5.01.13.06 PATIENT CONSENT, RIGHTS AND RESPONSIBILITIES

- **I hereby consent to physical therapy treatment.**
- **I authorize mutual exchange of information** between Stanwood Camano Physical Therapy, LLC, (SCPT), referring health care providers, and insurance carriers concerning my injury/condition and treatments.
- **I assign all payments to SCPT, LLC** for physical therapy services rendered to myself, or my dependents.
- **I understand that I am responsible for checking with my insurance provider** to confirm specific terms of physical therapy coverage. SCPT may call my insurance provider to confirm that I have coverage, but SCPT cannot guarantee that the information SCPT receives is accurate or complete. _____ ***Patient Initials***
- **I accept responsibility for my co-payment, co-insurance, any services applied to my deductible, services not covered by my insurance policy, and for any services I choose not to submit to my insurance plan.** I also understand, as a result of these charges, I am responsible to pay these fees in a timely manner and failure to do so will result in a 12% per annum interest fee on all amounts more than 30 days overdue. I also understand that failure to make substantial payments on my account for more than 90 days will result in me being sent to collections. _____ ***Patient Initials***
- **I understand that co-pays are due at the time of service** unless other arrangements are made.
- **Any visit for physical therapy treatment without any insurance benefit is payable at the time of service.**
- I give my consent to the use of video and photographic imaging of activities that I participate in at SCPT, LLC. I understand that some activities may include video and/or photographic recordings. The images are to be under the exclusive ownership of SCPT, LLC and used only for educational and marketing purposes as they relate to SCPT, LLC. I understand that there is no compensation for the generated images.
- **Cancellation Policy: Patients are responsible for making scheduled appointments**. There will be a $40.00 charge for NO SHOWS and for appointments not cancelled 8 hours prior to scheduled appointment and will be due at the time of next scheduled appointment. Failure to comply may result in early discharge from physical therapy. I understand this is a patient responsibility and is not billed to insurance. _____ ***Patient Initials***
- **I understand I have certain responsibilities as a patient.**
  - I understand I have the responsibility to provide the SCPT Business Office with current, updated medical insurance information, and pertinent business and billing information as requested.
  - I understand I have the responsibility to stay current on any patient payment responsibilities, and to work with the Business Office on any payments options.
  - I understand I have the responsibility to attend physical therapy sessions as scheduled, and to be courteous of other patients and their scheduled appointments.
  - I understand I have the responsibility to work with my therapist, and to help build an appropriate treatment plan that will meet quality health goals.
  - I understand that participation in the routines may require me to engage in many vigorous physical activities. I am voluntarily participating in these activities with the knowledge that there are possible risks involved. I hereby assume all risks and hazards incidental to such participation and agree to accept any and all risks of injury and/or death as a result of my participation in these routines.
  - I understand that it is not possible to guarantee or give assurance of a successful outcome.
- **I understand I have certain rights as a patient.**
  - I have the right to seek treatment with SCPT, LLC, and to be scheduled for an appointment in a timely manner.
  - I have the right to be treated with respect and dignity, and every attempt will be made to protect my modesty.
  - I have the right to have any clinic scheduling policies and procedures explained to me, including any possible patient payment responsibilities.
  - I have the right to request a copy of my billing, both insurance billing and patient responsibility.
  - I have the right to view my medical records, and to request copies of my medical records, as provided by state law.
  - I have the right to participate in the planning of my treatment, and to have the consequences of treatment, and alternative therapy choices explained to me. I also have the right to end treatment.
  - I have the right to discuss complaints, and to complete a Patient Satisfaction Survey at any time during my treatment and upon discharge.
  - I understand I may have other rights and responsibilities as allowed by State and Federal Law.

By signing below, I have read, agree with, understand, and comply with the above statements and have received a copy of the privacy policy.

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Patient Signature or Legal Guardian/Parent Signature (if minor under 18 years of age) **Date**