



NOTICE OF REFERRAL RIGHTS AND ACKNOWLEDGMENT

THIS NOTICE DESCRIBES YOUR REFERRAL RIGHTS WHEN YOUR HEALTH CARE PROVIDER REFERS YOU TO ANOTHER PROVIDER OR FACILITY FOR ADDITIONAL TESTING OR HEALTH CARE SERVICES.

In accordance with Oregon law, when you are referred for care outside or within our clinic, Northwest Rheumatology Associates, is required to notify you that you may have the test or service done at a facility other than the one recommended by your physician or health care provider.

Oregon law says (ORS 441.098):

- A referral for a diagnostic test or health care treatment or service shall be based on the patient's clinical needs and personal health choices.
- A health practitioner shall not deny, limit or withdraw a referral solely because the patient chooses to have the diagnostic test or health care treatment or service at a facility other than the one recommended by the health practitioner.
- A health practitioner or the practitioner's designee shall provide notice of patient choice at the time the patient establishes care with the practitioner and at the time the referral is communicated to the patient.
- The oral or written notice of patient choice shall clearly inform the patient:
 - (a) That when referred, a patient has a choice about where to receive services; and
 - (b) Where the patient can access more information about patient choice.
- The patient has a choice and when referred to a facility for a diagnostic test or health care treatment or service the patient may receive the diagnostic test or health care treatment or service at a facility other than the one recommended by the health practitioner;
- If the patient chooses to have the diagnostic test, health care treatment or service at a facility different from the one recommended by a practitioner, the patient is responsible for determining the extent of coverage or the limitation on coverage for the diagnostic test, health care treatment or service at the facility chosen by the patient.

By signing below, I acknowledge that I have read and understand my referral rights as outlined above.

_____	_____	_____
Patient Signature	Date	DOB

-OR-

_____	_____
Parent, Guardian, Responsible Party, Legal Representative Signature	Date

Description of Representative's Authority	