



# Preferred Physical Therapy

*Our mission is to heal. Our passion is to care*

## Patient Rights & Responsibilities

### **Cancellation/No show Policy:**

When cancelling an appointment due to scheduling conflicts, we ask for a minimum of 24 hours notice. Failure to provide a 24 hour notice or not showing for a scheduled appointment will result in a \$50 fee.

### **Medical Records Release:**

This will authorize Preferred Physical Therapy to release any general, medical, as well as psychiatric/psychological, drug/alcohol, and HIV testing information from my health records per patient's request.

### **Third Party liability:**

Preferred Physical Therapy does not believe that a liability case against a third party is reason to delay payment of services. I agree that payment for services rendered is not contingent upon any settlement, judgment, or verdict of which they may eventually recover as a result of such liability cases. I agree to be ultimately responsible for payment in full for all services rendered.

### **Circumstantial Risk**

I have been made aware of the possible benefits, effects, and possible risk or complications associated with my care. I agree to accept the treatment prescribed to me and recognize that I am free to seek other opinions relating to my health.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare Providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of this Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

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

Signature of Patient or Responsible Party: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_