BSMH Patient Agreement

This agreement cannot be modified. Any handwritten changes shall not be legally binding or enforceable.

This BSMH Patient Agreement ("Agreement") applies to services rendered at or through all Bon Secours Mercy Health, Inc.-owned or affiliated entities in the United States, including hospitals, physician and provider offices, ambulatory surgery centers, laboratories, telehealth programs, clinics, urgent care centers, freestanding emergency departments, imaging centers and other health care facilities (together, "BSMH"). A list of those entities is located at https://www.bonsecours.com/patient-resources/your-privacy-and-hipaa and at https://www.mercy.com/patient-resources/your-privacy-and-hipaa and each may be updated from time to time.

Consent to Medical Examination, Care & Treatment; Telehealth: I acknowledge that I am seeking medical care, a health care screening and/or other appropriate treatment to be rendered through one or more health care providers employed by or affiliated with BSMH. I voluntarily consent to and authorize the following, as applicable: (i) a physical and/or mental examination to be provided via an in-person visit or via Telehealth (as described herein); (ii) administration of diagnostic procedures; (iii) rendering of medical care and treatment; (iv) laboratory testing; (v) toxicology screening; (vi) radiological procedures; (vii) ordering and/or administration of medications; (viii) follow-up care; (ix) education on my health condition; and (x) all other related care and treatment, as is deemed necessary and advisable by my health care provider(s) (together, "Care"). I understand that there are risks of injury from Care. I understand that the practice of medicine is not an exact science, and that no guarantees have been made to me about the results or outcomes of my Care. I understand that it is my duty to disclose to my provider(s) truthful, accurate and complete information, including all details of healthcare services that I have received or may be receiving from other healthcare providers outside of the Care. I understand that I may request additional information regarding any recommended Care and that BSMH, or health care providers with BSMH, may require additional written consent from me for more complex Care, such as surgery. I understand that BSMH may adopt modified operations during a period of crisis or emergency made necessary by a pervasive (such as a pandemic) or catastrophic (such as a hurricane or tornado) disaster.

I understand that I may receive Care from BSMH on an in-person basis or through an electronic virtual platform that is generally referred to as "Telehealth." Telehealth involves the delivery of Care using electronic communications, information technology and/or other means (such as a wearable monitor) between a health care provider and a patient who are not located in the same place at the time Care is being provided. I understand that I have a right to be informed of all parties present and to request information regarding my provider's credentials, including training, licensure, location and contact information. I understand that a limitation inherent in a Telehealth visit is that my provider(s) will be unable to physically examine me which can limit the type and extent of Care that can be provided by me over the Telehealth visit. I **understand that Telehealth is not intended for emergency medical care and that if I am experiencing a medical emergency, I should go to the nearest hospital emergency department or call 911**. I understand that my provider may contact 911 if I experience a medical emergency during a Telehealth visit.

I understand that in the case of Care provided in-person and/or via Telehealth, while there are benefits, there are also some risks, including, but not limited to: (a) my health care provider may advise me to seek urgent or emergency care services; (b) my health care provider may determine I need to be examined in person and may recommend – possibly after consulting with another clinician – that I may need to seek Care from a specialist or other healthcare provider; (c) my health care provider may be able to provide preliminary diagnose and treatment; however, to complete a diagnosis, I may be advised to obtain follow up Care, including an in-person visit; and (d) given regulatory requirements in certain jurisdictions, my health care provider's ability to prescribe certain Care options (e.g., certain controlled substance prescriptions) may be limited, particularly if I am receiving Care via Telehealth. I acknowledge that the electronic systems or other security protocols or safeguards used in Care, including Telehealth, could fail, which could expose my health and/or other personal information to unauthorized individuals, even if BSMH uses HIPAA-compliant, secure technology platform(s). I understand that, duing a Telehealth visit, my connection with my Provider could disconnect and we may have to re-engage in the encounter in the same manner that we first connected electronically (e.g., via video conference). If I am unable to re-connect, I should contact the provider's office to re-schedule the visit. I understand that I have the option to sign up for the MyChart patient portal to contact my provider. I understand my Telehealth visit will not be recorded without my express consent. I understand that I can opt out of a Telehealth visit in favor of an in-person visit and that I may request information regarding my Telehealth provider's credentials, training and qualifications.

