PATIENT BILL OF RIGHTS POLICIES

The following is a list of policies and information that is made available to each patient before beginning any therapy program at Saguaro Rehabilitation and Aquatic Therapy. This document is available upon request and is posted in the lobby as well. If you have questions or concerns, please let us know.

As a prospective patient I am initialing the policies below, therefore certifying that I have read the information and understand their meaning as to the care I will receive at this facility. I realize that some of the policies may not pertain to me personally but are carried out for all patients for whom these policies may apply.

_____(int) Disclosure of Ownership and Business Information

_____(int) Patient Bill of Rights Policy

_____(int) Non-Discrimination Policy

_____(int) Access to Services for Persons with Impaired Hearing, Vision, or Speech

_____(int) Program Accessibility for Persons with Physical Handicaps

_____(int) Communication Policy for Patients with Limited English Proficiency Policy

_____(int) HIPAA Regulations (Health Insurance Portability and Accountability Act of 1996)

Advanced Healthcare Directive Rights:

_____(int) Yes, I have an Advanced Healthcare Directive, (Living Will and/or Healthcare Power of Attorney)

Contact Name: _____ Phone: _____

_____(int) No, I do not have an Advanced Healthcare Directive. Regardless of my condition,

I want my life to be Prolonged to the Greatest Extent Possible, within the limits of "Generally Accepted Healthcare Standards"

Consent To Release Medical Records

I authorize Saguaro Rehabilitation and Aquatic Therapy, LLC to use and disclose my personal health information for the purposes of treatment, payment, and health care operations, as defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and outlined in the Saguaro Rehabilitation and Aquatic Therapy "Notice of Privacy Practices". I understand that I can request a copy of those privacy practices at any time. I acknowledge that this Consent is valid for a period of 180 days, unless revoked with written notice.

Signature of Patient or Authorized Representative: _____

If other than patient, state relationship and authority to sign: _____

Date:_____

Witness Signature: _____