard continuity of care practice and seek to have you cared for by the same care team.

**Visitors:** If you fail to comply with the above expectations, you may be asked to leave campus and may be restricted from future visitation privileges.

Failure to comply with Freeman Health System Code of Conduct for Patient and Visitor Behavior and other applicable rules may result in additional action by Freeman Health System. These additional actions may include, but are not limited to:

- The presence of Freeman Health System Security staff during patient appointments and any other interactions with Freeman Health System staff.
- Involvement of local law enforcement.
- Prosecution for trespassing or criminal behavior, or both.

**NOTICE**  
**Informing Individuals About Nondiscrimination and Accessibility**  
**DISCRIMINATION IS AGAINST THE LAW**

Freeman Health System and their entities comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex (including sexual orientation and gender identity), age, or disability in covered health programs or activities. Freeman Health System does not exclude people or treat them differently because of race, color, national origin, sex (including sexual orientation and gender identity), age, or disability in covered health programs or activities.

Freeman provides free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters via video services and written information in other formats (large print, audio, accessible electronic formats, other formats).

Freeman provides free language services to people whose primary language is not English, such as qualified interpreters via telephone or video services and information written in other languages.

If you need these services, contact an Admissions Representative or your nurse at your local Freeman Health System facility.

If you believe that Freeman Health System has failed to provide these services or discriminated in another way on the basis of race, color, national origin, sex (including sexual orientation and gender identity), age, or disability you can file a grievance with:

Freeman Patient Relations (For any Freeman patient seeking care at any Freeman Facility)  
1102 W 32<sup>nd</sup> Joplin, MO 64804 Phone: 417.347.4940 Fax: 417.347.3610  
Text Telephone (TTY) Number: 800.735.2966 Voice: 866.735.2460

Freeman Fort Scott affiliated patients: Freeman Fort Scott Facility Administrator,  
401 Woodland Hills Blvd., Fort Scott, KS 66701 Phone: 620.768.0389 Fax: 417.347.0370

Freeman Pittsburg Surgery Center affiliated patients: Freeman Surgical Center of Pittsburg  
Facility Administrator, 100 N Pine Street, Pittsburg, KS 66762  
Phone: 620.231.9072 Fax: 417.347.1713

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Freeman staff is available to help you. Grievances will be addressed by a Patient Relations member within seven (7) business days of the receipt from the patient or hospital personnel.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at [ocrportal.hhs.gov/ocr/portal/lobby.jsf](http://ocrportal.hhs.gov/ocr/portal/lobby.jsf), or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 800.368.1019 [Phone], 800.537.7697 [TDD].

# Language Assistance

Language assistance is provided free of charge. Please contact an Admissions representative or nurse if you are in need of language assistance.

## Language Assistance Services for Individuals with Limited English Proficiency

1. **(English)** ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 417-347-1111 (TTY: 1- 800-682-8786).
2. **(Spanish)** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 417-347-1111 (TTY: 1- 800-682-8786).
3. **(Chinese)** 注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 417-347-1111 (TTY: 1- 800-682-8786)。
4. **(Vietnamese)** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 417-347-1111 (TTY: 1- 800-682-8786).
5. **(Serbo-Croatian)** OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 417-347-1111 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1- 800-682-8786).
6. **(German)** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche ilfsdienstleistungen zur Verfügung. Rufnummer: 417-347-1111 (TTY: 1- 800-682-8786).
7. **(Arabic)** مقرب لصتا ,ناجملاب كل رفاوتت ةيوغلا ةدعاسملا تامدخ نإف ,ةغلا ركذا ثدحتت تنك اذا :ةظوحلم  
همصلا مكبلأو: 1- 800-682-8786) مقر (1111)
8. **(Korean)** 주주: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 417-347-1111 (TTY: 1- 800-682-8786)번으로 전화해 주십시오.
9. **(Russian)** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 417-347-1111 (телетайп: 1- 800-682-8786).
10. **(French)** ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 417-347-1111 (ATS: 1- 800-682-8786).
11. **(Tagalog – Filipino)** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 417-347-1111 (TTY: 1- 800-682-8786).
12. **(Pennsylvanian Dutch)** Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 417-347-1111 (TTY: 1- 800-682-8786).
13. **(Persian (Farsi))** امش یارب ناگیار تروصب ینابز تالیهست ,دینک یم وگتفگ یسراف نابز هب رگا :هجوت  
مهارف یم دشاب .اب (417-347-1111 (TTY: 1- 800-682-8786) سامت دیریگب.

