Dream team PROSTHETICS

PATIENT BILL OF RIGHTS

As an individual receiving prosthetic patient care services from Dream Team Prosthetics LLC, let it be known and understood that you have the following rights:

1. To select those who provide you prosthetic services.
2. To be provided with legitimate identification by any person or persons who enters your residence to provide home care services to you.
3. To receive the appropriate or prescribed service in a professional manner without discrimination relative to your age, sex, race, religion, ethnic origin, sexual preference or physical or mental impairment.
4. To be dealt with and treated with friendliness, courtesy and respect by each and ever individual representing our Company who provides treatment or services for you, and to be free from neglect or abuse be it physical or mental.
5. To assist in the development and planning of your health care program that is designed to satisfy, as best as possible, your current needs.
6. To be provided with adequate information from which you can give your informed consent for the commencement of service, the continuation of service, the transfer of service to another health care provider, or the termination of service.
7. To express concerns or grievances or recommend modifications to your home care service without fear of discrimination or reprisal.
8. To request and receive complete and up-to-date information relative to your condition, treatment, alternative treatments, or risks of treatment.
9. To receive treatment and services within the scope of your health care plan, promptly and professionally, while being fully informed as to our company's policies, procedures and charges.
10. To refuse treatment, within the boundaries set by law, and receive professional information relative to the ramifications or consequences that will or may result due to such refusal.
11. To request and receive data regarding treatment or services or costs thereof privately and with confidentiality.
12. To request and receive the opportunity to examine or review your medical records.

I have received and understand the rights afforded me as a patient of Dream Team Prosthetics LLC.

Patient Signature:_____ Date: ____/____/____

Patient Name (print):_____

Signature on behalf of patient:_____

Print Name:_____ Relationship to patient_____

Prosthetist Signature:_____ Date: ____/____/____