Medical Education Programs: I acknowledge that among those who attend to my Care at BSMH may be health care personnel who are currently in professional education or training programs, including: medical students, physician residents, nursing students, etc. All students and resident physicians are supervised by licensed and trained health care providers, as appropriate, and I consent to Care provided by them. Unless otherwise requested by me, these students and resident physicians may be present and participate in my Care as a part of their education or training.

Affiliated Providers/Independent Contractors/Non-Employed Providers: I understand that many of the health care providers with BSMH, possibly including my attending and/or consulting physicians, are not employees or agents of BSMH but, rather, are independent contractors who have been granted the privilege of using one or more BSMH locations for the Care of patients. I understand that the actions or inactions of any health care provider who is not an agent or employee of BSMH is not directed or controlled by BSMH and that BSMH relies upon such health care provider(s) to use appropriate professional judgment in providing Care to me at BSMH. I agree that BSMH is not responsible for the acts or omissions of any health care provider who is not an agent or employee of BSMH.

Affiliated Provider Fees: I understand that BSMH's hospital and facility charges for my Care may not include the fees of health care providers who provided Care to me but who are not agents or employees of BSMH. I understand that I may receive a separate bill for my Care directly from such provider(s), including but not limited to, emergency department physicians, radiologists, pathologists, anesthesiologists, hospitalists, other specialists, etc. I understand that the level of insurance benefits payable for Care by health care providers who are not agents or employees of BSMH may be different from the level of insurance benefits payable for Care rendered through BSMH.

Left Without Being Seen; Non-Compliance with Care Plan: If I leave BSMH before a health care provider with BSMH has seen me or discharged me, or if I refuse to comply with my prescribed plan of care, I agree that I assume the full responsibility for this action and hold BSMH, its employees, and agents separately and individually harmless from any and all liability or harm as a direct or indirect result of my failure to be treated, my refusal to comply, and/or my departure from BSMH, and I will waive any and all rights and causes of action that I may now have or later acquire against BSMH, its employees, and agents as a direct or indirect result of any of the foregoing.

Uses/Access/Disclosure of My Health Information: I authorize BSMH, its duly authorized agents and affiliates to use and to disclose my individually identifiable information, including information about my Care, with other health care providers and facilities, both at BSMH and outside BSMH, who are involved in my Care, including for the purpose of coordinating my Care. I authorize BSMH to release my individually identifiable information, including information about my Care located in my BSMH-designated medical record about Care provided to me by BSMH and providers outside BSMH, and other financial and demographic information as required to obtain payment from my insurance or other payer(s) and their agents. I have been provided and/or offered a copy of the BSMH Notice of Privacy Practices which may be updated from time to time on BSMH's websites. I understand that this Notice of Privacy Practices outlines additional, authorized uses and disclosures of my health information by BSMH, as well as my rights to obtain my health information and to further restrict its use or disclosure.

Photography & Video Recordings: I consent to have my photograph taken by BSMH for purposes of confirming identification and for the treatment, payment and health care operations of BSMH. I understand that my Care at BSMH may include obtaining, using, and disclosing photographs, videos, and/or making audio recordings of me for Care-oriented purposes and/or for the health care operations of BSMH, including quality assurance, clinical documentation, education, or other purposes permitted by applicable law. To the extent that any such photography, video, and/or audio recording is included in my BSMH-designated medical record, I understand that BSMH will treat it as protected health information consistent with applicable law. *Notwithstanding the foregoing, I understand that I have the option at any time to decline to be photographed or videoed.*

Communications: I authorize BSMH, its agents and contractors (e.g., a billing company) to communicate with me directly by phone or by e-mail, text message and/or other forms of electronic communication that may be encrypted (together, "Electronic Messaging"). I understand that these authorized individuals will communicate with me using the phone number(s) and email(s) that I provide to BSMH. *Notwithstanding the foregoing, I understand that, at any time, I can direct BSMH to discontinue any or all Electronic Messaging by communicating my preferences to BSMH*. I further understand that withdrawing this authorization will not cause me to lose any benefits or rights to which I am otherwise entitled, including but not limited to, continued Care, payment options, enrollment or eligibility for programs/benefits offered by BSMH, etc.

I understand that authorized individuals may use Electronic Messaging to communicate with me regarding a wide range of healthcare-related issues, including: reminders of appointments; actions for me to take before an appointment; follow-ups from appointments; notices about preventive services, Care options, coordination of my Care and other available health care services; how to participate in patient satisfaction surveys; how to use BSMH's secure patient portal (MyChart); information regarding insurance, billing, eligibility for programs/benefits and account balances, etc. I understand that BSMH may use automatic dialers or pre-recorded voice messages when it communicates with me through Electronic Messaging.