14. **(Oromo)** XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 417-347-1111 (TTY: 1- 800-682-8786).
15. **(Portuguese)** ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 417-347-1111 (TTY: 1- 800-682-8786)
16. **(Amharic)** ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገኙዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 417-347-1111 (መስማት ለተሳናቸው፡ 1- 800-682-8786).
17. **(Cherokee)** Hagsesda: iyuhno hyiwoniha [tsalagi gawonihisdi]. Call 417-347-1111 (TTY: 1- 800-682-8786)
18. **(Micronesian-Pohnpeian)** Ni songen mwohmw ohte, komw pahn sohte anahne kawehwe mesen nting me koatoantoal kan ahpw wasa me ntingie [Lokaiahn Pohnpei] komw kalangan oh ntingidieng ni lokaiahn Pohnpei. Call 417-347-1111 (TTY: 1- 800-682-8786).
19. **(Laotian)** ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອອັດຕະໂນອາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 417-347-1111 (TTY: 1- 800-682-8786).
20. **(Japanese)** 注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。417-347-111 (TTY: 1- 800-682-8786) まで、お電話にてご連絡ください。
21. **(Hmong)** LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 417-347-1111 (TTY: 1- 800-682-8786).
22. **(Swahili)** KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 417-347-1111 (TTY: 1- 800-682-8786).
23. **(Thai)** เรียบน: ถ้ าคณพุดภาษาไทยคณสามารถใ้ บริการช วยเหลือทางภาษาได้ ฟรี โทร 417-347-1111 (TTY: 1- 800-682-8786).
24. **(Urdu)** لاك - نيہ بابتسد نيم تغم تامدخ يك ددم يك نابز وك پآ وت ، نيہ ے تلوپ و دراپآ رگا : رادر بخ (TTY: 1- 800-682-8786). ك
25. **(Burmese)** သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 417-347-1111 (TTY: 1-800-682-8786) သို့ ခေါ်ဆိုပါ။

# Advance Medical Directives and Durable Power of Attorney for Health Care

## **Advance Medical Directives: Protecting Your Rights**

Advance medical directives (AMD) safeguard your rights in the event that you become mentally or physically unable to make or communicate decisions about your medical treatment. As a competent adult, you have the right to accept or refuse medical care.

## **What is a Durable Power of Attorney for Healthcare?**

A Durable Power of Attorney for Health Care (DPOA) is a written document in which you designate a person (or persons) to act as your agent or proxy to make health care decisions on your behalf if you become unable to do so. You may also include your wishes regarding organ, bone, or tissue donation for transplantation in the event of your death. To be valid, this document must be signed and either notarized or witnessed:

- In Kansas, your signature must be notarized or witnessed by two individuals.
- In Missouri, your signature must be notarized.

It is Freeman Health System's mission to support a patient's right to participate in making decisions about their health care. Freeman Staff members provide patients and families with information about advanced health care instructions, health care treatment directives, and durable powers of attorney for health care.

## **Notary Service**

This service is only for health care-related documents, such as advanced directives and durable power of attorney for health care.

- An advance directive indicates what should be done if you are no longer able to make decisions.
- A durable power of attorney for health care lets you name a person to make decisions about your health if you cannot make them yourself.
- Please give a copy of your completed directive to your nurse so it can be placed in your medical record. Your wishes cannot be honored until a physical copy is available.
- We will provide you with information to create an advance directive if you don't have one and want one.
- Our policy is to honor your advance directive within the limits of the law and mission of Freeman Health System, with a few exceptions.
- If you have a *Do Not Resuscitate (DNR) Directive*, it will be placed on hold during surgery or procedures.

**Please Note:** Advance medical directives do not take effect while you are still able to communicate your wishes regarding health care treatment. Review your directives regularly and update them as needed. Inform your physician, family, and designated agent of any changes. You may revoke or revise your directive at any time, either orally or in writing. Freeman will honor your wishes as stated in a properly executed document.

**Need Assistance?** If you need assistance in completing this document, you may contact these offices from 8:00 am to 4:30 pm or ask for your nurse.

