Ruthe B. Cowl Rehabilitation Center

Patient's Responsibilities

Please help us by honoring your responsibilities as a patient:

I, _____ agree to:

1. Report changes in health condition to the therapist. (Ask questions to better comprehend the contemplated course of action and what is expected of you as a patient.)

2. Follow the plan of care recommended by the physician, therapist, and therapy staff. (Please keep your re-evaluation appointments as these are necessary to continue with the patient's treatment and must be approved each 30 days by your referring physician. If you miss this appointment, further treatments will not be provided until the re-evaluation appointment has been completed.)

3. Fullfill my financial obligations for health care services received as promptly as possible.

4. Be considerate of other patients & therapy personnel by attending the scheduled appointment(s) on time. (Patients arriving **15 minutes** or more late will be rescheduled to avoid interference with other patients scheduled appointments.)

5. Show up on the scheduled date. (If you forget when you are scheduled for an appointment, please feel free to call the Center and if patient misses 3 appointments/no shows, patient will be discharged.)

6. Report or phone in cancellations or late attendance to the Center. (Patients must give 24 hour advanced warning of any cancellation. Patients NOT calling will be charged a $10.00 fee for No Shows)

7. Follow Rehabilitation facility rules and regulations affecting his/her case and conduct. (This includes no cell phone, cameras, picture taking and/or personal music player usage during therapy sessions.)

8. Provide accurate and complete information about present complaints, past illnesses, hospitalization, medications, and other matters relating to the patient's health. (Patients must provide accurate and correct information at time of admission and during their treatment plan at the Center.)

9. ALL Guns, Knives, or Weapons are prohibited on these premises.

_____
Executive Director

_____ _____
Patient Signature **Date**

_____
Witness