I understand that BSMH cannot guarantee, but will use reasonable means to maintain, the security and confidentiality of Electronic Messaging. I consent to the use of Electronic Messaging upon the following conditions: (1) **IN A MEDICAL EMERGENCY, DO NOT USE ELECTRONIC MESSAGING, CALL 911**; (2) Urgent messages or needs should be relayed to BSMH by telephone call; (3) Non-urgent messages or needs should be relayed to BSMH by telephone call or BSMH's secure patient portal, MyChart; (4) Electronic Messaging may be made a part of my BSMH-designated medical record; (5) BSMH, its employees, and agents are not liable to me for any breach of confidentiality caused by me or any third party; and (6) I am solely responsible for any charges or other fees incurred under my agreement with my Electronic Messaging service provider (e.g., per minute, per message, per unit-of-data-received basis, etc.).

In consideration of BSMH's services and my authorization to receive Electronic Messaging as described in this Agreement, I release BSMH, its employees and agents from any and all claims resulting directly or indirectly from the Electronic Messaging, including any claims based on any alleged violation of applicable law (including the Telephone Consumer Protection Act, the Truth in Caller ID Act, the CAN-SPAM Act, the Fair Debt Collection Practices Act, the Fair Credit Reporting Act, the Health Insurance Portability and Accountability Act, any similar state and local acts or statutes, any federal or state tort or consumer protection laws, etc.).

Responsibility for Payment; Emergency Care: I understand that a list of BSMH's usual and customary charges for its health care services is available to me upon request. If I choose to pay for certain of these services out-of-pocket (i.e., self-pay) for the purpose of exercising my right to limit disclosure of my health information to my health insurer regarding those services, I understand that a separate financial agreement will be required regarding the self-pay services.

If I present to a BSMH emergency department seeking, or in need of, emergency medical treatment, I understand that screening and stabilizing treatment for any emergency medical condition will not be delayed or conditioned upon my ability to pay, method of payment, or my coverage status.

I understand that I am responsible for any amounts due for my Care that are not paid by my health insurer or any other applicable insurance plan, policy, or third party. Such amounts due may include, but are not limited to, deductibles, copays, and coinsurance amounts provided under any coverage source, charges for which there is no coverage source, etc. I understand and agree that I am ultimately responsible for any cost of my Care that is not covered by my insurance or other third party. I understand that my health care insurer may not provide the same benefits for in-person care that are provided for Telehealth visits and, in such a situation, I am fully responsible for payment, including all applicable co-pays, for Care provided via Telehealth. I understand that I am responsible for any unpaid balances due, plus the reasonable costs of collections, including any attorney fees and court costs associated with collecting an unpaid portion of the bill.

Financial Agreements; Insurers & Third-Party Payers; Assignment of Benefits; Authorized Representative; Agent: If applicable, I certify that any information given by me in applying for payment under the Medicare or Medicaid Programs is correct. I assign to BSMH all rights to benefits, covered payments, insurance reimbursements or other payments to which I may be entitled for Care provided to me at BSMH. I authorize BSMH to bill my insurance or any other responsible party(ies) and assign the payment of these benefits directly to BSMH.

I assign all rights to benefits, insurance payments, insurance reimbursements or other payments or judgments to which I may be entitled for hospital-based physician Care (pathology, radiology, cardiology, etc.) and emergency department Care to the physician or organization providing the professional Care. I also authorize submission of a bill(s) for professional Care provided to me through BSMH to my insurance or any other responsible party(ies) for payment.

I authorize and designate BSMH (including any third parties who perform retrospective reviews, denial and audit work) as my authorized agent(s) and designated representative(s) with the power to act on my behalf with respect to all matters related to all of my rights, benefits, privileges, protections, claims, causes of action, interests or recovery arising out of any coverage source, including but not limited to, the ability to request reconsideration and/or appeal payment decisions made by any group health plan, employee benefits plan, health insurance plan, any other applicable insurance plan or utilization review entity for coverage or grievance review (the "Plan"), etc. This includes, without limitation, the authority and right to: file medical claims with the Plan; file appeals and grievances with the Plan; request verification of coverage or pre-certification or authorization; file pre-service and post-service claims; request any and all information and documents under which the Plan is established or operated; request any and all policies, procedures and guidelines and protocols considered by the Plan in connection with the benefit claim determination; and to institute any alternative dispute proceedings, litigation and/or complaints against the Plan naming me as the plaintiff in such proceedings if necessary. I further designate and authorize BSMH to the fullest extent permissible under law the right and ability to act as my representative with respect to any ERISA-