- **Joplin Hospital Campus:**
  - Freeman Health System, Patient Liaisons 417.347.6677
  - Freeman Health System, Social Services Department 417.347.6614
- **Neosho Hospital Campus:**
  - Freeman Neosho Hospital, Social Services Department 417.347.4304
  - Freeman Neosho Admissions, 417.347.4346
- **Ft Scott Hospital Campus:**
  - Freeman Fort Scott Admissions, 620.768.0391

## ***Transportable Physician Orders for Patient Preference (TPOPP) Kansas-Missouri***

TPOPP is appropriate for patients who have a serious, progressive, and chronic illness and have talked with trusted health care providers about the type of medical care they want as their disease and symptoms worsen. It addresses a person's thoughts on CPR, medical care, and artificial nutrition. The TPOPP form is bright pink, it is signed by a doctor, and directs future medical care. Use of TPOPP is completely voluntary. TPOPP is practical and can be taken it into different healthcare settings such as: hospital, home, hospice, or nursing facility.

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***Important notes: If a physician, nurse, or other health care provider morally feels that he/she cannot follow the wishes expressed in the advance medical directive, and the advance medical directive is within state and federal law, it is the responsibility of the physician and hospital to help the patient find a health care provider, physician, nurse, or hospital that will follow the patient's advance medical directive.***

***Individuals shall not be discriminated against because of their advance medical directive.***

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## **Advance Medical Directive including Durable Power of Attorney for Health Care**

When selecting your health care agent, choose someone who knows you well. It should be someone you trust and who respects your views and values. This person should be able to make difficult decisions under stress. Often family members are good choices, but not always. Choose someone who will closely follow what you want and will be a good advocate for you. Take time to discuss this document and your views with the person(s) you choose to be your health care agent(s).

A health care agent must be at least 18 years old. Your health care agent may not be one of your health care providers, or an employee of your health care provider, unless he or she is a close relative.

This document **does not** give your health care agent authority to:

- Make financial or other business decisions.
- Make certain decisions about your mental health treatment.

### **To complete this advance directive**

This advance directive is divided into three parts:

Part 1 – My health care agent

Part 2 – Statement of desires, care institutions or limits

Part 3 – General Provisions

Follow the instructions in each of the three parts.

## DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND/OR HEALTH CARE DIRECTIVE<sup>1</sup> OF

(Print full name here) \_\_\_\_\_

(Address, City, State, Zip) \_\_\_\_\_

I make this Durable Power of Attorney and/or Healthcare Directive to exercise my right to determine the course of my health care and to provide clear and convincing proof of my treatment decisions when I lack the capacity to make or communicate my decisions. It is my intent that this document to be valid in any jurisdiction in which it is presented. The provisions of this document are separable, so that the invalidity of one or more provisions shall not affect any others.

### PART 1. DURABLE POWER OF ATTORNEY FOR HEALTH CARE

(If you *DO NOT WISH* to name someone to serve as your decision-making Agent, mark an "X" through Part I on pages 1 & 2 and continue on to Part 2.)

#### 1. Selection of Agent.

I, (your name printed) \_\_\_\_\_ **DOB:** \_\_\_\_\_ currently a resident of \_\_\_\_\_ County, \_\_\_\_\_ (State), appoint the following person as my true and lawful attorney-in-fact of

("Agent"): **Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone(s):** 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_

2. **Alternate Agent.** If my Agent resigns or is not able or available to make health care decisions for me, or if an Agent named by me is divorced from me or is my spouse and legally separated from me, I appoint the following persons in the order named below to serve as my alternate Agent and to have the same powers as my Agent:

#### First Alternate Agent:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

#### Second Alternate Agent:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

3. **Durability.** This is a Durable Power of Attorney, and the authority of my Agent, when effective, shall not terminate or be void or voidable if I am or become disabled or incapacitated or in the event of later uncertainty as to whether I am dead or alive.

4. **Effective Date as to Health Care Decision Making.** This Durable Power of Attorney is effective as to health care decision making when I am incapacitated and unable to make and communicate a health care decision as determined by my physician.



5. **Agent's Powers.** I grant to my Agent full authority as to health care decision making to:

- a. Give consent to, prohibit, or withdraw any type of health care, long-term care, hospice or palliative care, medical care, treatment, or procedure, either in my residence or a facility outside of my residence, even if my death may result, including, but not limited to, an out of hospital do-not-resuscitate order, with the following specific authorization (**check one of the following boxes to indicate your choice**):
  - I **wish to AUTHORIZE** my Agent to direct a health care provider to withhold or withdraw artificially supplied nutrition and hydration (including tube feeding of food and water);
  - OR I **DO NOT AUTHORIZE** my Agent to direct a health care provider to withhold or withdraw artificially supplied nutrition and hydration (including tube feeding of food and water);
- b. Make all necessary arrangements for health care services on my behalf and to engage or terminate medical personnel responsible for my care.
- c. Move me into, or out of, any health care or assisted living/residential care facility or my home (even if against medical advice) to obtain compliance with the decisions of my Agent.
- d. Take any other action necessary to do what I authorize here, including, but not limited to, granting any waiver or release from liability required by any health care provider and taking any legal action at the expense of my estate to enforce this Durable Power of Attorney for Health Care.
- e. Receive information regarding my health care, obtain copies of and review my medical records, consent to the disclosure of my medical records, and act as my "personal representative" as defined in the regulations [45 C.F.R.164.502(g)] enacted pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA");

