STANWOOD CAMANO
Physical Therapy
Movements to Live By

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, PLLC, (SCPT), referring health care providers, and insurance carriers concerning my injury/condition and treatments.
- **I assign all payments to SCPT**, P**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, PLLC. I understand that some activities may include video and/or photographic recordings. The images are to be under the exclusive ownership of SCPT, PLLC and used only for educational and marketing purposes as they relate to SCPT, PLLC. I understand that there is no compensation for the generated images.
- **Cancellation Policy: Patients are responsible for making scheduled appointments**. There will be a $80.00 charge for NO SHOWS and for appointments not cancelled 24 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, PLLC, 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.

_____ _____

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