NOTICE OF PRIVACY PRACTICES - *Patient Copy*

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 14 April 2008, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and applicable law permits the terms of this Notice at any time, provided such changes. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. Wright Physical Therapy utilizes an open treatment facility. It is possible that while under our care an unauthorized individual may have access to your protected health information via overheard verbal communications. We will do everything possible to protect your rights to privacy and confidentiality. During your care we also ask that you sign in each visit, subsequent patients will have the opportunity to read the names of those signed in before them.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an

opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose, to authorized federal officials, health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $ .10 (ten cents) for each page, $15.00 (Fifteen dollars) per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communications: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **(You must make your request in writing.)** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.
Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please request a complaint form or contact

us:

PATIENT INFORMATION

Evaluation Date: _____ Physical Therapist Initials: _____

Patient Last Name: _____ First: _____ Home Phone: ( ) _____ - _____

Address: _____ Work Phone: ( ) _____ - _____

City: _____ State: _____ Zip: _____ Cell Phone: ( ) _____-_____

E-Mail Address: _____

Whom may we contact in an Emergency: _____ Relation: _____

Address: _____ Phone: _____

Nearest Relative Not Living With You: _____ Relation: _____

Address: _____ Phone: _____

Birth Date: _____ Social Security Number: _____ -_____ - _____ Sex: M ☐ F ☐

Do you work Full/Part Time? _____ Are you a Student? _____ Marital Status: M S D W

Date of last Physician Visit: _____ Referring Physician: _____ Primary Care Provider: _____

Was this an Auto Accident? Y N Work Accident? Y N Date of Accident: _____ Attorney: _____

Tell us about your injury: _____

Diagnosis: _____ Code: _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR CLINIC? (Check all that apply)

☐Attorney ☐Billboard/Sign ☐Doctor ☐Insurance Provider ☐Newspaper ☐Phone Book ☐Radio
☐Return Patient ☐Television ☐Website ☐Family/Friend/Self ☐Other:____

RESPONSIBLE PARTY

Responsible Party Name or Business Name: _____ Phone: ( ) _____ - _____

Address: _____ City: _____ State: _____ Zip: _____ Relation to Patient: _____

Insured Party's Social Security Number: _____ - _____ - _____ Insured Party's Birth Date: _____ - _____ - _____

RESPONSIBLE PARTY EMPLOYER

Employer Name: _____ Phone: ( ) _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

PATIENT OR SPOUSE EMPLOYER

Employer Name: _____ Phone: ( ) _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Wright
PHYSICAL THERAPY
JOINT • SPINE • SPORT

Thank you for choosing Wright Physical Therapy. We look forward to helping you meet your rehabilitation needs. To help us serve you more efficiently, please read, sign, and date in the designated areas.

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Wright Physical Therapy to furnish medical care and treatment to ➔_____ as considered necessary and proper in diagnosing or treating his/her physical and mental condition.

➔Patient/Guardian_____Date_____

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, undersigned, do hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers to Wright Physical Therapy. A photocopy of the assignment is to be considered as valid as the original. I, the undersigned, do hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

➔Patient/Guardian_____Date_____

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered unless prior arrangements have been made. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. Any unpaid balance after the first 30 calendar days of treatment accrues 1.5% interest each month thereafter. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes and internal usual and customary fee schedule, you will be responsible for the remaining difference.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to Wright Physical Therapy.

The above does not apply for those patients that are treated under Worker's Compensation. However, be advised that if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

I understand and agree that my account if paid within 90 days of my discharge will be interest free, after 90 days my account will be subject to a 12% interest (APR). If I fail to make any payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

ESTIMATED INSURANCE BENEFIT:_____

Estimated patient payment/co-payment:_____

Arrangement for payment of patient's share:_____

NOTE: Estimated coverage information is provided as a courtesy to our patient, but is not intended to release them from total responsibility for their account balance.