6. **Effective Date as to other Authority.** In addition to the powers set forth above, I authorize effective upon my signature and without the need for a physician's certification of incapacity that my Agent be authorized to have one or more of the following powers (**check your desired choices**):

- Determine what happens to my body after my death (authority for right of sepulcher).
- Give consent after my death to an autopsy or postmortem examination of my remains.
- Delegate health care decision-making power to another person ("Delegee") as selected by my Agent, and the Delegee shall be identified in writing by my Agent.

With respect to **anatomical gifts of my body** or any part (i.e., organs or tissues), please initial your desired choice below:

**AUTHORIZATION OF ANATOMICAL GIFTS.** I wish to **AUTHORIZE** my Agent to make an anatomical gift of my body or part (organ or tissue).

<p><b>My donations are for the following purposes:</b> (check your desired choices):</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Transplantation</li><li><input type="checkbox"/> Therapy</li><li><input type="checkbox"/> Research</li><li><input type="checkbox"/> Education</li><li><input type="checkbox"/> All the above</li></ul>	<p><b>GIFT SPECIFICATIONS:</b> I would like to donate (check your desired choices):</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Any needed organs and tissues, as allowed by law.</li><li><input type="checkbox"/> Any needed organs and tissues as allowed by law, with the following restrictions:</li></ul>
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**PROHIBITION OF ANATOMICAL GIFTS.** I **DO NOT AUTHORIZE** my Agent to make an anatomical gift of my body or any part (organ or tissue)



## PART 2. HEALTH CARE DIRECTIVE

(If you **DO NOT WISH** to make a health care directive but only wish to have an Agent make your decisions without the directive, be sure that you have completed Part 1 on pages 1 & 2, mark an "X" through Part 2 on pages 2 & 3 and continue to Part 3.)

1. I make this HEALTH CARE DIRECTIVE ("Directive") to exercise my right to determine the course of my health care and to provide clear and convincing proof of my choices and instructions about my treatment.
2. If I am persistently unconscious or there is no reasonable expectation of my recovery from a seriously incapacitating or terminal illness or condition, I direct that the life-prolonging procedures that I have initialed below be withheld or withdrawn:
  - a.  **Artificially supplied nutrition and hydration**  
(including tube feeding of food and water)
  - b.  **Antibiotics**
  - c.  **Surgery or other invasive procedures**
  - d.  **All other "life-prolonging" medical or surgical procedures**  
(that are merely intended to keep me alive without reasonable hope of improving my condition or curing my illness or injury)
  - e.  **Heart-lung resuscitation (CPR)**
  - f.  **Dialysis**
  - g.  **Mechanical ventilator (respirator)**
  - h.  **Chemotherapy**
  - i.  **Radiation therapy**
  - j.  **Other procedures specified by me:** \_\_\_\_\_  
(Please describe)
3. However, if my physician believes that any life-prolonging procedure may lead to a recovery significant to me as communicated by me or my Agent to my physician, then I direct my physician to try the treatment for a reasonable period of time. If it does not cause my condition to improve, I direct the treatment to be withdrawn even if it shortens my life. I also direct that I be given medical treatment to relieve pain or to provide comfort, even if such treatment might shorten my life, suppress my appetite or may breathing, or be habit forming.
4. If I have chosen to not have life-prolonging procedures (any and all of the boxes above having been checked), (please check one of the following boxes):  I DO WANT or  I DO NOT want palliative care; hospice care; medication for anxiety, pain, and/or discomfort; ice chips; mouth swabs; and any other measures to keep me comfortable.
5. If I have already consented to be on the applicable State organ and tissue donor registry or my Agent has authorized the donation of my organs or tissues, I realize it may be necessary to maintain my body artificially after my death until my organs or tissues can be removed.

