Patients' Rights and Responsibilities

I understand that I will be responsible for payment of services from Stone Ridge Physical therapy should my insurance carrier deny payment.

I hereby consent to receive any appropriate medical services from Stone Ridge Physical Therapy as allowed by their licensure in the State of New York.

I authorization the release of any medical information required to process a claim. Additionally, I authorize payment of benefits to this provider of physical therapy services.

Rights:

1) Receive considerate and respectful care in a clean and safe environment.
2) Receive complete information about your diagnosis, treatment and prognosis.
3) Refuse treatment and be told what effect this may have on your health.
4) Participate in all decisions about your treatment.
5) Review your medical record without charge.
6) Obtain a copy of your medical record for which a reasonable fee can be charged.
7) Receive an itemized bill and explanation of charges.

Responsibilities:

1) Provide complete and accurate information about your health and insurance coverage.
2) Provide complete and accurate information about response to treatments.
3) Participate in the development of your treatment plan.
4) Participate in activities prescribed in your treatment plan.
5) Regular and prompt attendance.

Please be aware that if two (2) consecutive therapy sessions are missed without notice, we will assume that you are not returning for treatment and you will be discharged from therapy.

If you are discharged from therapy, a new physician referral (prescription) is required to resume services.

Cancellation/No-Show Policy:
In order to be respectful of the medical needs of all of our patients, please be courteous and call our office promptly if you are not able to attend an appointment. If it is necessary to cancel your appointment, we require that you call 24 hours in advance. To cancel an appointment you may call 687-8806. If you miss an appointment or cancel late you will be considered a "no-show" and be charged a $20 NO-SHOW FEE. (This is not covered by your insurance company.)

Patient Signature: _____ Date: _____
Parent/Legal Guardian

Print Name_____