governed benefit plans as provided in federal regulations with respect to any healthcare expense incurred as a result of the Care I received at BSMH. This authorization is applicable in the same manner as the other grants of authority conveyed within this paragraph, but I recognize they may be brought pursuant to federal ERISA regulations and case law. Similar to the provision in this paragraph, I recognize BSMH may assert any rights I may have under the plan even to name me as a plaintiff in an action against the plan. I understand I can revoke this authorization in writing at any time.

I acknowledge that BSMH reserves the right to file a lien where appropriate and permitted by applicable law.

I understand that if BSMH is not in contract with my plan or other coverage, there will likely be a balance due to me that is in excess of any co-pays, co-insurance or deductibles. I also agree that any attempt by a benefits coverage source to preclude BSMH from the ability to appeal a claim, to prevent balance billing if allowable by applicable law, or to disallow BSMH's right to take action by assignment, will not be acknowledged.

Although I previously acknowledged that BSMH reserves the right to receive payment from all applicable sources, I specifically authorize BSMH to pursue any and all applicable insurance(s) covering motor vehicle accidents as well as workers' compensation claims, and I agree to cooperate with BSMH by providing information and by completing any form(s) that BSMH may ask me to execute from time to time.

Finally, I understand that a health care provider with BSMH may order services, testing, items, or other Care that require pre-approval from my insurer or third-party payer before I receive such services, testing, items, and/or other Care. I agree to cooperate, aid and assist BSMH in obtaining all such approvals and possible insurance or other benefits for such services, testing, items, and/or Care (e.g., completing an application for insurance, providing timely information as requested, etc.).

Credit Balance Transfer: When a non-governmental credit balance exists on a BSMH account in an amount not exceeding $10.00, I agree that BSMH may adjust that balance to zero without investigation for overpayment, or improper/excess payment made to a practice/provider as a result of patient billing, or claims processing errors.

Pharmacy Benefit Programs: I understand that if I cannot afford medication prescribed to me during my Care at BSMH, or if that medication is not covered by my insurance, BSMH may be able to obtain reimbursement for certain medications through one or more Patient Assistance Programs sponsored by drug manufacturers. To qualify for the Program(s), it may be necessary to provide information regarding my financial status, illness, and/or treatment to the drug manufacturer sponsoring the Program(s). All information associated with these Programs will remain confidential and will only be provided to drug manufacturers in compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable law. My signature on this form authorizes BSMH and its authorized representatives to complete any necessary application forms. I release any claim to the medication I may receive as a result of my participation in the Program(s) and give my permission for any medication to be repackaged. This authorization shall remain in full force from the date signed, below, until I revoke it or until I no longer belong to any Programs, whichever occurs earlier.

BSMH Packet of Patient Information: I understand that BSMH offers Financial Assistance to those that meet certain eligibility criteria outlined in BSMH's Healthcare Financial Assistance ("HFA") Policy and that a copy of the Plain Language Summary of BSMH's HFA Policy is available upon request. I confirm that I am aware of the HFA Policy and that a copy of the Plain Language Summary has been offered to me. I agree that if I make an application for this Financial Assistance, BSMH is permitted to request, use, and disclose information as necessary to determine whether I am eligible for Financial Assistance.

I agree to comply with all guidelines, policies and procedures I may receive from BSMH at the time of my Care. I understand that information on BSMH's HFA Policy and its Plain Language Summary enumerate certain rights afforded to me as a patient and are consistent with the BSMH Code of Conduct. I acknowledge that BSMH has made available to me those notices that are required by State or Federal law, including Patient Rights & Responsibilities documentation, and I understand that I may ask BSMH any questions about such notices.

Responsibility for Valuables/Personal Property: I understand and agree that BSMH is not responsible for safeguarding my personal property or any other personal item. I agree to waive any and all rights and causes of action that I may now have or later acquire against BSMH, its employees, and agents as a direct or indirect result of any loss, theft, or damage to such property or item, including: jewelry, clothing, money, hearing aids, glasses, dentures, dental work, electronics, vehicles, etc. BSMH recommends that I leave my valuables at home or with a family member or friend.

