

**BREAKTHROUGH THERAPY SERVICES, INC.**  
STATEMENT OF PATIENTS RIGHTS AND RESPONSIBILITIES

**As a patient have the right to:**

1. Be given information about your rights and responsibilities for receiving outpatient therapy services.
2. Receive a timely response from Breakthrough Therapy Services, Inc. regarding your request for outpatient therapy services.
3. Be given information of Breakthrough Therapy Services, Inc. policies, procedures, and charges for services.
4. Choose your therapy providers.
5. Be given appropriate and professional quality therapy services without discrimination against your race, creed, color, religion, sex, national origin, sexual preference, handicap, or age.
6. Be treated with courtesy and respect by all who provide therapy services to you.
7. Be free from physical and mental abuse and/or neglect.
8. Be given proper identification by name and title of everyone who provides therapy services to you.
9. Be given necessary information so you will be able you give informed consent for your treatment prior to the start of any treatment.
10. Be given complete and current information concerning your diagnosis, treatment, alternatives, risks and prognosis as required by your physician's legal duty to disclose, in terms and language you can reasonably be expected to understand.
11. A plan of care that will be developed to meet your unique health care needs.
12. Participate in the development of your plan of care.
13. Be given an assessment and update of your plan of care.
14. Be given data and privacy and confidentiality.
15. Review your clinical record at your request with prior notice and physician's order.
16. Be given information regarding anticipated transfer of your care to another health care provider and/or termination of your therapy services to you.
17. Voice grievance with and/or suggest change in your therapy services and /or therapists without being threatened, restrained, and discriminated against.
18. Refuse treatment with the confines of the law.
19. Be given information concerning the consequences of your refusing treatment.

**As a patient you have the responsibility to:**

1. Give accurate and complete health information concerning your past illnesses, hospitalization, medications, allergies, and other pertinent items.
2. Inform Breakthrough Therapy Services, Inc., of any and all changes in insurance information, including group policy number, identification number, phone numbers, addresses, etc., as soon as possible.
3. Honor all appointment times. If your child is sick please call us to cancel their session 24 hours in advance. Three no shows/cancels will result in your child's scheduled appointment time to be cancelled.
4. Arrive on time.
5. Assist in developing and maintaining a safe environment.
6. Participate in the development and update of your health care plan and home program.
7. Adhere to your developed/updated health care plan and home program.
8. Request further information concerning anything you do not understand.
9. Give information regarding concerns and problems you have to the therapists.

STATE OF FLORIDA: Department of Health and Rehabilitative Services  
TO REPORT ABUSE, NEGLECT, OR EXPLOIAIOTN PLEASE CALL TOLL-FREE 1-(800)-96-ABUSE  
THIS SERVICE IS AVAIABLABE 24 HOURS A DAY 7 DAYS A WEEK

I understand my Bill of Rights and have received a copy of it.

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SIGNATURE OF CLIENT/CLIENT REPRESENTATIVE

\_\_\_\_\_  
DATE