

**Patient Bill of Rights & Responsibilities**

**In recognition of our responsibility in rendering patient care, these rights and responsibilities are affirmed in the policies and procedures of Three Rivers Therapy Services, LLC**

**Patient Rights**

* To receive services without regard to race, color, age, gender, sexual orientation, religion, marital   status, handicap, national origin or sponsor.
* To be provided reasonable physical access.
* To be provided a safe environment.
* To be provided with appropriate privacy.
* To be treated with respect, consideration and dignity.
* To expect that all disclosures, communications, and records are treated confidentially, except when required by law, and to be given the opportunity to approve or refuse their release.
* To be provided, to the degree known, complete information concerning their diagnosis, treatment and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient to be a legally authorized person.
* To be given the opportunity to participate in decisions involving their health care, except when participation is contraindicated for medical reasons.
* To receive from his/her physician information necessary to give informed consent prior to the start of any procedure and/or treatment, except in emergencies. Such information for informed consent should include the specific procedure and/or treatment, significant medical risks involved, and the probable duration of incapacitation. Where significant alternatives for medical care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information and the consequences of not complying with therapy.
* To know the names and professional status of individuals providing service to you and to know the physician primarily responsible for your care.
* To have the appropriate assessment and management of pain
* To be informed, when appropriate, of the treatment policy for minors not accompanied by an adult.
* To refuse treatment and be informed of consequences of refusing treatment or not complying with therapy.
* To be informed as to:
  + Expected conduct and responsibilities as a patient
  + Services available from the facility
  + Provisions for after hours and emergency care
  + Fees for services
  + Payment policies
  + Right to refuse participation in investigational studies or clinical trials
  + Methods for expressing grievance and suggestions to the facility without threat of discrimination or reprisal
  + Disclosure of ownership
* To be informed of their rights to change primary or specialty physicians if other qualified physicians are available.
* To be provided with methods of effective communication.
* To review his/her medical record and to have the information explained or interpreted as necessary, except when restricted by law.

**Patient Responsibilities**

* To demonstrate behavior that shows respect and consideration for other patients, family, visitors, all health care personnel and property of Three Rivers Therapy Services, LLC.
* To provide accurate and complete information about your health history, demographics and insurance information.
* To ask questions and seek clarification until you fully understand.
* To accept the consequences of your actions if you should refuse a treatment or procedure, or if you do not follow the plan of care given to you by the physician or other health care providers.
* To keep appointments, cancel appointments, and notify Three Rivers Therapy Services, LLC of these changes.
* To assure that the financial obligations for health care rendered are paid.
* To notify Three Rivers Therapy Services, LLC of any changes in your medical condition, health history, demographics, and insurance information.
* To be responsible for your valuables that you bring to Three Rivers Therapy Services, LLC.
* To provide positive and negative feedback in a constructive and appropriate manner about the care you have received at Three Rivers Therapy Services, LLC.

I have reviewed and understand my rights as a patient of Three Rivers Therapy Services, LLC.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_