Statement of Non-Discrimination: BSMH complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, ethnicity, religion, sex or sexual identification, national origin, sexual orientation, age, ancestry, disability, veteran era status, or any person with HIV infection, whether asymptomatic or symptomatic, or AIDS, in any other manner prohibited by applicable State or Federal law, or in the treatment of patients. BSMH does not exclude people or treat them differently because of race, color, ethnicity, religion, sex, national origin, sexual orientation, age, ancestry, disability, veteran era status, or any person with HIV infection, whether asymptomatic or symptomatic, or AIDS, or in any other manner prohibited by applicable State or Federal law.

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BY SIGNING BELOW, I CONFIRM ALL THE FOLLOWING: I have read this Agreement or have had it effectively communicated to me; any questions I may have had about this Agreement have been asked and answered to my satisfaction; I acknowledge that a separate consent or agreement may be required prior to receiving certain Care with BSMH; I understand and accept all the terms and conditions of this Agreement; I am the patient or his/her duly authorized personal representative; and I am signing this Agreement voluntarily.

_____	**OR**	_____
Signature of Patient		Signature of Personal Representative
Date & Time: _____		Date & Time: _____
_____		_____
Patient Printed Name		Personal Representative Printed Name

PLAIN LANGUAGE SUMMARY OF HEALTHCARE FINANCIAL ASSISTANCE POLICY

Overview

In with the light of its mission to improve the health of its communities, with special emphasis on the poor and underserved, and in the spirit of the healing ministry of Jesus, Bon Secours Mercy Health is committed to providing financial assistance to its patients. This is a summary of the Bon Secours Mercy Health Healthcare Financial Assistance (HFA) Policy.

Availability of Financial Assistance

Eligibility for financial assistance is determined by the ability of the patient or his/her guarantor to pay after all available resources have been utilized and all available assistance programs have been assessed. Financial assistance is available for emergency and other medically necessary care provided by Bon Secours Mercy Health hospitals (and certain other providers) to uninsured and underinsured patients who live in the community served by a Bon Secours Mercy Health hospital, and whose family income does not exceed four times the Federal Poverty Guidelines (FPG).

Eligibility Requirements

Financial assistance is generally determined by a sliding scale of total household income based on the FPG. Individuals eligible for financial assistance under our Policy with an income level at 200% FPG or below receive free care. Individuals with an income level from 201% to 300% FPG, and 301% to 400% FPG, respectively, receive discounted care based on a sliding scale, as set forth in the Policy. The specific percentage discounts for the 201%-300% FPG, and 301% to 400% FPG, income levels are updated annually for each market commensurate with changes in the charge master.

No person eligible for financial assistance under the HFA policy will be charged more for emergency or other medically necessary care than amounts generally billed to individuals who have insurance covering such care. If an individual has sufficient insurance coverage or assets available to pay for care, he/she may be deemed ineligible for financial assistance. For those uninsured patients who do not qualify for any of the financial assistance discounts described in the HFA policy, Bon Secours Mercy Health extends an automatic (selfpay) discount to their hospital bills. Please refer to the full HFA Policy for a complete explanation.

About the Application Process

The process for applying for financial assistance under our HFA Policy includes these steps:

- Complete the HFA Application Form and include required supporting documents.
    - We look at your income and family size to determine the level of assistance available to you. We use a sliding scale, based on FPG outlined above.
    - We require that you must first explore eligibility for some type of insurance benefits that would cover your care (i.e. worker's compensation, automobile insurance, etc.) We can help direct you to the appropriate resources.
- We will contact you to tell you whether you are eligible for financial assistance under our HFA Policy.
- We can help you arrange a payment plan for any remaining charges or bills that are not covered under our HFA Policy.
    - A payment plan will consider your financial situation to set payments that you can manage.

Where to Obtain Information

You may obtain a copy of our HFA Policy and the HFA Application Form, as well as information about the financial assistance application process: (i) by visiting our website at www.bsmhealth.org/financial-assistance, www.mercy.com/financial-assistance, and www.fa.bonsecours.com, (ii) by contacting Bon Secours Mercy Health Patient Financial Services by telephone at 1-877-918-5400, (iii) by mailing a request to Bon Secours Mercy Health, 11511 Reed Hartmann Highway, Blue Ash, OH 45241, Attn: Financial Counseling, or (iv) by contacting our financial counselors in person at any of our hospital locations (see the full HFA Policy for a complete listing of facilities and addresses).