The above information has been read and explained to me.
I UNDERSTAND MY FULL RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____ _____

➔Patient/ Guardian/ Responsible Party **Date**

_____ _____

Wright Physical Therapy Representative/ Witness Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

	Check Yes or No ↓		Then Initial ↓
A. I was given a copy of Wright Physical Therapy's Notice of Privacy Practices.	☐YES	☐NO	Initial _____←
B. I agree to the open treatment area used by Wright Physical Therapy.	☐YES	☐NO	Initial _____←
C. I agree that, due to this open format, unauthorized individuals may have the opportunity to learn of my protected health information. (By this we mean others may see you in the clinic but we will not share your information with anyone.)	☐YES	☐NO	Initial _____←
D. I agree, that if necessary, I may be treated in a private treatment area. Otherwise I will be treated in the open treatment area.	☐YES	☐NO	Initial _____←
E. I agree that PT/PTA students may participate in my physical therapy care.	☐YES	☐NO	Initial _____←
F. I agree that I must sign a sign-in sheet at each visit and I understand that subsequent visitors have the opportunity to read my name.	☐YES	☐NO	Initial _____←
G. I authorize Wright Physical Therapy and its employees to call me at my home with regards to my health status	☐YES	☐NO	Initial _____←

→_____ →_____ →_____

Signature Please Print Name Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign
____ Communications barriers prohibited obtaining the acknowledgement
____ Emergency situation prevented us from obtaining acknowledgement
____ Other (Please Specify) _____

_____ _____ _____

Signature Wright Physical Therapy Representative Please Print Name Date

PATIENT MEDICAL HISTORY

Name: _____ Family Physician:_____

Date of 1st MD visit for this injury: _____ Referring Physician: _____

Is an Attorney involved in this case? YES NO
Have you had surgery for this injury? YES NO
Type of Surgery: _____Date: _____

Please list all prescription and non-prescription medication you are currently taking:

Please check and date any of the following Medical services for *this* Injury/Episode:

- ☐ Orthopedist _____
- ☐ Neurologist_____
- ☐ General Practitioner _____
- ☐ Physical Therapist _____
- ☐ Podiatrist _____
- ☐ Occupational Therapist _____
- ☐ Chiropractor _____
- ☐ Other _____
- ☐ X-Rays _____
- ☐ MRI _____
- ☐ CT Scan _____
- ☐ Emergency Room Care _____
- ☐ EMG / NCV _____
- ☐ Myelogram _____
- ☐ Massage Therapy _____

Do you now have or have you ever had any of the following:

- ☐ Asthma, Bronchitis, or Emphysema
- ☐ Shortness of Breath
- ☐ Chest Pain / Angina
- ☐ Coronary Heart Disease
- ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ Heart Attack or Heart Surgery
- ☐ CVA (Stroke) / TIA (Mini Stroke)
- ☐ Blood Clot / Emboli
- ☐ Epilepsy / Seizures
- ☐ Thyroid Dysfunction / Goiter
- ☐ Anemia
- ☐ Infectious Diseases
- ☐ Diabetes
- ☐ Cancer / Chemotherapy / Radiation
- ☐ Arthritis / Swollen Joints
- ☐ Osteoporosis
- ☐ Gout
- ☐ Sleep Disorders
- ☐ Emotional / Psychological Problems
- ☐ Bowel and/or Bladder Dysfunction
- ☐ Severe or Frequent Headaches
- ☐ Vision or Hearing Difficulties
- ☐ Dizziness or Fainting
- ☐ Numbness or Tingling
- ☐ Weakness
- ☐ Unexplained Weight or Energy Loss
- ☐ Hernia
- ☐ Varicose Veins
- ☐ Allergies
- ☐ Any Pins or Metal Implants
- ☐ Joint replacement
- ☐ Neck Injury / Surgery
- ☐ Shoulder Injury / Surgery
- ☐ Elbow / Hand Injury / Surgery
- ☐ Back Injury / Surgery
- ☐ Knee Injury / Surgery
- ☐ Leg / Ankle / Foot Injury/ Surgery
- ☐ Are you Pregnant?
- ☐ Do you Smoke?

Please provide us with any other information that would assist us in your care: _____

What are your expectations while in this program? _____

➔**Patient / Guardian Signature: _____Date: _____**

Patient Attendance Policy

Attendance to Physical Therapy is important to your recovery. We take it seriously and want you to as well.

- If you are sick, please call by 9 A.M. to avoid a $20 reschedule fee.
- If you need to change or miss an appointment, please give a 24-hour notice to avoid a $20 reschedule fee.
- If you are late for your appointment, it may be shortened or cancelled at our discretion.

Thank you for actively participating in your care.

Please sign that you have read and understand our Attendance Policy. A copy of this policy is available upon request.

Patient Signature

Wright Physical Therapy Witness Signature