



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 understand that copays 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 **\$25.00 charge for NO SHOWS** and for appointments not cancelled 8 hours prior to scheduled appointment. 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 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.

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

 Date