A picture containing logo

Description automatically generated **PRO-HEALTH SERVICES**

**PATIENT RIGHTS AND** **RESPONSIBILITIES**

**Patient Rights:**

1. I have the right to expect quality medical care.

2. I have the right to receive my test results in a timely manner with the responsibility to communicate with the office if I have not received them within 2 weeks of being performed. I understand the test results will be communicated to me electronically through the patient portal.

3. I have the right to have my medical care explained to me in a manner that I understand.

4. I have the right to be seen for medical services offered at this office. However, I might not be a candidate for the desired treatment. If I am under the age of 18, I will not be seen without written permission of my parent or legal guardian. If I am under the age 16, I cannot be left unaccompanied in the office.

5. I have the right to request a copy of my medical records. I must first sign a written release to receive this and there might be a charge for this service. However, I also understand that I have access to my medical records through [www.yourhealthfile.com](http://www.yourhealthfile.com), I should activate my portal account as soon as possible, and from the portal I can download my records and forward them to any third party of my choosing at no charge.

6. I have the right to privacy of my medical information and my care will not be discussed with anyone unless I have given written permission for this.

7. I have the right to be treated with dignity and respect.

8. I have the right to be notified and refuse if a visiting trainee or student wishes to participate in my care.

**Patient Responsibilities:**

1. I understand that payment is expected in full at the time of service. In the event I have an outstanding balance, no further appointments or services will be offered until this balance is paid in full.

2. Cash, VISA, Mastercard, Discover and American Express are the accepted forms of payment. CareCredit is accepted for pre-paid medical weight loss programs and non-invasive aesthetic procedures only. CHECKS ARE NOT ACCEPTED.

3. I understand 24 hours advanced notice is requested if I am unable to keep my appointment. Although some things do come up with short notice, if I do not give the office adequate notice, the office might not be able to offer my appointment time to another patient needing medical services. As a result, the office reserves the right to charge me $25.00-$75.00 for a missed appointment without sufficient prior notice.

4. I agree that for any professional liability claim I will follow binding arbitration. I realize that this may help decrease the cost of medical care in Ohio. By doing so, I am doing my part to help lower medical costs.

5. I understand that I am responsible for my health, complying with my treatment and asking questions when appropriate.

6. I understand that for my physician/physician assistant to best serve me, I should call during business hours. Otherwise, the physician/physician assistant is unable to review my chart to advise me. In addition, I understand medications will only be refilled during normal business hours and prior authorizations will only be done when the office is open.

7. I understand that once services are rendered, refunds are not available. Any refund prior to services being rendered will be at the sole discretion of management.

I acknowledge my rights and responsibilities and agree to fulfill my responsibilities.

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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