**IF I HAVE NOT DESIGNATED AN AGENT IN THE DURABLE POWER OF ATTORNEY, PART II OF THIS DOCUMENT IS MEANT TO BE IN FULL FORCE AND EFFECT AS MY HEALTH CARE DIRECTIVE**

## PART 3. GENERAL PROVISIONS INCLUDED IN THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND HEALTH CARE DIRECTIVE

1. **Relationship Between Durable Power of Attorney for Health Care and Health Care Directive.** If I have executed both the Durable Power of Attorney for Health Care and Health Care Directive, I encourage my Agent to:
  - a. First, follow my choices as expressed in the above Directive or otherwise from knowing me or having had various discussions with me about making decisions regarding life-prolonging procedures.
  - b. Second, if my Agent does not know my choices for the specific decision at hand, but my Agent has evidence of my preferences, my Agent can determine how I would decide. My Agent should consider my values, religious beliefs, past decisions, and past statements. The aim is to choose as I would choose, *even if it is not what my Agent would choose for himself or herself.*





# PATIENT SAFETY

During your stay at Freeman Health System, we'll strive to give you the best possible care.



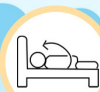
## BE CAREFUL NOT TO FALL

Call a nurse before attempting to get out of bed. Get up slowly and wear non-skid socks, slippers, or other slip-resistant footwear. Clear an obstacle-free path that gives you plenty of room to move freely.



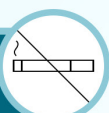
## WASH YOUR HANDS

Clean hands help lower the risk of infection. Your visitors and those who care for you at home should also wash their hands or use hand sanitizer often.



## PROTECT YOUR SKIN

To prevent bedsores, safely adjust your position in bed frequently, and move as much as you're safely able to do so. Check your skin each day, and keep it as clean and dry as possible.



## DON'T SMOKE

Non-smoker patients recover more quickly. If you smoke, ask your doctor for help with quitting. This is a great time to quit!



## GET MOVING

Ask your nurse how soon you can safely get out of bed. While lying down, move your legs and ankles, and ask your doctor about devices that keep blood flowing through your legs and feet.



## TAKE YOUR MEDICATION

It's important to take your medication exactly as your doctor has instructed. Be mindful of side effects, and speak up if you experience any adverse effects or reactions.



## SPEAK UP IF YOU'RE IN PAIN

Let someone know if you're experiencing pain or side effects from medication. Pay close attention to how you feel, and let us know.

# Freeman Health System Financial Assistance Program

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The Freeman Health System Financial Assistance Program exists to provide eligible patients with partially or fully discounted emergent or medically necessary care. Patients seeking financial assistance must apply for the program.

## **ELIGIBILITY:**

Freeman offers financial assistance for eligible patients receiving emergent or medically necessary care at Freeman hospitals or clinics. Services must be billed by Freeman to qualify. Some external services, such as pathology, may be eligible—patients should contact those providers directly.

To qualify, patients must have received eligible services, submitted a completed Financial Assistance Application with all required documentation, and been approved by Freeman.

## **HOW TO APPLY:**

Patients may download the Financial Assistance Application at [freemanhealth.com](http://freemanhealth.com), where the form is editable. Applicants can enter their personal information, save the completed form to their device, and email it—along with all required documentation—to our Eligibility Partners at [freemanfinancialassistance@freemanhealth.com](mailto:freemanfinancialassistance@freemanhealth.com).

Alternatively, you may request an application at any main registration desk within Freeman hospitals or clinics. Applications are also available in person at the Freeman Patient Accounts Department, located at 3220 McClelland Boulevard, Joplin, Missouri. You may contact the department by phone at 417.347.6686 or submit a written request.

If mailing, send the completed application with all documentation and information specified in the instructions to: Freeman Health System: **Patient Accounts** 1102 W. 32nd St. Joplin, MO 64804

## **DETERMINATION OF FINANCIAL ASSISTANCE ELIGIBILITY:**

Patients may qualify for financial assistance. Discounts are offered for financial assistance up to 100 percent, for those who qualify. Please find application and current financial assistance policy on our hospital website.

Freeman reviews completed applications in accordance with its Financial Assistance Policy. Incomplete applications will not be processed, but applicants will be notified and given a chance to provide missing information.

## **Need help? Have questions?**

For questions about *Price Transparency*, requesting a *Good Faith Estimate*, or understanding protections under the *No Surprises Billing Act*, please visit [freemanhealth.com](http://freemanhealth.com).

You may also contact Freeman Patient Accounts at 417.347.6686, Monday through Friday, 8:00 am to 4:30 pm, to speak with an account representative.