We accommodate all significant populations served by Bon Secours Mercy Health that have limited proficiency in English by translating copies of our HFA Policy, Application Form, and this Summary in the primary languages spoken by those populations. We may also elect to furnish translation aids, translation guides, or provide assistance through use of qualified bilingual interpreters.

Patient initials **OR** Authorized representative initials: _____

Language Interpreters

Bon Secours Mercy Health, Inc. ("BSMH") provides free aids and services to people with disabilities to communicate effectively with us such as:

- Qualified sign language interpreters
- Written information in other formats (large print, Braille, audio, accessible electronic formats, other formats)

You can contact the person at the registration desk to receive information on how to obtain the free aids and services for persons with disabilities or access the interpretation services.

All patients have access to interpretation services 24/7 at no personal cost to them.

- يتمتع جميع المرضى بإمكانية الوصول إلى خدمات الترجمة الفورية على مدار الساعة طوال أيام الأسبوع من دون فرض أي تكلفة شخصية عليهم. (Arabic)
- 所有患者都可以 24/7 全天候获得口译服务，无需支付任何个人费用。 (Simplified Chinese)
- تمام مریضان به خدمات ترجمه 24 ساعته 7 روز هفته بدون هیچ مصرف شخصی دسترسی دارند. (Dari)
- Tous les patients ont gratuitement accès à des services d'interprétation disponibles 24 heures sur 24, 7 jours sur 7. (French)
- બધા દર્દીઓને કોઈ વ્યક્તિગત ખર્ચ વગર 24/7 દુભાષિયા સેવાઓની સુલભતા હોય છે. (Gujarati)
- Tout pasyan yo gen aksè pou jwenn sèvis entèprèt 24/7 san li pap koute yo anyen. (Haitian Creole)
- सभी रोगियों के लिए बिना किसी व्यक्तिगत खर्च के अनुवाद सेवाएँ 24/7 उपलब्ध हैं। (Hindi)
- គ្រប់អ្នកជំងឺទាំងអស់មានសិទ្ធិទទួលបានសេវាបកប្រែផ្ទាល់មាត់ 24/7 ដោយឥតគិតថ្លៃ។ (Khmer)
- 모든 환자는 개인 비용 부담 없이 24시간 연중무휴로 통역 서비스를 이용하실 수 있습니다. (Korean)
- सबै बिरामीहरूसँग अनुवाद सेवाहरूमा 24/7 निःशुल्क पहुँच छ। (Nepali)
- ټول ناروغان 24/7 پرته له کوم شخصي لګښت څخه د ژباړې خدمتونو ته لاسرسی لري. (Pashto)
- Todos os pacientes têm acesso aos serviços de interpretação 24 horas por dia, sete dias por semana, sem nenhum custo pessoal a eles. (Brazilian Portuguese)
- ਸਾਰੇ ਮਰੀਜ਼ਾਂ ਦੀ ਉਹਨਾਂ ਲਈ ਕਿਸੇ ਨਿੱਜੀ ਖਰਚੇ ਤੋਂ ਬਿਨਾਂ ਅਨੁਵਾਦ ਸੇਵਾਵਾਂ ਤਕ 24/7 ਪਹੁੰਚ ਹੁੰਦੀ ਹੈ। (Punjabi)
- Toți pacienții au acces gratuit la servicii de interpretare non-stop. (Romanian)
- Все пациенты имеют бесплатный доступ к услугам переводчика круглосуточно и без выходных. (Russian)
- Todos los pacientes tienen acceso a los servicios de interpretación las 24 horas del día, los 7 días de la semana, sin ningún costo personal para ellos. (Spanish)
- Tất cả bệnh nhân đều được hỗ trợ dịch vụ thông dịch 24/7 mà không mất phí. (Vietnamese)

Complaints and Grievances

If you believe BSMH has failed to provide these services or discriminated in another way on the basis listed above, you can file a grievance. BSMH can provide a copy upon request of its grievance filing procedures and contact information for individual(s) who can assist in filing and addressing the grievance.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office of Civil Rights electronically through the Office of Civil Rights Complaint Portal, available at https://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 509 F, HHH Bldg, Washington DC 20201 [1-800-368-1019 or 1-800-537-7697 {TDD}].